

**COMPOSURE Behaviours of Advanced Beginner Nurses and their Effects
on the Wellness Outcome among Selected Orthopaedic Patients:
Basis for Action Plans**

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APPROVAL SHEET

In partial fulfilment of the requirements for the Degree of Doctor of Nursing Management, this dissertation entitled “**COMPOSURE BEHAVIOURS OF ADVANCED BEGINNER NURSES AND THEIR EFFECTS ON THE WELLNESS OUTCOME AMONG SELECTED ORTHOPAEDIC PATIENTS: BASIS FOR ACTION PLANS**” has been prepared and submitted by **Mrs. Bea-Gracia M. Cruz**, who is hereby recommended for Oral Examination.

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DEDICATION

*In loving memory of my Father and Mother,
Who always believed in me and told me that God will
always give my heart's desire by keeping the faith.*

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THESIS ABSTRACT

**Title : COMPOSURE Behaviours of Advanced
Beginner Nurses and their Effects on the
Wellness Outcome among Selected Orthopaedic
Patients: Basis for Action Plans**

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The study determined the effects of the COMPOSURE behaviours of advanced beginner nurses on the wellness outcome among selected orthopaedic patients and used quasi-experimental 2-group pretest posttest design.

There were 12 advanced beginner nurse participants that attended the COMPOSURE behaviours and there were 25 selected orthopaedic patients in each group for a total of 50 patients as respondents.

The data were statistically treated using the frequency distribution and percentages, Pearson r and chi square test, t-test, and ANOVA.

Findings, Conclusions and Recommendations

Generally, the age of the orthopaedic patients were found out mostly belong to the age group of 60 – 64 years old. Majority of the respondents were male and mostly are Catholics.

Majority of the respondents have normal vital signs. Most of the patients experience pain on a scale of scale of 1 – 2. The majority of the respondents have above normal level of red blood cells. Likewise, the white blood cells, eosinophils, monocytes, platelet counts, MCV, MCH, and MCHC of the respondents are mostly have a normal level. However, majority of the respondents have below normal level of lymphocytes, haemoglobin, and hematocrit.

In terms of the COMPOSURE behaviours of advanced beginner nurses: The advanced beginner nurses manifest good interpersonal and communication skills in dealing with patients and able to extract significant information to aid in planning and delivery of effective nursing care. However, they rarely develops health education plan based on the assessed and anticipated needs of the patients.

It also revealed that advanced beginner nurses always allows some moment of silence. But they rarely pray with the patients.

Indeed, they often establish the purpose of the interaction and often display interest to the patient. Moreover, they sometimes spend time with patient even in silence.

The advanced beginner nurses often create an environment of trust and rapport. On the other hand, they sometimes listen attentively to patient.

Likewise, the advanced beginner nurses always tell patient what he can do, what he is suppose to do, and how to do it. More so, they often encourage patient to evaluate his action.

The advanced beginner nurses to often encourage the patient to feel comfortable in the nurse-patient relationship. More so, they often clarify the message through the use of question and feedback.

The advanced beginner nurses always call the patient by his/her preferred name and utilize “po” and “opo” when being asked and they also provide options before making decisions.

They always evaluate and document the patient’s response to the intervention, observe his/her breathing, and ask if he/she is feeling relaxed yet they sometimes take note of facial expression and unnecessary body movements.

It also shows that they always encourage expression of feelings; focus on verbal and nonverbal behaviour and they often provide continuous feedback.

In terms of the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses:

In particular, the highest mean in terms of physical **before** the COMPOSURE behaviours of the advanced beginner nurses was the patient feels bone pain on the affected area when she/he perform physical activities. However, the lowest mean among them is the patient can walk without difficulty. **After** the COMPOSURE behaviours of advanced beginner nurses, the physical biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was the patients exercise every day and they feel rested when they wake up in the morning. Nevertheless, the lowest mean among them is the patient can walk without difficulty.

The highest mean among the intellectual biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour was the patients know that fruits and vegetables should always be part of their daily diet. Nonetheless, the lowest mean is that they are alert and aware of what is happening around them. **After** the COMPOSURE behaviours of advanced beginner nurses, the intellectual biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was the patients know exercise is good for their bones. Although the lowest mean among them is they are alert and aware of what is happening around them.

In addition, the highest mean among the emotional biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour is they know how to relax at the end of the day. On the other hand, the lowest mean is they get angry easily. **After** the COMPOSURE behaviors of advanced beginner nurses, the emotional biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was they love and take care of their selves, they do not care about others especially if it do not affect them and their values guide their daily life. The lowest mean among them is they get angry easily.

As for the highest mean among the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour is they leave to God what they cannot take or change. However, the lowest mean is they reflect on their personal life and how they affect others. **After** the COMPOSURE behaviors of advanced beginner nurses, the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was they leave to God what they cannot take or change. Still, the lowest mean among them is they reflect on their personal life and how they affect others and they are all connected with people and surroundings.

In terms of the significant relationship between demographic profile and physiologic wellness outcome of orthopaedic patients: there is a significant relationship between the demographic profile and physiologic wellness outcome of

orthopaedic patients specifically their red blood cells and their mean corpuscular haemoglobin concentration or MCHC.

In terms of the significant relationship between demographic profile and biobehavioral wellness outcome of orthopaedic patients: In particular, **before** the COMPOSURE behaviours of advanced beginner nurses, age and biobehavioral wellness outcome of selected orthopaedic patients has a significant relationship. However, gender and religion shown otherwise. Likewise, **after** COMPOSURE behaviour, age and biobehavioral wellness outcome of selected orthopaedic patients has a significant relationship. However, gender and religion shown otherwise.

In terms of the significant difference in the physiologic wellness outcome of orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses: Furthermore, there is a significant difference in the physiologic wellness outcome, specifically the red blood cells, of orthopaedic patients **before** and **after** the COMPOSURE behaviours of advanced beginner nurses. However, most of the physiologic wellness outcome shows otherwise.

In terms of the significant difference in the demographic profile to wellness outcome of the selected orthopaedic patients: On the other hand, there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their **age before** COMPOSURE behaviours of

advanced beginner nurses. Furthermore, there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their **gender before** COMPOSURE behaviours of advanced beginner nurses.

There is **a significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **religion BEFORE** COMPOSURE behaviours of advanced beginner nurses. More so, there is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **age after** COMPOSURE behaviours of advanced beginner nurses.

Again, there is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **gender after** COMPOSURE behaviours of advanced beginner nurses.

There is **a significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **religion AFTER** COMPOSURE behaviours of advanced beginner nurses.

In terms of the significant difference among the two groups in the wellness outcome before and after the COMPOSURE behaviours of advanced beginner nurses: Thus, there is **no significant difference** on biobehavioral wellness outcome of the selected orthopaedic patients when grouped according to their

physical aspect **before** and **after** COMPOSURE behaviours of advanced beginner nurses.

There is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **intellectual** aspect **before** and **after** COMPOSURE behaviours of advanced beginner nurses.

There is **no significant difference** on biobehavioral wellness outcome of the selected orthopaedic patients when grouped according to their **emotional** aspect **before** and **after** COMPOSURE behaviours of advanced beginner nurses.

There is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their spiritual aspect **before** and **after** COMPOSURE behaviours of advanced beginner nurses.

In the light of the findings and conclusions of the study, the researcher offers the following recommendations:

1. Most of the respondents are elderlies that are prone for a fracture because of fall, may it be in households or occupation-related hazards, both for men and women. In response to this, the researcher may suggest that households, working areas and establishment may become oriented with fall prevention practices.

2. The results of the blood examinations showed that most of them had below normal level of lymphocytes, haemoglobin, and hematocrit which can be addressed by strengthening nutritional support for patients with fracture in a hospital and/or home setting to prevent nutritional deficiencies to speed up bone recovery. Malnutrition is common in the hospitalized elderly with hip fractures and has been linked to poorer recovery and increased complications.
3. Nurses may learn how to develop health education plan based on the assessed and anticipated needs of the patients. This may contain the following: Precautions before and after surgery, surgery preparation, medications before and after surgery, pain management, positioning before and after surgery, exercises before and after surgery, expectation during hospital stay, expectation during rehabilitation, everyday activity after surgery, and nutritional build up guides.
4. It is highly recommended to implement prayer schedules (i.e., 3 o' clock habit) as often as possible all throughout the hospital via paging system. It will be very helpful also if there is a consistent schedule for a chaplain services or pastoral care that patients can avail anytime. Moreover, when a patient asks to pray, it is highly recommended for the nurse to recommend talking with patients to determine their prayer preference before starting to

pray. Some patients will want to pray silently. Some patients will want the nurse to be present while they say a prayer out loud. Others will want the nurse to lead them in prayer. Some will want to pray now, others may want the nurse to keep them in their prayers.

5. It will be very helpful to provide training for nurses on how to listen attentively to patients such as active listening and focusing which will be very helpful both for patients and nurses.
6. Rehabilitation protocol is highly suggested to be strengthened as part of the routine care for the patients to promote speed recovery. This may include orthopaedic surgeons, registered nurses, physiotherapists, physical therapists, and occupational therapists.
7. Anger management, emotional support and/or referral to psychiatrists may be beneficial for the improvement of patients' mental health status. Apparently, fracture can be a life-changing event that often leads to depression, sadness, hopelessness and fear of the unknown. Support systems from family, friends, and health care professionals can be of great value at this moment.
8. To strengthen pain management protocol. This may include pain as part of their vital signs and may be monitored concurrent with other parameters

every 4 hours. This intervention may highly increase the feeling of comfort to the patients.

9. Apparently, fracture is a life-changing event to patients that require them to have spiritual care available when needed.
10. Last but the least, it is highly suggested to conduct a similar study utilizing different research method and bigger sample of respondents from different nursing specialty to generate new knowledge for nursing profession.

Chapter 1

THE PROBLEMS AND ITS BACKGROUND

Introduction

What does it really take for a patient to be well? In reality, nurses' behaviours affect the patient's wellness in a tremendous way. The frequent question is, in what way and how exactly? Large amount of documents and literatures stated that nursing interventions such as medication administration and the like can really save lives. No question with that. But how about if the nurse will give medicine AND prayer with mixture of open-mindedness, stimulation, understanding, relaxation, and empathy? Will it makes a difference?

According to Association of Deans of Philippine Colleges of Nursing (ADPCN) 2008, stated that nursing is a dynamic discipline. It is an art and a science of caring for individuals, families, groups, and communities geared toward promotion and restoration of health, prevention of illness, alleviation of suffering and assisting clients to face death with dignity and peace. It is focused on assisting the client as he or she responds to health-illness situations, utilizing the nursing process and guided by ethico-legal moral principles.

In a nutshell, patient wellness outcome can only be achieved through holistic care. Nursing is a dynamic way used to show how we care for others. It is

an essential field that delivers optimum quality care for the patients. Without nurses, patients' conditions will not be monitored and quality nursing care will not be possible.

Moreover, **Harper et al (2007)** stated that attitudes of nurses caring for orthopaedic patients affect the quality of care provided. A recent research on positive and negative attitudes of such nurses has shown that knowledge deficits shape most of the negative attitudes. The cultural background of nurses also has an influence on the attitudes and there are reports of nurse's disagreements with patients' self-report, especially in pain assessment.

Background of the Study

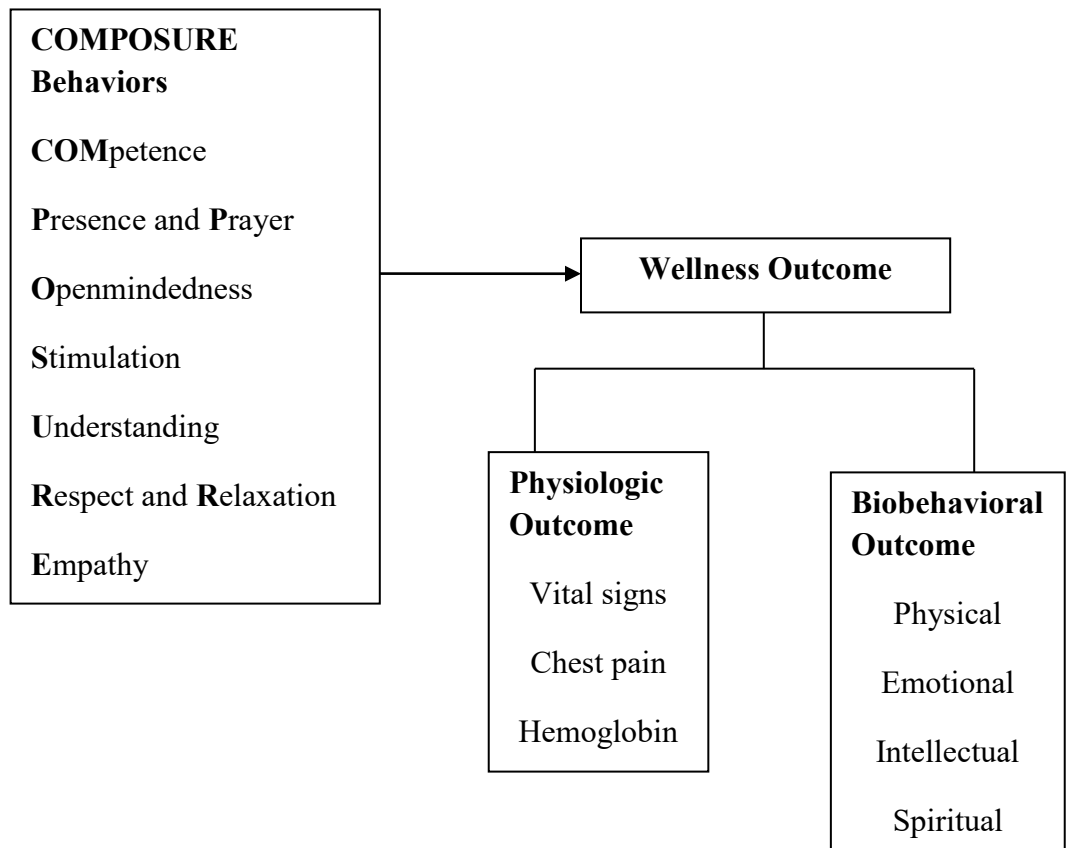
Caring has been considered as the essence of nursing. It is also believed that caring enhances patients' health and well-being and facilitates health promotion (**Khademian & Vizesfar, 2008**). Giving different interventions to patients do enhance their health but together with care, it boosts their self-assurance to get better therefore facilitating health promotion.

In the Philippine setting, especially for orthopaedic patients, there is an increase incidence of motor vehicular accidents. Indeed, orthopaedic patients have a lot of different needs.

Together with this situation and the desire of the researcher to test the applicability of COMPOSURE behaviour theory (Divinagracia, 2001) in a different clinical condition thus this undertaking is being pursued.

Theoretical Framework

This study is anchored on Dr. Carmelita C. Divinagracia's Theory of COMPOSURE Behaviors. She is a Filipino nurse specialist, described a set of nursing behaviours known as the COMPOSURE behaviours such as written below:



Divinagracia (2001) conducted a study to determine the effects of COMPOSURE behaviours of the advanced practitioner on the recovery of selected

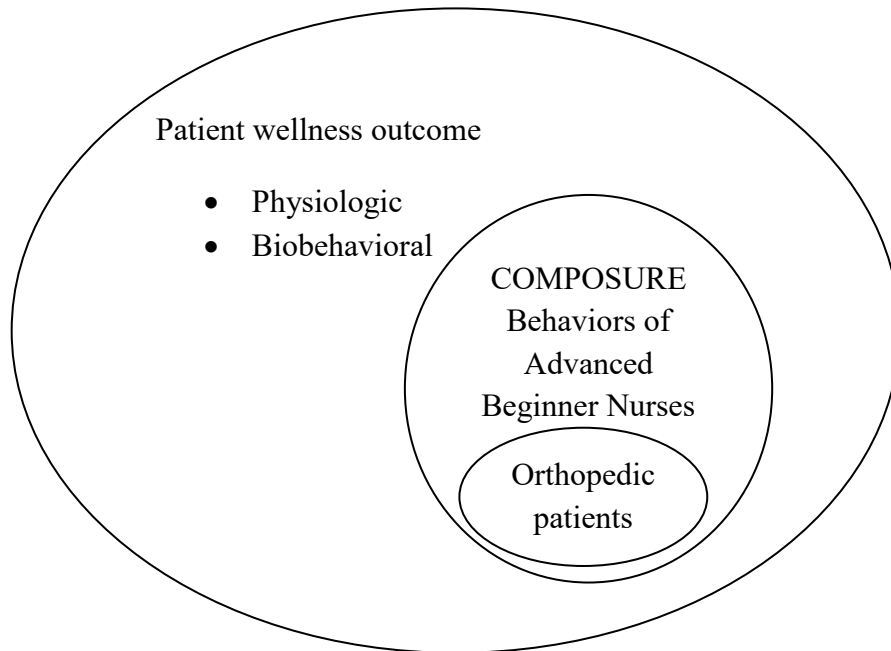
patients at the Philippine Heart Center. Behaviours include competence, presence and prayer, open-mindedness, understanding, respect, and empathy.

Competence is an in depth knowledge and clinical expertise demonstrated in caring for patients. Presence and prayer is a form of nursing measure which means being with another person during times of need. This includes therapeutic communication, active listening, and touch. It is also a form of nursing measure which is demonstrated through reciting a prayer with the patient and concretized through the nurse's personal relationship and faith in God. Open-mindedness is a form of nursing measure which means being receptive to new ideas or to reason. It conveys a manner of considering patient's preferences and opinions related to his current health condition and practices and demonstrate the flexibility of the nurse to accommodate patient's views. Moreover, stimulation is a form of nursing measure demonstrated by means of providing encouragement that conveys hope and strength, guidance in the form of giving explanation and supervision when doing certain procedures to patient, use of complimentary words or praise and smile whenever appropriate. Appreciation of what patient can do is reinforced through positive encouraging remarks and this is done with kind and approving behavioural approach. Understanding, according to her conveys interest and acceptance not only of patient's condition but also his entire being. This is manifested through concerned and affable facial approach; this is a way of making the patient feel important and unique. Respect is acknowledging the

patient's presence. Use of preferred naming in addressing the patient, po and opo, is a sign of positive regard. It is also shown through respectful nods and recognition of the patient as someone important. Relaxation entails a form of exercise that involves alternate tension and relaxation of selected group of muscles. And lastly, empathy senses accurately other person's inner experience. The empathic nurse perceives the current positive thought and feelings and communicates by putting himself in the patient's place. Through the COMPOSURE behaviours of the nurse, holism is guaranteed to the patient.

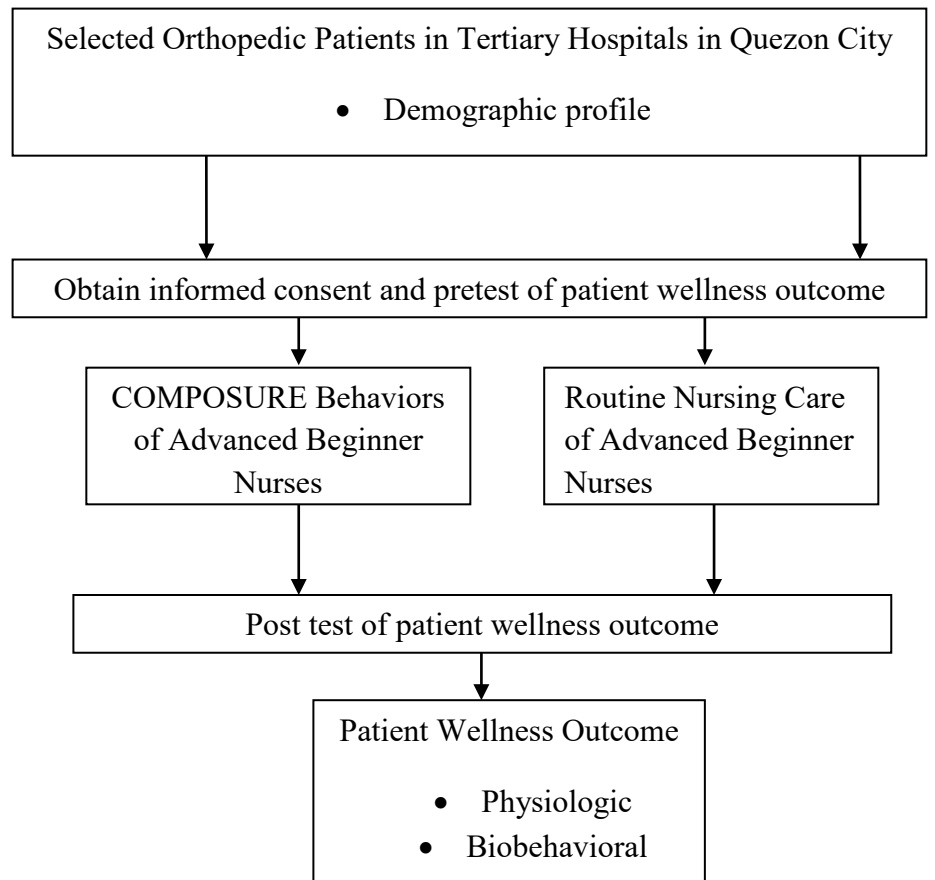
Furthermore, **Divinagracia (2001)** stated that nursing is a profession that surpasses time and aspects of the individual as one of its clients. From the time the nurse admits a patient to the time of his discharge, the nurse's presence becomes a meaningful occasion for the two parties to develop mutual trust, acceptance, and eventually satisfying relationships.

Conceptual Framework



This framework represents the orthopaedic patients, COMPOSURE behaviours of novice nurses, and the patient wellness outcome such as physiologic and biobehavioral. The innermost part of the oval is the orthopaedic patients. Being the recipient of care, they are being influenced by many factors and one of those are the behaviours of nurses in implementing quality nursing care. As the COMPOSURE behaviours of novice nurses envelopes the orthopaedic patients as shown above, the researcher believe that there will be an essential improvement in the patient wellness outcome, may it be on physiologic and/or biobehavioral wellness outcome.

Research Paradigm



The research paradigm shows the flow of the different areas to be explored in the study. The four principal areas, namely, the selected orthopaedic patients, COMPOSURE behaviours of advanced beginner nurses, routine nursing care, and the patient wellness outcome are to be looked deeply by the researcher by adding the profile variables of the patients and the given set of nursing care. The significant differences and relationships made the study more comprehensive.

Statement of the Problem

This study aims to determine the effect of the COMPOSURE behaviours of advanced beginner nurses on the wellness outcome among selected orthopaedic patients.

Specifically, it answers to the following questions:

1. What is the demographic profile of the orthopaedic patients in terms of:
 - 1.1 age,
 - 1.2 gender, and
 - 1.3 religion?
2. What is the physiologic wellness outcome of selected orthopaedic patients in terms of:
 - 2.1 vital signs,
 - 2.2 bone pain sensation, and
 - 2.3 complete blood count?
3. What is the COMPOSURE behaviours of advanced beginner nurses in terms of:
 - 3.1 competence,
 - 3.2 presence and prayer,
 - 3.3 open-mindedness,
 - 3.4 stimulation,

3.5 understanding,

3.6 respect and relaxation, and

3.7 empathy?

4. What is the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses?
5. Is there a significant relationship between demographic profile and physiologic wellness outcome of orthopaedic patients?
6. Is there a significant relationship between demographic profile and biobehavioral wellness outcome of orthopaedic patients?
7. Is there a significant difference in the physiologic wellness outcome of orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses?
8. Is there a significant difference in the demographic profile to wellness outcome of the selected orthopaedic patients?
9. Is there a significant difference among the two groups in the wellness outcome before and after the COMPOSURE behaviours of advanced beginner nurses?
10. Based from the results of the study, what action plans can be proposed?

Hypotheses

1. There is no significant relationship between demographic profile and physiologic wellness outcome of orthopaedic patients.
2. There is no significant relationship between demographic profile and biobehavioral wellness outcome of orthopaedic patients.
3. There is no significant difference in the physiologic wellness outcome of orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses.
4. There is no significant difference in the demographic profile to wellness outcome of the selected orthopaedic patients.
5. There is no significant difference among the two groups in the wellness outcome before and after the COMPOSURE behaviours of advanced beginner nurses.

Significance of the Study

This dissertation is important to discern the effect of the COMPOSURE behaviours of advanced beginner nurses on the wellness outcome among selected

orthopaedic patients. This new knowledge can aid us in enhancing nursing care to promote health.

- To the orthopaedic patients, this can be one factor for their fast recovery and rehabilitation and helps them to return to their usual routine in life.
- To the nursing community, this can help us to enhance our nursing care interventions and behaviours to provide quality care that can increase the wellness outcome of our patients.
- To the future researchers, this can support and benefit them as their guide. This can also be utilized as a basis for further study about the topic related to patient wellness outcome and COMPOSURE behaviours of nurses.

Scope and Delimitation

The study focused on the effect of COMPOSURE behaviours of advanced beginner nurses on the patient wellness outcome of selected orthopaedic patients of two tertiary hospitals in Quezon City to see if they have some degree of relationship and difference to their profile variable considered in this study.

The inclusions of this study focused on those with fracture without complications, male or female. Patients with tubes (i.e., endotracheal,

tracheostomy, and chest tubes), as well as those patients with difficulty in communicating and has hearing problem will be excluded.

The respondents of this study were the orthopaedic patients while the participants were the trained research assistants who observed our advanced beginner nurses.

The study adapted the 40-item patient wellness status assessment tool of Dr. Divinagracia's COMPOSURE Theory but modified some items to suit the kind of patients under study and made some revisions on format of the likert scale.

Definition of Terms

COMPOSURE behaviours – this refers to the model for patient care created by Dr. Carmelita C. Divinagracia which consist of competence, prayer and presence, open-mindedness, stimulation, understanding, respect and relaxation, and empathy.

Demographic profile of selected orthopaedic patients – this refers to their age, gender, and religion

Advanced beginner Nurses – this refers to BSN graduate, Registered Nurse with 1 - 3 clinical experience in an orthopaedic unit or hospital.

Orthopaedic patient – this refers to those patients, male or female, who has fracture without complications.

Patient wellness outcome – this refers to the perceived wellness of selected orthopaedic patients after receiving nursing care in terms of physiologic and biobehavioral.

Physiologic wellness outcome – this refers to the perceived wellness of selected orthopaedic patients after receiving nursing care in terms of vital signs, bone pain sensation, and complete blood count

Biobehavioral wellness outcome – this refers to the perceived wellness of selected orthopaedic patients after receiving nursing care in terms physical, intellectual, emotional, and spiritual.

Chapter 2

Review of Related Literatures and Studies

This chapter contains various articles, studies, and facts that give additional knowledge relevant in the conduct of this study. The researchers find this section as an important part of every thesis because it inculcates learning to the readers. Also, included here is the framework of the study and definition of terms.

Local Literature

Orthopaedic Nursing in the Philippines

In order to become a competent Orthopedic Nurse, one must attain the knowledge, skills and attitude of an Orthopedic Nurse. Thus, an orthopaedic nurse must be able to cater the needs of the surgical team (pre and post op care), the patient and the patient's relative all at the same time.

Nurse Directory (2012) stated that orthopaedic nurses are nurses who specialized in the treatment, care and prevention of people with musculoskeletal disorders or muscle and bone problems. These musculoskeletal problems typically included bone fractures, joint displacements, back pains, Arthritis/

rheumatism, congenital malformations, musculoskeletal injuries and chronic disorders such as bone density losses.

These musculoskeletal disorders require specialized treatment and procedural skills that Orthopaedic nurses must be knowledgeable. These skills include continuous passive motion therapy, which involves the constant but controlled motion of a joint using a CPM device for rehabilitation; casting/splinting or the encasing of a limb or body to keep broken bones together while healing; and external fixation or the surgical procedure in which holes are drilled and bolts/wires are used to align the bones when healing.

An orthopedic nurse is a registered nurse that undergoes special certification training and exams for the practice of orthopedic nursing. The certification is a proof of one's proficiency and specialty. They may work in an ER department and operating rooms of a hospital or in nursing facilities where patients are recovering. Because of the additional training and specialization of an orthopedic nurse, their salary prospects apparently average higher than ordinary registered nurses.

Orthopedic nursing is a demanding expertise that requires physical strength, patience, and flexibility to adjust to different patients, who are often in a frustrating disposition in coping with their newly acquired disabilities and

limitations. Hence, the need to empathetic and gentle, yet rigid when necessary is a enviable quality. Orthopedic nurses may sometimes need to encourage patients repeatedly to push them to work hard through pain in order to attain their wellness goals. While this may be difficult and stressful, patients who are able to get through the pain and successfully reach their wellness goals is the most rewarding experience in this specialized field.

Reyes, M.A. (2012) stated that the Department of Health (DOH) has announced it will bid out the construction of the new Philippine Orthopedic Center next month under the PPP. The modernization program is expected to cost P5.6 billion and was approved by the National Economic and Development Authority (NEDA) last week.

The winning bidder, according to the DOH, will be awarded a 25-year lease contract.

A feasibility study conducted by international consultancy firm Deloitte Touche has shown that the project will be self-sustaining beginning on the fifth year of operations.

Aside from the MPIC hospital group, other parties have also expressed interest in bidding for the project.

The new 700-bed orthopedic center will be built adjacent to the Philippine Heart Center and the Philippine Lung Center on East Ave. in Quezon City. At present, it is located along Banawe St. also in QC. The old facility will be converted into rehabilitation and prosthesis manufacturing centers.

The DOH said 70 percent of the capacity will be for use of Philhealth members and indigents while the rest will be for paying patients.

Aside from the orthopedic hospital, the DOH is also looking at the modernization of 25 other hospitals, including eight cancer centers, department officials said.

MPIC is in talks with a number of Quezon City and Manila-based hospitals for possible acquisition or investments, as the country's biggest hospital group continues to expand its chain of institutions.

Umil, A.M. (2012) stated where will the poor go once government hospitals are privatized through outright sale, corporatization, or public-private partnerships?

Health workers and patients of public hospitals staged the nationally-coordinated mass protest action to denounce the privatization of public hospitals and health services by the administration of President Benigno S. Aquino III.

A new orthopedic hospital will be constructed in the National Kidney and Transplant Institute (NKTI) Complex in East Avenue, Quezon City. About 80 to 90 percent of indigent patients will be displaced if the POC's sale will push through. According to news reports, business tycoon Manny V. Pangilinan is the buyer of Philippine Orthopedic Center (POC). Pangilinan has also invested in the Makati Medical Center and sits as chairman of the Makati Medical Center Foundation; he also signed a memorandum of agreement with the Rizal Medical Center for the hospital's privatization.

The POC is also the major referral center for spinal injuries in the country and the only hospital that offers rehabilitation services with minimal fees.

Corporatization of public hospitals would also result to crippling debts, due to the decreasing national government subsidy for these hospitals.

Health workers strongly oppose the said bills because it endangers not only the lives of poor sick people but also the security of tenure of government health workers. They decried the threat of massive streamlining once government hospitals are privatized. Once privatized, the hospital's operation and maintenance will be outsourced and contractualized. Examples of outsourced services are: janitorial, dietary, and security services.

According to **St. Luke's Medical Center (2012)**, the Institute of Orthopedics and Sports Medicine was founded to bring first-world orthopedic care to the Philippines. The Institute performs all relevant services for clinical and surgical procedures complemented by specialized equipment and facilities. Its Specialized Orthopedic Care Unit is equipped with a circular bed, Stryker bed for spine trauma cases, and a wide range of traction equipment and various bed frame devices. The Institute's Sports Medicine and Rehabilitation Section, the first hospital-based sports medicine unit in the country, boasts of having performed the most number of successful arthroscopic-assisted surgeries in the Philippines, many of which were for the country's top athletes.

The Spine section has been the trailblazer in spine surgery not only in the country but in the region as well. In 1993, its "Awake Anesthesia" program introduced the Minimally Invasive Spine Surgery using Microscopic Decompression for Lumbar Degenerative conditions such as Slipped Disc and Spinal Stenosis; the procedure was performed either progressive, local or epidural or a combination of all three. It was the first to use Intra-operative Spinal Cord Monitoring for spinal surgery especially Scoliosis Surgery in 1991, Image Guided Surgery for Spine Instrumentation in 2004, and performed the First Total Disc Replacement in 2005.

In addition to Spine, Trauma and Sports Medicine, the Institute also offers its expertise in Adult Orthopedics, Musculoskeletal Tumors, Adult Joint Reconstruction, Pediatric Orthopedics, and Hand and Microsurgery. It also offers the latest technology in limb lengthening and straightening through Fitbone technology.

The St. Luke's Bone Bank (SLBB) is also an addition to the Institute of Orthopedics and Sports Medicine's commitment to provide optimum medical care in the field of reconstructive orthopedics. The St. Luke's Bone Bank (SLBB) is the country's first such facility in a private hospital setting.

Bone Growth, Formation and Maintenance

Human bones are strongest after puberty until before the age of 40. Bones are not fully formed yet during puberty, thus allowing an individual to grow in height as well as length. A long bone has a rounded end referred to as the epiphysis, where new bone is formed. While one's bones are more flexible during puberty, they are relatively weaker due to the presence of epiphyses, which are cartilaginous in nature. After the age of 40, bones tend to become less flexible and more brittle due, respectively, to demineralization (the loss of calcium and other

essential minerals) and to the loss of collagen fibers that give bone its tensile strength.

Statistically, between the ages of 6 years and 40, males get more fractures than females. It is supposed that this is because males tend to engage in more dangerous work and physical activity than females do.

Some diseases can cause bones to become weak and thus become more susceptible to fractures. These diseases can be metabolic, infectious, or neoplastic in nature and they can affect a bone's structural integrity. A break caused by such a disease is called a pathological fracture.

A fracture that would normally occur when muscles are tense may not occur when the muscles are relaxed. Bones have a certain degree of flexibility to them, but when their surrounding muscles are tense, bones become rigid. **(Bonifacio, V. M., 2010)**

Physiologic changes of the musculoskeletal system with aging are as follows: (1) connective tissues lose some of their elasticity and resilience, especially the articular cartilage of the joints and the intervertebral discs of the spine, (2) muscles lose bulk, tone and strength as amount of physical activity decreases, (3) bone resorption takes place more rapidly than bone growth; especially in postmenopausal women, calcium is lost from the bone, (4) the

shoulders may become stooped and narrower, (5) the knees and hips may be slightly flexed when standing or walking, often because of pain associated with joint degeneration, (6) posture becomes stooped as the body attempts to compensate for changes in the center of gravity, (7) height decreases by 6 to 10 centimere because the vertebrae loss bone density, and (8) gait may become unsteady because of loss of muscle strength and coordination and the individual is more subject to falls. (**Udan, J.Q., 2009**)

COMPOSURE Behaviors

According to **Gopez, J.D. (2012)**, The Department of Health (DOH) has officially launched a program called “DOH Nursing Certification Program (NCP)” in Manila. The ceremonies were lead by Health Secretary Enrique Ona. The NCP is a certification system. It is a program that aims to develop and improve the competency and the skills of Filipino Nurses. According to Secretary Ona, the launch of the program will be the first one ever in the history of the Department of Health. It is a program that shall strengthen the theoretic knowledge and clinical skills of nurses in specific areas of nursing practice.

The NCP will be supervised directly by the DOH. It adopts a level-progression scheme towards certification of competencies across the different

clinical areas. The standards and the performance criteria are established by the DOH and are used across all DOH hospitals. The NCP provides a criteria and a framework for higher level performance of nurses, using specific behaviors identified for each level and area as performance standards; all the whilst providing a mechanism for progressing to one level of expertise to another. A Certification of Competency shall be awarded to a nurse who has satisfactorily satisfied the criteria and standards for each level.

Specialty Programs are assigned to select DOH specialty hospitals which will develop Level III, IV and V competencies of nurses. List of Specialty Programs under NCP with their respective Heads:

1. Cardiovascular Nursing – Philippine Heart Center
2. Renal Nursing – National Kidney and Transplant Institute
3. Pediatric Nursing – Philippine’s Children Medical Center and National Children’s Hospital
4. Pulmonary Nursing – Lung Center of the Philippines
5. Mental Health Nursing – National Center for Mental Health
6. Maternal and Child Nursing – Dr. Jose Fabella Memorial Hospital
7. Infectious Disease Nursing – San Lazaro Hospital
8. Orthopedic and Rehabilitation Nursing – Philippine Orthopedic Center
9. Trauma and Emergency Nursing – East Avenue Medical Center

The program was developed by selected DOH Teaching and Training Hospitals as supervised by the DOH-HHRDB. The system for the certification includes the following: a) competency definitions for each level of general or specialty areas; b) requirements for entry into each level; c) competency-based assessment process to determine entry into as well as satisfactory completion of requirements for a given level; d) learning and development interventions for each level, using existing development programs in the hospitals and building on them; and e) certification of competency for each level of progression.

In this note, **Venzon (2003)** as cited by **Butcon (2010)** discussed that the new staff nurses are given opportunities to become competent nurses by pairing with senior staff nurses. They imitate both the proper nursing practice and good qualities of their partner. New staff nurses also attend seminars and conferences pertaining to the innovation in nursing practice, making them updated with the standards of nursing practice.

Umil, A.M. (2012) stated that the Department of Health's RN Heals project was cited as an example of the massive contractualization in public health institutions. Nurses who are employed under this program receive a meager P8,000 (\$193) monthly allowance and an additional P2,000 (\$48) from the employer, which is either a public hospital or a local government unit. This is way

below what plantilla nurses receive, which is at least P17,000 (\$410) plus other benefits.

The Health Department's RN Heals project or the Registered Nurses for Health Enhancement and Local Service was conceived in 2010 as a response to the glut in nursing graduates in the country, which was brought about by the decision of the US and UK governments to stop importing nurses. It is a continuation and an enhancement of the NARS project in 2009, wherein nurses were hired for only six months.

The Philippines is a predominantly Christian nation, with Roman Catholics making up around 81% of the population (**Central Intelligence Agency, 2010**). **Miranda and colleagues (Miranda et al, 1998)** found that deeply religious Filipinos tended to attribute illness to reasons of God or a higher power. The predominant belief in the causes of disease was the 'will of God', even though individuals also believed in personal responsibility.

The family is the basic social and economic unit of Filipino kinship. Although family is important in many cultures, the central role that the family plays in the lives of its members in the Philippines is unusually significant, with family being rated the most important source of happiness (**Virola, 2010**). In times of illness, the extended family provides support and assistance (**Wright et al, 2008**). Important values that might affect interactions between providers and

patients and families in the context of terminal illness include a strong respect for elders, a strong reliance on family as decision makers in case of illness, and strong expectations of care by the family.

Pascua, H. (2010) stated that Filipino-Austrian nurses and hospital and nursing home personnel were recognized for their dedication and hard work in Vienna.

“These Filipino nurses possess professional training that is why they are very much loved by the Viennese people. I want to thank you for your excellent work in Vienna’s hospitals. Your presence has been an enriching experience for us,” said Mag. Sonja Wehsely, head of the Vienna Health Sector.

On September 20, 2010, the City of Vienna awarded the deserving healthcare workers with Certificates of Recognition. This was made possible through the initiative of the League of Filipinos in Austria.

“For decades a number of Filipino nurses and midwives work in the hospitals, geriatric centers and nursing homes in the city of Vienna. They are an integral part of the health system of the city,” the league said.

The Philippine migrant community in Austria has indeed grown since the 70’s when the City of Vienna welcomed its first batch of Philippine nurses.

Ambassador Lourdes Yparraguirre acknowledged that Filipino nurses have come to embrace Austria as their home.

“Many of them have acquired Austrian citizenship. Some are married to Austrian nationals and raised a second or even third generation Filipino-Austrians. They vote in elections, they sing “Land der Berge” – the national anthem – and they pay their taxes. Many have stories to tell about complexities of integrating into local communities. But because as Filipinos, you are naturally adaptable, open-minded, have facility in learning foreign languages, have a good temperament and share the same Christian traditions in Europe, you have blended and assimilated easily into the Austrian society,” Yparraguirre added.

Anica Matzka-Dojder Member of the Austrian Parliament likewise expressed her gratitude to the services of Filipinos in the health sector not only in Vienna but also in the whole country.

“Thank you so much for the many years of valuable work in the Austrian health sector. I want also to take this opportunity to promise, to make sure that we will continue our political work with the commitment to protect and uplift your interest as migrants working and living in Austria,” the Social Democratic politician said.

About 90% of the total population of Filipinos in Austria are working as nurses, midwives in hospitals and old folks homes all-over the country.

It is with nurses that patients are longest and most directly in contact in the patient's most vulnerable state: administering prescribed drugs, taking blood pressure and temperature, monitoring the progress of our ailment and recovery, paying heed to discomforts.

From Dame Nightingale to Mother Theresa, the nurse's code has been the hard and iron duty to be soft with those who are hurting, to be firm with those who are malingering, to watch at every step the progress of an illness or recovery so that nothing but wellness is irreversible; always and ever to care for as long as there was a living spark there. While there is life, there is need for care, and if there is no more hope of recovery, there is always the imperative of nurturing every living moment that remains. Because life however short it is expected to be, however long its suffering must extend, deserves a nurse's total care. **(Locsin, T.L., 2010)**

The domain of nursing as a profession appears hazy and blurred, and often not demonstrated at all. Nurses' activities revolve around the domain of medicine which is diagnosis and treatment of diseases pathology. Nursing's domain is supposed to be care and comfort of the patient, and activities of daily living

contributing to health, or its recovery, or a peaceful, dignified death when death is imminent. Areas of concern within this domain – such as personal hygiene (skin, hair and nail care, oral care, perineal care), nutrition, sleep and rest, exercise, elimination, hydration, prevention of complications like bedsore, hypostatic pneumonia, muscle contracture, footdrop, etc., prevention of reduction of anxiety and stress while in the hospital, health teachings to enhance the patient's and his and her's family's ability for self-care, and preparation for discharge so that he/she and his/her family can continue proper care at home, as well as prevent the same health problem from happening again, or worsening – are seldom or not given any attention at all. There is hazy application of the nursing process, and in most instances, there is seldom assessment of nursing needs. **(Reyes, S. G., 2009)**

In 1979, Jean Watson proposed the return of caring and humanism when she wrote that “Nursing is both scientific and artistic”. Seeking to combine science with humanism, she underscores that “Nursing is a therapeutic interpersonal process, a scientific discipline that derives its practice for research”. Furthermore, nurses can expect to hear more about the caring aspect of nursing as a counterbalance to the dazzling array of technologies anticipated in the future.

Watson's theory involves ten processes which are as follows: (1) humanistic – altruistic values: practice of loving-kindness and equality with self and others; (2) enabling faith and hope: being present authentically; (3) sensitivity

to self and others: ongoing spiritual development; (4) developing authentic trusting caring relationships; (5) allowing expression of positive-negative feelings: listening to another's story; (6) creative problem-solving caring process; (7) relational teaching-learning/inner subjective meaning; (8) creating healing environments: being/becoming the caritas field; (9) assistance with basic needs: sacred acts; and (10) openness to existential-spiritual unknowns allowing for mystery and miracles.

Watson proposed that nurses must reclaim nursing arts which have scientific bases. She mentioned the following modalities: intentional (therapeutic healing) touch, visualization or imagery, music therapy, expressive journaling, massage, humor, pet therapy, meditation, dance-movement and other biobehavioral interventions.

The outcomes of the caring interventions are well-being, healing from illness at the fast possible pace anxiety reduction. She proposed the following caring science indicators criteria: caring economic indicators, patient satisfaction, anxiety reduction, classic levels of caring research bio-acidic-biogenic, nurse education patient data outcomes. **(Laurente, C. M., 2010)**

Health is a fundamental right of every individual. The Filipino registered nurses believe in the worth and dignity of each human being recognizes the primary responsibility to preserve health at all cost. This responsibility

encompasses promotion of health, prevention of illness, alleviation of suffering, and restoration of health. However, when the foregoing are not possible, assistance towards a peaceful death shall be his/her obligation.

To assume this responsibility, registered nurses have to gain knowledge and understanding of man's cultural, social, spiritual, psychological, and ecological aspects of illness, utilizing the therapeutic process. Cultural diversity and political and socioeconomic status are inherent factors to effective nursing care.

The desire for the respect and confidence of clientele, colleagues, co-workers, and the members of the community provides the incentive to attain and maintain the highest possible degree of ethical conduct. **(Venzon, L.M., 2010)**

Caring in nursing practice involves providing presence, comforting, listening, knowing the client, spiritual caring and family care.

Providing presence is when a nurse establishes reassuring presence, eye contact, body language, voice tone, listening, and having a positive and encouraging attitude, act together to create openness and understanding.

Comforting involves the use of touch and the skilful and gentle performance of nursing care procedures.

Listening involves paying attention to an individual's words and tone of voice, and entering into his/her frame of reference.

Knowing the client is at the core of the process by which nurses make clinical decisions. To know the client means that the nurse considers the client as a unique individual.

Spiritual caring offers a sense of interconnectedness intrapersonally (with oneself), interpersonally (with others and the environment), and transpersonally (with the unseen God, or a higher power).

Family care involves knowing of the family as thoroughly as one knows the client. A nurse demonstrates caring by helping family members become active participants in the client care. (Udan, J.Q., 2009)

Patient wellness outcome

According to **Octaviano (2008)**, nursing in the Philippines has never been dynamic as before. Filipino nurses are exemplary models to other nationalities through their innate caring traits. They lead the world in rendering compassionate service to the sick and well clients, comforting the grieving and the needy and extending love and concern to all of mankind. Filipino nursing leaders contribute greatly in enhancing and strengthening the knowledge, skills and attitude of

Filipino nurses, leaving a significant and beneficial influence in nursing discipline.

Divinagracia (2001) as cited by **Leocadio (2009)**, conceptualized forty statements that represented the dimensions of wellness which include the physical, emotional, intellectual, and spiritual domain. Physical domain involves muscle strength, mobility, posture, gait exercise, and activity tolerance and cardio-respiratory endurance. Emotional domain includes awareness, orientation, understanding of own and other personal feelings and ability to control and cope with emotions. Intellectual domain refers knowledge and perception of a healthy self and ability to recognize the presence of risk factors and preventive measures and spiritual domain is defined as development of inner self or one's soul through a relationship with God and others.

Dr. Jose Bulalacao developed Holistic Approach of Health Care satisfactorily through constant practice which at the start, he called it "Responsible Healing".

Such advocacy is to treat illness, the cause and the patient as a whole person (body, mind, and spirit) based on the overall laboratory results as well as dialogue with patient and family. The physician is able to discern well how to heal, with empathy and compassion, the sick as a whole person to the satisfaction

of all concerned. Education or counselling helps the patient recover from illness and learn to take care and be responsible for his own health.

With the patients' cooperation, such advocacy of health care is the easiest, safest and the least expensive, yet with amazing results. Physicians, being fully informed of their patients' condition acquired through holistic approach, enable them to treat patients accurately or humbly refer them if necessary to the right specialists or medical institutions to ensure healing. **(Bulalacao, J., 2010)**

Foreign Literature

Orthopaedic Nursing

Orthopaedic and trauma nursing is a dynamic specialty with a history of changing, often dramatically, in reaction to developments in society, healthcare provision, disease patterns technology, medical and nursing developments and, of course, patient needs. This ability to react and adapt will continue to shape the specialty in the future.

Many of the changes seen in the last 20 years have related to increased life expectancy, increased emphasis on the prevention of ill health and accidents, shorter periods of hospital care, increased community-based healthcare and

changes in the multidisciplinary team in terms of roles and increased collaboration. Nursing has and will continue to adapt to these challenges.

The demographic changes have led to an increased elderly population, more of whom are fit, active and independent in their 8th and 9th decades. There are also fewer children affected by severe long-term physical disability because health problems are being identified earlier and improvements have been made in surgical and therapy techniques to correct musculoskeletal problems.

Orthopaedic and trauma nurses are involved in a wide range of specialist roles, nursing developments and collaborative working approaches. They need to understand how changes and challenges affect themselves, their peers, patients, carers, and others. Specialist orthopaedic nurses are often in a prime position to lead nursing practice. The development of leadership skills must therefore be supported to ensure an appropriate approach is taken, that inspires, innovates, supports and empowers the nursing team and patients.

It is this diversity of interest, challenges, and experiences which makes orthopaedic and trauma care a dynamic specialty. **(Kneale et al, 2009)**

According to **Davis (1994) as cited by Kneale et al (2009)**, the most significant and obvious change in orthopaedic nursing is seen in the derivation of the term from the Greek language, in which *orthos* means straight and *paedios*

means child, the implication being that the specialty developed from the needs of children affected by crippling musculoskeletal problems. Indeed, when the first orthopaedic nurse was appointed in 1841, the majority of patients were children with congenital and developmental conditions including spinal curvatures and foot deformities. The majority of orthopaedic patients are now adults with traumatic injuries and conditions related to old age.

The history of orthopaedic nursing in Britain covers the developments of nursing and medicine over the 19th and 20th centuries. The first orthopaedic hospital, now the Royal Orthopaedic Hospital, Birmingham, opened in 1871. This was well before the first preliminary training school for nurses opened in 1890. Dame Agnes Hunt (1867 – 1948) opened her home for crippled children in Baschurch, near Oswestry, which, with the help of Sir Robert Jones, became an orthopaedic hospital in 1900. Other hospitals continued to open across the country, leading in the 1920s to concerns about the recruitment and training of orthopaedic nurses.

Following the support of the British Orthopaedic Association and the General Nursing Council, a nationally recognised and standardised 2-year training for nurses in orthopaedic hospitals was established in 1937. This course offered a good grounding in nursing skills prior to commencing nursing or physiotherapy training. Approval was also given for a 1-year course for qualified nurses (**Davis**

2002) and from this point all orthopaedic courses have developed. The more recent changes in nursing education, especially the integration of nurse education into universities, have led to orthopaedic courses now being available at diploma, degree, and post-graduate level in Britain.

As we begin the 21st century, nursing in general and orthopaedic nursing in particular continue to face the issue of constant change, not only within the profession itself but also in relation to the environments in which care takes place.

The changes in healthcare over the last decades and developments in nursing generally have led to a proliferation of specialist and advancing roles within orthopaedic and trauma nursing, including the role of nurse consultant.

Traditionally orthopaedic care has been delivered mainly within inpatient settings. In recent years, there has been a move towards the provision of orthopaedic care within community, primary and outpatient settings. This shift in emphasis aims to minimize the institutional separation of primary and secondary care, promoting seamless integrated services for patients and their families while maximizing the efficient use of available resources. The major developments exemplifying the transference of responsibility from secondary to primary care are:

- Early screening and preoperative assessment in primary care for elective surgery patients
- More minor surgery in general practice
- More hospital-at-home schemes
- More community hospitals offering rehabilitation and step-down services
- Fewer follow-up appointments in the outpatient department
- The provision of health maintenance and health promotion services in primary care

These developments present orthopaedic nurses and other members of the multidisciplinary team with specific challenges. Practitioners need to adapt their expertise and skills in orthopaedic care to a variety of settings, to facilitate liaison between primary and secondary care and ensure orthopaedic patients receive high quality, evidenced-based care and treatment. **(Kneale, J. 2009)**

Orthopaedic nursing, like all other disciplines in nursing, is visualized as both an art and a science which, together with knowledge, are essential for providing high quality care. The art of nursing involves consideration of the values, beliefs and cognitive elements of nursing practice. The science involves reasoning and decision making based on scientific knowledge as well as that which comes from nursing art **(Artless & Richmond 2000 as cited by Kneale, J. 2009).**

Orthopaedic nursing is focused on:

- The care of an individual, family, or other group
- Where a musculoskeletal disorder, trauma, or their consequences are present
- Involving people of all age groups from birth to old age and
- Involving people from across all socioeconomic, cultural, and ethnic groups

Each person is viewed as an individual with a diverse and complex set of problems and needs. Consequently, they are viewed as a whole, including physical, psychosocial, and environmental factors affecting their health. In orthopaedic nursing, the patient is seen very clearly as the central pivot of care, with their family and the multidisciplinary team around them. **(Kneale, J. 2009)**

Musculoskeletal problems can be acute or chronic with the effects potentially being wide reaching. Most obvious are the presence of pain and the impact on mobility that can be visualized as a continuum of the patient's desired health status and degree of altered health status. The role of the nurse is to assist the patient in moving towards or achieving their desired health status or to adapt to an altered health status **(Balcombe 1994 as cited by Kneale, J 2009)**. Many musculoskeletal disorders and traumatic injuries lead to a permanent and long-

term disability so rehabilitation has to be the central focus of recovery once the acute stage is over.

Consideration of health status is important for providing holistic, patient-centred care. This involves attention to psychological and social well-being as well as the physical aspects of health. It is equally important to consider the psychological aspect of, for example, joint replacement surgery or major trauma as it is to consider the physical issues. As these events affect all aspects of patients' lives they must also be considered in a socio-cultural context.

The patients' contact with orthopaedic nursing can take place in all healthcare settings and healthcare environments. The trauma patient's care journey will be different to that of the patient with a more chronic condition and to the experiences of a patient having elective orthopaedic surgery.

Orthopaedic nursing skills are required in all settings including the accident and emergency department, acute hospital ward, operating department, rehabilitation unit, outpatients department and nursing home, as well as other distinct settings within the community. The challenge for nurses working in these settings is to ensure that a seamless and high quality service is provided, no matter what part of the journey the patient is on **(Lucas 2002 as cited by Kneale, J. 2009)**.

It is important for orthopaedic nurses to consider the patient's environment in a global context. Healthcare is provided across all frontiers with specific issues surrounding migration. Nursing theory is no longer confined to national boundaries but must be considered within environments as diverse as a large multicultural metropolis, to rural areas in developing countries. The patterns of orthopaedic problems vary from one environment to the next but the nursing skills required are similar in each environment and are transferable to different settings once the cultural context is taken into account. **(Kneale, J. 2009).**

Nurses follow a process in caring for patients arranged systematically. Nursing process is a systematic, rational method of planning and providing individualized care. The phases of the nursing process are: (a) assessing, in this phase, the nurse gathers data about the client, organize, validate, and document data, (b) diagnosing, the nurse identify health problems, risks and strengths of patient, (c) planning, in this phase, the nurse prioritizes the problems or diagnoses and also formulating goals, select nursing interventions, (d) implementing, the nurse renders intervention for the client, and (e) evaluating, in this phase the nurse assesses the client for the outcome of the care implemented and also the nurse draw conclusions about problem status of the client.**(Kozier & Erb, 2008)**

According to **Shenkman (2011)**, an orthopaedic nurse cares for patients after arthroscopic surgery to help them regain their strength and mobility. They

could also work with patients who have problems with their muscular skeleton systems before surgery. Some of these injuries or conditions could be total hip replacement or spine surgery. They could also be providing pain management, support and educating patients to enable them to perform to their highest function level. Helping provide patient education about using equipment such as braces, prosthetics and other orthopaedic equipment also would be part of the job. They will learn about various equipment used to make patient more comfortable, improve mobility, and help patients to prevent complication. Orthopaedic nurses also work with pre-and post operative orthopaedic patients that have hand or upper extremity surgery, micro surgery, sports injuries, and spine procedures. They can also work with patients who have arthritis, diabetes, fractures, and congenital malformations.

Bone Growth, Formation and Maintenance

The skeletal system is the framework of the body. It consists of bone and associated connective tissue such as cartilage and dense fibrous tissue. Bone is a specialized form of connective tissue and is important for its mechanical properties and the maintenance of mineral homeostasis. (Kneale, J. 2009)

The functions of the skeleton are as follows:

- Support: the skeleton provides a framework for the body, with surface markings for the attachment and insertion of muscles
- Protection: the skeleton maintains body shape, protecting from injury many of the internal organs such as the brain, heart, lungs, and spinal cord
- Movement: bones and muscles act as levers, producing body movements through joints
- Mineral storage: bones store minerals such as calcium and phosphorous
- Blood cell formation: red bone marrow produces red blood cells, white blood cells and platelets. This process is called haematopoiesis.

Bone tissue is highly vascular, combining organic and inorganic material. A system of collagenous fibers forms the organic component, providing resilience and flexibility. The inorganic material consists mainly of mineral salts which form a matrix providing strength and weight-bearing capabilities. Bone is three times stronger than wood and as tensile as cast iron. It is the strength and rigidity of this matrix that give bone its characteristics. **(Kneale, J. 2009)**

Bone is composed of two types of specialized cells, arising from different stem cells:

1. Osteogenic cells are unspecialised cells derived from the mesenchyme. These are to be found in the periosteum, endosteum, Haversian and Volkmann's canals.

- a. Osteoblasts do not have mitotic potential. They are involved in bone formation by secreting organic components and mineral salts. They are found on the surface of bones.
 - b. Osteocytes are osteoblasts that become trapped within bone and do not have mitotic potential. They maintain the structure of the bone tissue.
2. Osteoclasts develop from the macrophage-monocyte system. Their function involves the resorption of bone; as a result they have the key role in the continuous modelling of bone.

Bone is normally made up of organic (30-35%) and inorganic (65 – 70%) material. The organic component consists of protein fibers which are mainly collagen. These collagen fibres make up 90 – 95% of the organic matrix.

Mineral salts, such as those of calcium and phosphorous, predominate in the inorganic component. These complex crystals combine to produce rod-shaped hydroxyapatite crystals that are uniform in shape. The ratio of calcium content to phosphorous content varies depending on the nutritional state of the individual. The levels are controlled by the parathyroid hormone and calcitonin produced in the parathyroid and thyroid glands.

Other substances are present, attached in the form of ions: magnesium, sodium, potassium, and carbonate.

The chemical composition of bone makes it susceptible to damage. For example, radioactive chemicals attach strongly to the hydroxyapatite crystals. This includes emissions from nuclear power stations such as uranium, plutonium, and strontium. These destructive chemicals are ionically similar to calcium and phosphorous; these do not pass out of the body but accumulate and irradiate bone marrow. **(Kneale, J. 2009)**

The embryonic development of bone involves the migration of mesenchymal tissue into the area where bone formation is to begin. The mesenchymal cells increase in size and number and differentiate into osteogenic cells. Then the osteogenic cells differentiate into osteoblasts or chondroblasts. In the embryo, fibrous membranes and cartilage are shaped like bone. Ossification begins around the 6th or 7th week of embryonic life.

The fetal bones are outlined as fibrous or cartilaginous tissue. As the fetus develops, calcification of the bone occurs as calcium salts are deposited and osteoblasts lay down bone to replace the cartilage. **(Kneale, J. 2009)**

There are variations in the rate of development between bones and parts of bones, for example:

- In the femur the distal epiphysis appears around 36 fetal weeks
- In the tibia the proximal epiphysis appears around 40 fetal weeks

- The metatarsal bones appear at 8 – 16 fetal weeks
- The calcaneus appears at 24 – 26 fetal weeks
- The talus bone appears at 26 – 28 fetal weeks

Knowledge of these factors is useful in the treatment of disorders such as developmental dysplasia of the hip or clubfoot, where early intervention before the bone is fully developed may influence the outcome.

Ossification or osteogenesis is the formation of bone by osteoblasts. This process involves the synthesis of an organic matrix and the addition of mineral salts such as hydroxyapatite. **(Kneale, J. 2009)** It occurs in two ways:

1. Intramembranous: the formation of bone within connective tissue membranes
2. Endochondral: the formation of bone from cartilage

Fracture and Bone Healing

Bone formation and resorption is a continuous process requiring an adequate intake of calcium and vitamin D. The skeleton contains approximately 99% of the total body calcium which is equal to about 1kg weight. The calcium within the cells is constantly changing with the calcium in the extracellular field; this is called dynamic equilibrium. This process, known as bone turnover,

continues through life but is especially high during childhood. It is therefore important that the child is provided with an adequate diet to build good bone stock for later life. Calcium salts are present in greater quantities in adult bone than immature bone, which tends to be more elastic with a loose matrix. If trauma occurs in a child, it may result in a “greenstick” or partial fracture, instead of a complete break that normally occurs in mature dense bones. In a freshly healed fracture, the bone matrix is less dense than normal, making the requirement for calcium higher than normal.

The formation of bone is affected by pituitary growth hormone, sex hormones (oestrogens and androgens) and thyroid hormone.

If resorption exceeds deposition, osteoporosis develops; in fact, many problems might develop if this fine balance is disrupted. **(Kneale, J. 2009)**

Repair and maintenance of bone occurs as a result of several different stimuli:

- Remodelling during bone growth involves the replacement of old bone by new bone tissue
- Additional bone is deposited in response to exercise and mechanical stress

- The time taken for a fracture to repair will depend on the type of fracture. It will take longer in the elderly because of decreased blood supply and general inefficiency of the repair processes

Remodelling takes place in bone growth, during an alteration in shape, in response to mechanical stress and in the repair process. Bone constantly remodels its matrix. The process allows worn or injured bone to be replaced and helps to regulate the storage of calcium for the rest of the body, as calcium is essential for the normal functioning of many of the body's tissue. **(Kneale, J. 2009)**

Normal bone replacement relies on sufficient dietary intake or production of:

- Hormones
- Calcium and phosphorous
- Manganese and boron
- Vitamin D which aids the absorption of calcium from the gastrointestinal tract into the blood, removes calcium from bone and reabsorbs calcium from the kidney tubules
- Vitamin C which maintains the intercellular substance of bone and other connective tissue
- Vitamin A which controls the activity, distribution and coordination of osteoblasts and osteoclasts

Human growth hormone, secreted by the anterior pituitary gland, is responsible for bone tissue growth. Under- or oversecretion during childhood may result in dwarfism or gigantism, respectively. Growth hormone stimulates interstitial cartilage growth and appositional bone growth. The thyroid gland produces calcitonin, which is essential for normal growth. Calcitonin inhibits osteoclast activity and accelerates the absorption of calcium by bone. **(Kneale, J. 2009)**

Parathormone, produced in the parathyroid glands, increases osteoclast activity, releasing calcium and phosphate ions from the bones into the blood system.

Sex hormones stimulate bone growth. Oestrogen and testosterone increase the activity of osteoblasts and promote new bone formation. The burst of growth during puberty is due to a release of male and female sex hormones. These hormones stimulate ossification of the epiphyseal plate as skeletal growth is completed. Girls usually stop growing earlier than boys. The loss of bone density occurs as hormone levels decrease, especially in menopausal women, and may result in osteoporosis, thus increasing the risk of bone fracture. **(Kneale, J. 2009)**

Bone is capable of altering its strength in response to a mechanical stress. Mechanical stress increases the deposition of mineral salts and the production of

collagen fibres. An absence of this type of stress promotes the removal of mineral salts and collagen fibres.

Athletes whose bones are subjected to a high degree of stress have thicker bones than non-athletes. The effect of regular exercise is to stimulate bone growth and increase the production of calcitonin, thus inhibiting bone resorption.

Bones vary considerably in the length of time they require to heal. As a rule, in adults upper limb fractures take 6 – 8 weeks to heal and lower limb fractures require 8 – 12 weeks. **(Kneale, J. 2009)**

The following stages occur in the repair of a fracture:

- Stage 1: Inflammatory phase. As a result of a fracture, the bone ends and surrounding tissue bleed and hematoma is formed. The bone ends are subsequently sealed by the fracture hematoma, where osteocyte and periosteal cell death occurs. This results in an inflammatory response with vasodilation and the gathering of polymorphonucleocytes and histiocytes.
- Stage 2: Reparative phase. This stage is characterized by the formation of callus. External callus is produced by mesenchymal cells from the periosteum, forming a bridge between the bone ends. Direct endosteal proliferation also takes place on the exposed, broken surfaces of the

diaphysis. The cells are gradually replaced by mineralized trabeculae of “woven” bone. At this stage the callus is visible on x-ray.

- Stage 3: Remodelling. Remodelling of the original structure takes place over a period of time. Any fragments of dead bone are resorbed by the osteoclasts and compact, lamellar bone replaces spongy bone around the fracture. On x-ray the surface of the bone will usually retain some evidence of the fracture site.

Repair and maintenance of body tissues vary according to age and must be considered together with other aspects such as nutritional factors or the presence of infection. **(Kneale, J. 2009)**

The adult skeleton is dynamic. The maintenance of this dynamic sequence relies on the coordinated action of osteoblasts and osteoclasts on the trabecular surfaces and in the Haversian systems. Remodelling in each section of bone, first described by Frost in 1964 as a bone remodelling unit, takes between 3 and 4 months. Balance is dependent on optimum conditions in terms of such processes as hormonal control and kidney function. The repair of the damage incurred will increase demand for nutrients, especially calcium and vitamin D. **(Kneale, J. 2009)**

COMPOSURE Behaviors

The science and art of nursing have also evolved. The art of nursing is exemplified in the interaction between the nurse and the patient. Good relationships are based on interpersonal and communication skills, and knowing when to remain quiet, sit and listen to a patient. Intuitive nursing actions develop from knowledge, skills, values and beliefs, with expert nurses developing intuitive feelings, awareness and confidence through experience (**Benner 1982 as cited by Kneale, J. 2009**). These attributes enable the nurse to judge when to act and when to empower patients to take control of their own health and care (**Artless & Richmond, 2000 as cited by Kneale, J. 2009**). The science of nursing involves the application of knowledge and skills to specific patients' needs. Nurses need to keep pace with changes in nursing and medical knowledge and adapt to the technology involved in care. In addition, they need expert knowledge of the patient's orthopaedic condition, to understand how their needs can be met and complications are prevented (**Powell 1986 as cited by Kneale, J. 2009**).

Many aspects of the content and delivery of orthopaedic courses and the principles of care can be traced back to the vision, energy and determination of the pioneers of orthopaedic nursing (**Davis 1994 as cited by Kneale, J. 2009**). These changes have paved the way for orthopaedic and trauma nursing to move from (**Davis 1994**):

- A medical to a nursing model of care
- An ill-focused to a health-focused approach
- Viewing the patient as a disease or condition to a holistic patient-centered view of care

Orthopaedic care will continue to evolve and develop to meet the challenges and needs of society, healthcare and patients. Orthopaedic nurses need to adapt, meet these challenges and continue to lead healthcare developments in the future. Several current influences on orthopaedic nursing are broadly discussed here: taking a health and health promotion approach, changes in the setting of orthopaedic care, the development of an evidenced-based healthcare approach and leading developments in healthcare (**Kneale, J. 2009**).

Although musculoskeletal care mainly takes place within the acute hospital environment, orthopaedic and trauma nurses are working in a variety of healthcare settings. This has led to an increased diversity in orthopaedic nursing roles.

Several developments within trauma care have reduced the impact of injuries, enabling patients to reach hospital in a more stable condition (**McEwan 2002 as cited by Kneale, 2009**) including:

- Injury prevention at national, local and personal levels

- Prehospital care and the training of paramedic teams
- Triage both at the scene of an accident and in the accident and emergency (A & E) department
- The implementation of rapid assessment processes
- The improved management of trauma patients in hospital

Trauma assessment courses have enabled a systematic approach to emergency care. They have also led to nurses developing their skills in identifying injuries, assessing patients and managing their emergency care within a skilled multidisciplinary team approach. Although these activities relate to the care of patients prior to their arrival on a trauma ward, they have had a great impact on the health of the trauma patient, their treatment and recovery from injury.

The trauma nurse coordinator role has facilitated the admission of patients, allowing a smoother transfer of care from one unit to another. The remit of these roles varies widely but specific advantages are seen in:

- Improved communication between the A & E department and trauma wards
- Reduced time spent in the A & E department, especially for elderly patients

- Improved care of trauma patients admitted to non-trauma wards if the coordinator has a role in supporting the care of patients admitted to other wards
- Improved communication between the operating department and trauma wards, with smoother running of trauma theatre lists, particularly when the coordinator has a role in planning theatre lists

For trauma ward nurses, developments in medical management, especially the increased use of limb-salvaging techniques and external fixation, have led to a dramatic reduction in the use of traction. However, these have brought new nursing challenges, for example in identifying best practice in pin-site care and psychological problems relating to body image. Nursing care has changed to meet these demands. **(Kneale, J. 2009)**

At the other end of the patient's journey, the involvement of trauma nurses in rehabilitation is changing. More patients are referred within days of their injury or surgery to intermediate care. This has led to more patients receiving their rehabilitation care in less acute settings. Equally, trauma nurses have developed new roles that facilitate the transfer of patients into intermediate care, long-term rehabilitation or the community. Schemes linked to local nursing homes and hospital-at-home are increasing in number.

Within other areas of musculoskeletal care, other new roles are continuing to develop. More osteoporosis and rheumatology nurse specialist roles are available to support patients and practitioners. These are often both hospital and community-based, some with research and specific education remits linked to local academic centres. **(Kneale, J. 2009)**

A prime example of practice development, now seen in most centres for orthopaedic surgery, is the use of preadmission clinics. These have facilitated the reduction in patient length of hospital stay and reduced the number of patients who have their surgery cancelled on the day of admission. Many are multidisciplinary, involving nursing, anaesthetic, physiotherapy and occupational therapy assessments of the patients. These clinics have enabled nurses to develop their skills in patient assessment, diagnostic processes and the interpretation of medical investigations. In some areas, a home assessment is also completed prior to admission for surgery. These developments have ensured that patients are fitter, better prepared for their surgery, more informed about their care and, where possible, their active cooperation in treatment regimes and rehabilitation is promoted.

Rehabilitation is moving away from the traditional medical model to one that crosses professional, health, hospital, community, and agency boundaries **(McEwan 2002 as cited by Kneale, J. 2009)**. When good rehabilitation services

are provided, the patient's length of hospital stay is reduced, ensuring they spend no longer than necessary in the acute care setting.

The aim of rehabilitation is to maximise the patient's independence, physically and socially, allowing them to return to their normal place of living wherever possible. Plans for rehabilitation care begin in the preadmission clinic or on admission for a trauma patient, with many patients being transferred to intermediate care or long-term rehabilitation once recovered from the intermediate effects of their trauma and surgery.

Rehabilitation care must include the cognitive and emotional aspects of recovery. Trauma patients are particularly vulnerable to psychological changes, especially an altered body image or stress from the trauma event, medical interventions, loss and bereavement. These reactions are also seen in patients following planned surgery but can be pre-empted; for example, patients having an external fixator or a leg-lengthening procedure are offered information, education and support through the preadmission clinic or outpatient services.

The rehabilitation environment is also changing with more patients being transferred to intermediate care in a rehabilitation unit, community hospital, elderly care unit or hospital-at-home facility. The rehabilitation setting must have an appropriate mix of nurses and therapists. The orthopaedic nurse is ideally placed to act as the coordinator of rehabilitation care (**McEwan 2002 as cited by**

Kneale, J 2009) and to be the lead practitioner of the service. This change from medically led services reflects the development of practice and practitioners to meet the needs of patients and the service in the 21st century. The increase in generic healthcare worker roles has enhanced this area of care and increased the flexibility of the rehabilitation team.

The development of hospital-at-home schemes is just one of many community-based orthopaedic nursing roles. In paediatric care, the orthopaedic nurse may be involved in providing home nursing care for a child and support for parents caring for their child on traction, with an external fixator or in a hip spica. In adult care, the nurse may be involved in falls assessment, home assessments and acting as a support link between the acute care and intermediate care environments.

When at home, more patients are integrating traditional medical care with complementary therapies to alleviate their pain, increase mobility, reduce swelling, relax or provide the motivation to continue their level of activity. For some patients, these therapies are part of their lifestyle and they may forget or not realize that occasionally interactions and contraindications exist between, for instance, homeopathic remedies and medical drugs that can affect the potency and effectiveness of both forms of treatment. Orthopaedic nurses need to develop an

awareness of the role these therapies may play in patient care, especially for those with long-term musculoskeletal problems.

The community aspects of orthopaedic and trauma roles are likely to develop further in the future. In particular, there is likely to be increased integration and collaboration between primary and secondary care services that will provide new avenues for orthopaedic nurses and nursing developments.

The role of the orthopaedic nurse has been described as the “harmonist” **(Santy 2001 as cited by Kneale, J. 2009)**. Orthopaedic nurses act as harmonists within the disruption caused to patients by orthopaedic disorders, surgery or trauma, providing a link between the many environments on the patients’ journey. This is in keeping with **McMahon’s (1998) as cited by Kneale, J. 2009** therapeutic activities in nursing, which range through developing the nurse-patient relationship, caring and comforting, to using evidence-based physical interventions, teaching, manipulation of the environment and adopting complementary health practices. The harmonist role therefore fosters a holistic approach to patient care.

Six core activities have been identified for orthopaedic nursing **(Santy 2001 as cited by Kneale, J. 2009)**. These fit in with the work of **Love 1995 as cited by Kneale, J. 2009** who takes a different approach to identifying the

activities of the orthopaedic nurse although the activities can be mapped against the harmonist model.

These activities require varying degrees of knowledge, experience, and skills from those practising the art and science of orthopaedic nursing. It is often specialised knowledge of the musculoskeletal system and the factors involved in the related disorders and trauma that make the orthopaedic nurse instrumental in patients' recovery and rehabilitation. Experienced orthopaedic nurses develop a special sense of how musculoskeletal problems affect an individual's posture and movement, and identify nursing needs from these. This is often called the "orthopaedic eye" (Powell 1986 as cited by Kneale, J. 2009). This view of orthopaedic nursing is still developing and its use as a framework for understanding practice and as a tool for developing competencies for orthopaedic nursing is a role for the future.

The partner role in orthopaedic nursing is a complex phenomenon, discussed in the nursing literature in a variety of different ways. **McMahon 1998 as cited by Kneale, J. 2009** describes the therapeutic partnership in nursing and refers to **Muetzel's 1988 as cited by Kneale, J. 2009** three concepts of partnership, intimacy, and reciprocity. Patients who receive supportive interaction in their treatment and nursing do better than those who are isolated or feel alone. When the nurse, as provider of care, becomes a partner with the patient, the

results can be synergistic (**Scherwitz et al 1997 as cited by Kneale, J. 2009**) and lead to positive outcomes. This nursing function involves building a relationship with the client, similar to that of a friend. Some writers in nursing have termed this a therapeutic relationship (**McMahon 1998 as cited by Kneale, J. 2009**); it is built on trust and rapport and usually involves a degree of advocacy.

One of the important aspects for the nurse is being someone who can be trusted, who feels like a friend but also has inside knowledge of the “system”, of what is happening and what is likely to happen to the patient during and after their journey through care. This being a friend “in the know” is very important in the engendering of trust, reducing the patient’s anxiety, and is best fulfilled when the nurse promotes trust by making an effort to get to know and spend time with the patient. Trust is also earned by the demonstration of skill and knowledge (**Fosbinder 1994 as cited by Kneale, J. 2009**) in dealing with the patient and others. As the patient’s trustee, the nurse has a particular role to play as a mediator between the medical world and the patient, acting as a translator for the patient, ensuring they understand what is happening and what the implications might be. In particular, this role fulfils the client’s need for information about their condition, surgery, and management; for example, the patient admitted for elective surgery will be less anxious when the nurse has explained what will happen to them and what the potential results can be. Most importantly, the

patient feels there is someone with whom they can share fears and in whom they can place trust.

Orthopaedic patients in particular have a discrepancy between their mobility, ambulation needs and capabilities (**Ouellet & Rush 1998 as cited by Kneale, J. 2009**), and their ability to self-care. The nurse has a vital role to play in helping the patient to overcome this deficit through rehabilitation. The nurse first has to motivate the patient to put effort into their rehabilitation and use all the skills of a good trainer or mentor to enable the patient's progression towards their goal achievement (**Geelen & Soons 1996 as cited by Kneale, J. 2009**). This aspect of care often involves being with the patient whilst they mobilize, providing psychological and physical support along with constructive feedback and encouragement.

There is considerable debate about the role of the nurse in rehabilitation, particularly in the field of elderly care. Many question whether the nurse has an active role to play and what the nursing rehabilitation interventions are (**Ellul et al 1993, Johnson 1995, Myco 1984 as cited by Kneale, J. 2009**). There is a distinct nursing role arising from the trustee and translator aspects fostered in the working relationship.

The word "encouragement" is often used to describe the motivating role in rehabilitation. This is closely linked to the friend-trustee role because of the need

for the patient to have confidence and trust in the nurse who takes responsibility for their motivation and guidance in rehabilitation, a position that other health professionals cannot fulfil in the short amounts of time they spend with patients in comparison to nurses. Some of this involves acting as a coach to the patient during the early phase of remobilization and rehabilitation.

There is a wealth of literature discussing the role of comfort in well-being, linking the achievement of patient comfort to the concept of caring (**Fagerstrom et al 1998, Morse et al 1994 as cited by Kneale, J. 2009**).

There are two aspects of comfort in the orthopaedic setting. The first is the maintenance of a suitable fluid and dietary intake, fulfilment of elimination needs, the need for privacy and dignity as well as the maintenance of personal standards of hygiene and dress. A great deal of comfort enhancement involves positioning plus moving and handling techniques, requiring considerable specialist skills, especially for the patient confined to bed (**Bjork 1995, Morse & Procter 1998 as cited by Kneale, J. 2009**). Moving and handling is closely related to risk management in terms of musculoskeletal safety and the prevention of the complications of immobility such as pressure damage development.

The second area of importance in comfort enhancement is the assessment and management of pain related to the orthopaedic condition and its management. Orthopaedic nurses use a variety of ways of assessing and managing pain to

ensure comfort can be gained without the need for unnecessary analgesic administration.

The orthopaedic nurse acts as mediator, coordinator, and gatekeeper. This nursing role, in all phases of care, sees the nurse acting as a link between the patient, the interdisciplinary and interagency teams, family, and friends. As a result of the 24-hour nature of nurses' contact with the patient, they are best placed to hold detailed information and understanding of the patient's problems and needs. **(Kneale, J. 2009)**

The orthopaedic nurse acts as the main manager of risk for patient. Following trauma and orthopaedic surgery, complications are a major concern, making prevention and early recognition essential for avoiding any short or long term effects. The risks of potential and actual complications tend to fall into four major categories related to:

- Immobility
- The peri- and postoperative period
- The injury
- Those due to management and treatment

The most common complications are pressure ulcers, wound infections and osteomyelitis, post fall syndrome, chest infection, deep vein thrombosis,

pulmonary embolus, fat embolus and compartment syndrome. In many instances interventions to prevent their development fall within the scope of nursing practice, with orthopaedic nurses developing expertise in their recognition and management.

These risks and their management are a highly specialized area of orthopaedic nursing practice, related to the specialist management of orthopaedic problems. Knowledge of these and the ability to assess and record the risks, signs, monitoring parameters and appropriate nursing interventions are essential in providing effective nursing care (**Slye 1991 as cited by Kneale, J. 2009**). Once a risk has become a reality, the nursing activity tends to move into the technical domain.

Increasingly, the orthopaedic nurse has a technical role to play in many aspects of patient management and care, generally in support of the medical and surgical treatment and management of orthopaedic and traumatic conditions.

In the trauma setting, this is often related to the strategies used to stabilize fractures, including the application and care of casts and appliances, the application and management of traction, the care of external fixators and skeletal pins and the use and management of electronic apparatus in the care of the patient such as infusion pumps and monitoring equipment.

As nursing practice moves forward and extends its scope, these technical activities will increase. Orthopaedic nurses are now commonly working in situations requiring technical skills related to diagnosis and care management.

Holism is a philosophical ideal that suggests human beings require wholeness and integrity to make life worth living (**Owen & Holmes 1993 as cited by Kneale, J. 2009**); this links in many ways to the concepts of caring. Seeing human beings as whole people rather than just specific aspects of their personhood is a basic moral issue in modern society. The development of the concept of holism reflects the fact that a historical approach to healthcare did not always recognize the importance of considering every aspect of a person. Medicine in particular tended to focus on the illness rather than the whole person affected by that illness. Holism encourages us to focus on the physical aspects of care along with the psychological, spiritual, cultural, social and economic aspects of an individual's experience of life.

The focus on holism in nursing is therefore central to its humanistic practice (**Kolcaba 1997 as cited by Kneale, J. 2009**) and an important moral aspect of care. Without it, patients become objects of care rather than partners with care providers. Many nursing models and theories include holism within their central ideas as an important aspect of the goal of nursing. In orthopaedic nursing practice, holistic approaches to care encourage the individual to be

viewed as a human being with many physical and psychological issues contributing to their nursing needs rather than viewing the individual as, for example, an isolated limb injury or condition.

The nature of musculoskeletal disorders and injury suggests that the notion of mobility is central to orthopaedic nursing and the nature of the orthopaedic patient (**Balcombe 1994 as cited by Kneale, J. 2009**). Mobility is an important concept that appears frequently in discussions about nursing care, in care plans, and in the orthopaedic nursing literature.

Mobility is central to maintenance of independence but is often severely impaired by orthopaedic conditions, surgery, and trauma. Orthopaedic nurses need to understand its features in detail as their main role is in improving the mobility of patients and clients. Underpinning this knowledge must be an understanding of how the musculoskeletal and neurological systems affect mobility and how psychological issues can affect. For example, an older person with arthritis may have considerable difficulty in mobilizing but in addition, depression associated with pain or isolation can add to their mobility problems.

Rehabilitation is often seen as central to orthopaedic nursing (**Powell 1986 as cited by Kneale, J. 2009**) as the means of restoring a person to their normal life (**Hawkey & Williams 2001 as cited by Kneale, J. 2009**). One of the major

problems for patients who have an orthopaedic condition, surgery or sustained trauma is the physical disability that can lead to dependency.

The nurse is the health professional who has most contact with client, largely due to the unique 24-hour nature of nursing and its focus on the client's physical needs. This offers unrealized opportunities for the nurse to develop strategies to enhance the patient's rehabilitation potential. There has been considerable debate over the last two decades regarding the role of the nurse in rehabilitation, particularly whether there is a therapeutic role for the nurse. Nursing practice in this area has been slow to focus attention on the patient's desires and psychological needs that impact on successful rehabilitation. The literature that considers these issues recognizes that nurses have not yet defined a role in rehabilitation other than that focusing on physical needs (**Nolan et al 1997, Waters & Luker 1996 as cited by Kneale, J. 2009**) and orthopaedic nursing is no exception.

Hawkey & Williams 2001 as cited by Kneale, J. 2009 identify eight categories that are central to evolving rehabilitation nursing and these need to be considered within any orthopaedic rehabilitation context: essential nursing skills, therapeutic practice, coordination, education, advocacy, political awareness, advice and counselling, and clinical governance.

Motivation is a concept often seen as central to successful rehabilitation. Rehabilitation professionals have long suspected that a client's motivation plays an important role in determining the outcome of therapy. It is commensurate with many factors such as self-efficacy, contextual support, emotions, needs, incentives, rewards (**Geelen & Soons 1996, Rensick 1996, Thomas 1999 as cited by Kneale, J 2009**), courage and encouragement (**Beck 1994 as cited by Kneale, J 2009**).

This complex phenomenon may influence the successful rehabilitation of orthopaedic patients. Many factors are likely to influence rehabilitation motivation, including goals, humour, caring and kindness, belief in the staff and rehabilitation, encouragement, basic personality, power within relationships, domination in rehabilitation, responses to domination and beliefs (**Rensick 1996 as cited by Kneale, J. 2009**). In particular, involvement of the client in decision making appears to be vital.

Basic concepts are often taken for granted, ignored, or dismissed as simplistic. Encouragement is one such concept. The word is in daily use in nursing practice yet there is to date no nursing literature that has examined it as either a concept or an intervention.

The nature of disease, ill health and injury causes individuals to frequently suffer from fear, helplessness, frustration, lack of motivation, and

discouragement. A potentially important and untapped aspect of the caring role in nursing may be to use encouragement practices to dissipate fear, demotivation and discouragement and thereby facilitate recovery and health. The literature indicates that to encourage is to promote and activate social interest and a sense of belonging, value, worthwhileness, and welcome in the human community **(Dinkmeyer & Eckstein 1995 as cited by Kneale, J. 2009)**.

In Adlerian psychology, the loss of courage or discouragement is understood to be the basis of mistaken and dysfunctional behaviour, seen for example in a patient's reluctance to take an active part in their rehabilitation.

Encouragement is mainly discussed in the literature of educational psychology, the field in which the most evaluative research has taken place in an attempt to identify the benefits of encouragement. **Carns & Carns 1998 as cited by Kneale, J 2009** offer the following elements of encouragement seen in educational psychology which lend themselves well to an elucidation of encouragement in rehabilitation nursing practice: value individuals as they are, use words that build the individual's self-esteem, plan for experiences that create success, demonstrate genuineness to individuals, demonstrate non-verbal acceptance through touch, use humour, spend regular time with individuals, recognize effort, avoid emphasis on disabilities, show appreciation for the individual's cooperation, and avoid comparing individuals.

Such strategies are likely to be useful to nurses when encouraging orthopaedic patients during rehabilitation. Put simply, verbal encouragement while completing a difficult mobility task can make all the difference to patients' rehabilitation outcomes.

Thrall, T. H. (2009) stated that nurses who leave tend to do so in the first two years of a job, studies show, so Fairview Southdale Hospital, Edina, Minn., decided to target recent hires. Last year, it schooled staff nurses in "welcoming behaviors," and gave new hires the option of having a "buddy nurse" to meet with weekly. The hospital also created a new, paid position--the support coordinator, who plans activities for new nurses and helps them with their concerns.

All this is in addition to the hospital's long-standing preceptor position, a senior nurse paired with a new nurse to care for a group of patients from four to six weeks. The preceptor works on the clinical skills, while the buddy nurse helps the new hire make the cultural adjustment, says Jeanne Jacobson, R.N., vice president for patient care services. "Coming out of an academic environment and going to acute care is a pretty big leap for some people," she says.

The program benefits existing staff as well as new nurses, Jacobson says. For instance, an entire unit might get together at an event for new hires, strengthening connections between all the nurses.

The strategies seem to be working. Since April 2002, Fairview Southdale has hired 131 nurses, and only three left because of dissatisfaction. Turnover overall dropped 7 percentage points last year to 10.3 percent, and costs for agency nurses fell. "Retaining is a far greater challenge than recruitment," Jacobson says. "Failing at this generates higher costs in turnover and decreases our ability to provide continuity of care for our patients."

Mercy Medical Center-Dubuque and Dyersville, in Iowa, recognized that nurses who would rather remain in direct patient care sometimes accept promotions to management just for the higher pay.

"We wanted a career model where nurses can stay at the bedside," says Kay Takes, R.N., vice president of patient care at Mercy. Under the system, launched Jan. 1, nurses can move through five stages of expertise, with accompanying pay raises--and without forsaking patient care for management. All nurses who have been with the medical center at least two years automatically are pegged at the middle of the five stages, while new nurses receive the "novice" rank. To be promoted, nurses must write narratives describing their care of patients to show they've reached the next stage in areas such as clinical knowledge, and caring and collaboration. They present the narratives to panels of their peers.

Giving nurses new challenges is a way to keep them engaged, Takes says, and that should result in a richer experience for nurses and patients.

St. Marys Hospital Medical Center, Madison, Wis., which is fostering nurse retention under a shared governance model, is a pioneer in creating a meaningful environment for nurses.

One element of St. Marys' work culture is to keep nurses learning. Nurses have grand rounds, similar to physicians, in which interesting cases are presented. Also like doctors, nurses elect one of their own to chair a council that coordinates the work of the unit working councils. That nurse, Debra Geier, worked at the hospital before and after the shared governance model. "Before, you felt like you checked your head at the door," she says. "Now, nurses are expected to think." Geier's peers, it seems, never stop thinking; she carries a notebook to jot down their ideas and questions.

All that thinking has led somewhere. Last year, one nurse council confronted the unpopular practice of "floating," in which nurses go to floors they don't normally staff if their own unit's census is too low. "It's a great dissatisfier," says Joan Beglinger, R.N., St. Marys' vice president of patient care services. The council redesigned the practice to make 13 of the hospital's 18 units "self-staffed," responding to their own census highs and lows. If a unit isn't busy, nurses have

the option of taking the day off, or going to another unit. If the staff needs to be increased on a unit, nurses are called in from a sign-up sheet, so they know who's on call on a particular day.

"The nurses are so thrilled," Beglinger says. "It allows them to have more control over their lives." Shared governance does require Geier and other clinicians to attend meetings and do research during work hours. "Some of my time is spent on things that are not patient care," she says, "but ultimately, they affect patient care." Beglinger argues that shared governance pays for itself. Her hospital doesn't use agency nurses and has low turnover. Replacing one nurse, she says, can cost \$50,000. Other hospitals in her market have to recruit nurses from the Philippines.

Perhaps the most meaningful benefit is that satisfied, stimulated nurses make for good clinical outcomes and high patient satisfaction. "You will never have satisfied patients if you don't have satisfied practitioners," Beglinger says.

MEDCEU Continuing Education Courses CEU for Nurses and Healthcare Professional (2012) stated that the issues around nursing education extend into the practice setting. Whether a nurse graduates from a two-year, three-year or four-year nursing program, the transition into practice is quick, with little time for mentoring or on-the-job training. Indeed, with many shifts short-staffed

today, managers are reluctant to pull experienced nurses away from patient care activities to serve as trainers and mentors.¹ According to a report in the *Chicago Tribune*, half of all hospitals have reduced orientation programs for newly graduated nurses. Once hired, new nurses receive an average of 30 days of training, in contrast with the three months of hands-on training provided five years ago.

New nurses begin practice feeling unprepared, and, in fact, too often they are. In two recent studies from the National Council of State Boards of Nursing, which asked entry-level nurses and employers of newly licensed nurses to rate the adequacy of nurses' preparation to perform a variety of patient care tasks, both groups ranked the adequacy of preparation low. Employers' rankings were much lower for every variable. Among these tasks, the ability of new nurses to respond to emergency situations, supervise the care provided by others, and perform psychomotor skills were rated at the lowest levels. There is what has been described as a "continental divide" between nursing education and nursing practice. In the academic setting, nurses, like other health professional disciplines, are educated in a silo.

This problem is compounded by the lack of awareness of nursing faculty about actual nursing practice today; the virtual absence of clinical experience from the nursing school curriculum; and the lack of involvement of nurse

clinicians in the education process. The professional knowledge of new nurses about physicians, pharmacists, allied health professionals and others is in the abstract until they are plunged into the reality of the workplace. Yet, nurses are the pivotal providers of care, often responsible in the end for coordinating all of the actual care received by the patient. Nurses' ability to fulfill this role successfully is dependent on their knowledge, professional confidence, and ability to interact effectively with all members of the care-giving team.

Team training, both at the undergraduate and post-graduate levels, is increasingly becoming a critical curricular need. At a time when patients are sicker, care delivery more complex, and nurses thinly spread, new nurses are entering a highly stressful environment. Where the Flexner Report of 1910 made hands-on training obligatory for newly graduated medical students, no such requirement exists for nursing. Isolated nursing residency programs have been created at various hospitals and academic centers, particularly for specialty training.

However, these programs vary in length, structure and content, reflecting their inherently "home grown" nature. Graduate medical education, which is funded in substantial part through the Medicare program, is standardized by discipline under the purview of the Accreditation Council for Graduate Medical Education. For nursing, there are no structured residency programs, no standards,

no oversight body to assume that the standards are met, and no funding. Structured post-graduate training programs for nurses could provide the opportunity for skill-building in real clinical settings, just as residencies do for young physicians. Such experience would smooth the transition from nursing schools and help to build the confidence and competence of the trainees before they fully enter nursing practice.

The content, length and structure of these residency programs could vary as a function of levels of undergraduate preparation as well as the roles eventually to be assumed by the trainees. Establishment of standardized nursing residency programs would require collaboration between schools of nursing and hospitals, the creation of an appropriate accrediting or certifying body, and identification of stable funding sources. A residency program model is currently being implemented through a partnership between the American Association of Colleges of Nursing (AACN) and the University HealthSystem Consortium (UHC). Currently a demonstration project offering standardized curricula across five UHC-member academic medical centers, the UHC/AACN one-year residency program is for baccalaureate degree nurses.

In addition to developing clinical judgment and leadership skills for new nurses at the point of care, the goal of the residency program is to strengthen the trainee's commitment to practice in the inpatient setting by making that first

critical year a positive working and learning experience. The residency program also includes an outcomes measurement component so that its impact on the care provided by first-year nurses can be measured. Upon successful completion of the UHC/AACN residency demonstration project, the program is to be offered to all UHC member organizations. This important demonstration project could serve as the critical model for more broadly based nursing residency programs.

Nurses provide spiritual care to patients and their immediate families for it is an expected part of nursing care (**Matthew, 2010**). Although most schools of nursing teach that biopsychosocialspiritual care is what nursing is all about, the spiritual care content is often minimal. Nursing texts tend to discuss spiritual care as a part of psychosocial care, with a one-sentence admonition to pay attention to the spiritual beliefs of the patient. Spiritual care is being used in the narrow sense of requiring a religious belief system which can be activated for patient comfort.

According to **Matthew (2010)**, when the patient is gravely ill, and the nurse does not always know what has been told to the patient about his/her condition, the question, “Am I going to die?” provokes a lot of anxiety. Nurses should be ready with a thoughtful response. The response both buys time for the nurse to think and should solicit some further response from the patient. Most nursing texts address this issue and suggest ways to handle it. Role playing will

prepare the nurse for when, not if, this occurs. The concerned, caring manner of the nurse is the most important aspect of the exchange, not the precise words.

Furthermore, **Matthew (2010)** believes that nurses who are themselves spiritually active are more likely to be caring people, sensitive to the spirit of their patients. This transcends the theology of religions, and is dependent upon the belief that human life is precious. This human life is something to be valued above all else, to be loved and cared for because there is a God who values, loves, and cares for all. This human life embodies the spirit of the person. This is the spirit people address when they want the person to “will to live”, or to “fight for life.” We as nurses, minister to the spirit, through our own caring actions, the tender hands that say to the patient that they are a person of value.

Whatever the religious belief of the nurse, each nurse can give spiritual care, either directly or indirectly provided there is respect for the patient as a human being. As long as that spiritual belief system has room for a Supreme Being who can be addressed, the nurse can ask for guidance strength, and wisdom in solving the problems that will present themselves. **Matthew (2010)** believes that the foundation of spiritual care is provided when the nurse approaches his/her assignments in a prayerful manner. Prepared in this manner, every nurse can give spiritual care to those in need of nursing care.

Caring for the spiritual needs of patients is a neglected and misunderstood aspect of nursing care. This is due to the lack of instruction nurses receive in the spiritual dimension of nursing. **Rogers (2010)** personally attest to this because in her experience as a nursing student, spirituality was identified as part of the holistic approach to providing patient care, but the subject was never explored. Until this aspect of nursing care is addressed, patients will receive care that is fragmented and not holistic.

According to **Health Volunteers Overseas or HVO (2012)**, openness is a quality and attitude that will serve you well as a volunteer. You are entering a new culture; be open to its possibilities and its wisdom. Come prepared, having done some research on the culture, medical practices, and traditions. Be sensitive to the different nuances in the culture, particularly in terms of personal space, eye contact, touch, and proper attire. In some program sites, there are health care providers from a variety of cultures, so it is important to recognize such a diverse team and acknowledge that you are working across a lot of different cultural styles. Respecting and valuing diversity allows you to learn from your colleagues as well. By remaining open-minded, volunteers can appreciate what is culturally valuable, medically sound, and technologically feasible in order to build upon local knowledge rather than replace it. Being open to the new culture also brings a sense of humility as volunteers recognize that they have much to learn from their colleagues, who are working under harsh conditions with limited resources.

Marshall, B. (2012) stated that to provide the best possible patient and family care, we first must take a step back as clinicians. We need to assess our values, our beliefs, our customs, and ourselves. We need to feel comfortable with our previous experiences and reactions. Clinicians cannot start to care for a culturally diverse patient if they are not first comfortable with their own identity and beliefs. You must also be prepared to remove any preexisting prejudices or ideas about others that may be clouding your mind.

Self-awareness is both a cognitive and an emotional process. Through self-examination, the clinician can achieve a sense of self and can become more aware of self-attributes that may create barriers to effective communication across cultures. Removing internal barriers is the first vital step to initiating a trusting relationship with your patient.

American Academy of Orthopedic Surgeons or AAOS (2011) stated that after orthopaedic surgery, your doctors and nurses will make every effort to control your pain. While you should expect to feel some discomfort, advancements in pain control now make it easier for your doctor to manage and relieve pain.

Surgeons and their patients are increasingly using alternative methods, such as relaxation techniques and acupuncture, to supplement conventional

medicine. A combined approach to pain management is often the best option because it allows the surgeon to tailor pain control methods to each individual patient.

Caring behaviours are defined as behaviours evidenced by nurses in caring for patients. The top ten caring behaviours, derived from nursing literature are: attentive listening, honesty, patience, responsibility, providing information so the patient can make an informed decision, touch, sensitivity, respect, and calling the patient by name, **(Vance, 2011)**

In making a nursing assessment of an elderly person, it is essential that the orthopaedic nurse is meticulous in taking the patient's history and that an accurate physical examination is carried out. The nurse must be able to differentiate between the ageing process and pathological change. **(Kneale, J. 2009)**

Joints that are not put through a range of movement at regular intervals will become stiff and eventually a joint contracture will occur due to the ligaments and tendons not being stretched and instead becoming denser, contracted and less elastic. For example, wearing shoes with high heels for a period of time reduces the range of dorsiflexion of the ankle; the Achilles tendon shortens and contracts, causing ankle stiffness. When flat shoes are worn again, stretching of the Achilles tendon can often be felt. If the contraction is significant

or the individual elderly, the tendon may become painful, damaged or even torn when full dorsiflexion is imposed by wearing flat shoes.

Many of the patient problems so far discussed require a close working relationship between the nurse, physiotherapist, occupational therapist, and patient, but as **Ouellett & Rush 1998 as cited by Kneale, J 2009** identify, there is a tension between these professionals and the role of the nurse. The skill of the healthcare professional is in getting the balance between activity and rest right, at any point in time, so that the patient can achieve an optimum rate of recovery and degree of comfort, with minimal complications.

Powell 1986 as cited by Kneale, J 2009 proposes that active exercises have four main purposes.

1. To retain movement to prevent stiffness in joints and maintain normal tone in the muscles controlling them
2. To restore movements which have been lost owing to disuse, injury, or disease
3. To redevelop muscles and to restore muscle balance that has been lost through disuse, injury or disease.
4. To retain the memory of movement patterns and to regain functional control in general.

These exercises all require patient cooperation and participation. They may be classified according to the degree of participation and the degree (or lack) of movement required.

- Free active exercises: carried out by the patient on their own, the aim being to gain or retain joint movement and strengthen muscles. They also stimulate and assist the circulatory system to prevent circulatory stasis.
- Isometric exercises (static contractions): these are performed by the patient and involve muscular contractions without movement of the joints. The patient performs them, for example, when their leg is immobilized in a plaster cast, to maintain the tone and strength of the quadriceps muscles. Thus recovery is speeded up and circulatory stasis reduced.
- Assisted active exercises: active movements performed by the patient but with the assistance of a healthcare professional such as the physiotherapist or nurse, or a mechanical device or the patient's sound limb.
- Resisted active exercises: carried out by the patient against a resistance such as a footboard or weight attached to a limb or against the physiotherapist or nurse.

Individuals should be provided with written instructions on their exercise programme, to prevent joint and muscle deterioration due to disuse and to enable them to continue progressive rehabilitation once discharged from hospital. Many

day centres now provide exercise classes for the elderly to enable them to maintain muscle strength and their range of joint movement and so help them avoid the potential problems of reduced physical mobility and improve their quality of life. For instance, to strengthen a patient's shoulder, they are given a programme of exercises they are expected to perform twice daily.

The patient does not perform passive movements. Instead, the physiotherapist, nurse, or a mechanical device such as a continuous passive mobilizer puts the patient's joints through a range of movement and stretches their muscles. These movements are necessary for patients with impaired physical mobility due, for example, to polyneuritis, multiple sclerosis or motor neuron disease. They aim to prevent tightness and contractures of joints and muscles. The nurse is usually instructed and assisted by the physiotherapist to ensure continuity and consistency and that appropriate movements are used. **Downie & Kennedy 1980 as cited by Kneale, J. 2009** emphasize that care must be taken when carrying out passive movements because the joints and tissues are easily damaged by excessive vigour or overextension of the range of movement of relatively unprotected joints and muscles because all the soft tissues are weakened by disuse.

Impaired physical mobility may cause a toileting self-care deficit, such as inability to maintain or achieve continence, leading to constipation, renal calculi

or a urinary tract infection. These problems are further exacerbated by therapies or nursing interventions such as the drugs given for pain management, premedications or restricted fluid intake before and after surgery. The lack of privacy and the discomfort of using bedpans, commodes and urinals while confined to bed only add to the patient's difficulties. **(Kneale, J 2009)**

Whether the patient is at home or in hospital, the inability to eliminate without assistance leads to an inevitable loss of privacy and dignity and causes discomfort.

Western culture and basic human anatomy and physiology ensure that patients are unprepared for eliminating while in bed, in the presence of others and into strange receptacles. Postures such as lying and restriction of movement and position due to casts or traction add to the problem. This makes it difficult for the individual to relax sufficiently to urinate. As defecation occurs best in a squatting position, this function is also inhibited by environmental and positioning restrictions which therefore may lead to constipation.

Psychological stimuli such as running water may help a patient to urinate but other interventions should also be carried out to help alleviate inhibiting factors:

- Ensuring maximum privacy for the patient when they are using a bedpan

- Allowing the patient to communicate that they have finished or need assistance, for example by giving them a call bell rather than keep checking on them
- Ensuring the patient is comfortable and feels safe
- Providing toilet paper and leaving it within reach
- Whenever possible, allowing the patient to use the toilet or commode rather than bedpan or urinal
- Providing hand-washing facilities

Good nutrition is fundamental to physical well-being and is important for many activities of living including elimination. However, poor nutrition must not be confused with self-care deficits in feeding which are more specific in nature and related to problems of mobility. Self-care deficits in feeding relate mainly to physical disability, motivational factors, the patient's position, and the availability of assistance. **(Kneale, J 2009)**

To overcome the individual's self-care deficit, the orthopaedic nurse must have empathy, patience, resilience and common sense. Arthritic patients, for example, suffer from joint deformity and pain. If these are severe and involve the joints of the hand, the grip strength is reduced and holding cutlery is difficult. Arthritic patients tend to use both hands to support cups while drinking and built-up handles on cutlery can help a weak grip. **Mandelstam 1990 as cited by**

Kneale, J 2009 offers valuable information on assessing the disabled individual, for decisions on and obtaining appropriate aids to help them eat and drink in hospital and the community, along with details on the rights of disabled individuals. The provision of sandwiches and other finger foods for some meals offers a simple, effective solution (**Wainwright 1978 as cited by Kneale, J 2009**) but can lead to a restricted diet.

Some patients require assistance varying from arranging and cutting up food to inserting food into the patient's mouth. Whenever possible, the patient's ability to feed themselves must be maintained, which requires the orthopaedic nurse to use all their knowledge and skills. A patient who has undergone spinal surgery and is confined to a supine or prone position is still able to use their arms. With mirrors, careful selection and preparation of food and drink and the use of suitable utensils and aids, these patients are able to feed themselves. This gives them more control over their situation and is psychologically beneficial.

Bathing, grooming, and dressing are all personal and private aspects of everyday life. One of the stabilizing and often pleasurable aspects of daily living is removed if the individual is unable to carry out these activities. Dressing, in particular, is one way for people to demonstrate individuality and show they have control of their lives and possess decision-making capabilities. All these activities reflect, to some extent, people's social and economic position and niche in life.

The inability to perform personal cleansing and dressing activities is predominantly due to impaired physical mobility as result of:

- Pain on movement
- Prescribed restrictions, such as plaster of Paris casts or bedrest
- Limited range of movement
- Reduced muscle strength
- The lack of a desire to move

The absence of breathing is obviously serious, as in respiratory arrest or apnea. Other problems may occur with breathing and the gaseous exchange in the lungs owing to:

- The quality of breathing
- The quality of the breathed air
- The condition of the individual's lungs and cardiopulmonary system

Ideally the lungs should be able to expand easily on inspiration and the lung bases should be aerated regularly by taking deep breaths. There are several reasons why this may not occur in orthopaedic patients.

- Impaired physical mobility: this can be local, such as when wearing a tight plaster jacket, or general, for example owing to conditions such as rheumatoid arthritis or from a prescribed therapy such as bedrest

- Posture: lung expansion is easiest in the upright position
- Pain and its management
- Physical deformity
- Surgery

Pain prevents deep breathing and coughing. Also some analgesics, such as morphine, depress the respiratory centre and reduce the depth and rate of breathing. Physical deformities such as scoliosis and the effects of ankylosing spondylitis reduce lung expansion. General anaesthetic agents reduce respiratory function by depressing breathing and paralyzing the cilia of the respiratory tract that keep the lungs clear of mucus and debris.

By encouraging regular deep breathing, more oxygen enters the bloodstream to respond to increased metabolic demands, especially following injury or surgery. Additionally, the lung bases are aerated by dilation of the bronchioles and alveoli, preventing the mucus secretions stagnating in them. If secretions do collect, they can solidify and act as mucus plug in the bronchioles. This plug is difficult to expectorate; the air distal to the plug is absorbed but fluid still exudes from the walls of the alveoli, providing an ideal medium for bacterial growth. The resultant chest infection further reduces gaseous exchange. Deep breathing also reduces the negative pressure in the thorax, thus drawing venous blood back to the heart more effectively and reducing the risk of DVT.

The orthopaedic nurse needs to work closely with, and often under the guidance of, the physiotherapist in teaching patients deep breathing exercises and helping them to maintain these.

The upright position allows greater diaphragmatic freedom and thus encourages increased ventilation of the lungs with less effort from the patient, as the abdominal contents drop with the assistance of gravity on inspiration. As **Boylan & Brown 1985 as cited by Kneale, J 2009** describe clearly, inspiration is an active process whereas expiration is passive. Therefore, inspiration requires greater energy and motivation from the patient and is more tiring. Often the orthopaedic nurse needs to be innovative and flexible, as the patient's condition or therapy may prevent or make difficult the achievement of this posture. The patient must be encouraged to be up and walking as soon as possible. Sitting upright, well supported, in a chair is also beneficial.

An environment that is airy, well ventilated and with a constant warm temperature is pleasant and psychologically beneficial to the individual. The opposite can be harmful to physical, social, and psychological health. For example, a hot, stuffy, smoky atmosphere for even a short time can cause coughing, sore throat, headache, tiredness and lethargy. Impaired physical mobility may reduce the patient's ability to control their environment and thus makes them dependent on the nurse. However, whenever possible, they should be

encouraged to be outside in the fresh air as this will have psychological benefits as well.

Good ventilation keeps unpleasant odours to a minimum and reduces the prevalence of airborne bacteria and viruses. Pleasant-smelling aromas from oils will encourage deep breathing and have therapeutic benefits. The use of aromatherapy essential oils, such as lavender which helps relaxation and promotes sleep, dates back to the ancient Egyptians who used oils for religious and medical reasons.

A patient who smokes should be given information, encouragement and support to stop or reduce their smoking, although the decision to do so has to be the patient's. The patient's health would benefit generally and ensure quicker, more efficient therapy and better quality of life if recovery or cure were not possible.

Undoubtedly, sleep pattern disturbance causes discomfort and interferes with the desired lifestyle; it may also lead to ill health or be the result of ill health. Recovery from orthopaedic conditions and their treatment is hindered or prevented by a lack of adequate sleep and rest.

Since nurses tend to spend more time in close contact with orthopaedic patients than do other healthcare professionals, the responsibility for dealing with

sleep pattern disturbance rests largely with them. A limited understanding of the nature of sleep and rest, reinforced by general attitudes which belittle their importance can lead to nursing and medical staff providing inappropriate or inadequate care for patients with a sleep pattern disturbance.

Pain is probably the most significant cause of sleep pattern disturbance **(Closs et al 1997 as cited by Kneale, J 2009)**. Medications, such as hypnotics, are not a suitable solution to the long-term chronic pain and sleep disturbance for many orthopaedic patients, owing to the effects of increased tolerance, dependence, and side effects. However, immediately prior to surgery or for a few days post trauma, they can help promote sleep and rest. Interventions such as relaxation techniques, aromatherapy, massage, and instructions on self-relaxation are preferable and can be used with pain-reducing medication.

If sleep is accepted as important to the patient's health, recovery and well-being, then orthopaedic nurses must be more knowledgeable and systematic in their nursing care. Patients vary significantly in their sleep needs and the factors that promote or hinder them.

Assessing sleep pattern disturbance and evaluating nursing interventions may be achieved relatively easily. Subjective methods used are similar to those for pain management:

- Visual analogue scales
- Questionnaires
- Interviews
- Daily sleep charting

In many cases the nurse and patient must make the best sleep and rest environment despite adverse situations. Positioning patients wearing casts and splints or in traction can be restricted; however, imaginative use of pillows and supports together with pain and anxiety-reducing interventions and a quiet, warm, well-ventilated environment will all help to promote and ensure better quality sleep.

A nurse has been suspended from her job for offering to pray for an elderly patient's recovery from illness. Caroline Petrie, a committed Christian, has been accused by her employers of failing to demonstrate a "personal and professional commitment to equality and diversity".

She faces disciplinary action and could lose her job over the incident. Mrs Petrie, a married mother of two, says she has been left shocked and upset by the action taken against her.

She insists she has never forced her own religious beliefs on anyone but politely inquired if the elderly patient wanted her to pray for her – either in the woman's presence or after the nurse had left the patient's home.

Mrs Petrie, 45, is a community nurse employed by North Somerset Primary Care Trust to carry out home visits to sick and elderly patients.

The incident which led to her suspension took place at the home of a woman patient in Winscombe, North Somerset.

However, after the incident on December 15, she was contacted by the trust and asked to explain her actions.

The woman patient, who is believed to be in her late 70s, is understood to have complained to the trust.

Mrs Petrie will not disclose the woman's name or reveal the precise nature of her ailment because it would breach patient confidentiality.

Mrs Petrie, who lives in Weston-super-Mare, North Somerset, said she was initially confronted the next day by a nursing sister who said the patient had been taken aback by her question about prayer.

Mrs Petrie said that she often offers to pray for her patients and that many take her up on it.

She either prays with them or after she has left their home. The nurse has been a committed Christian since she was ten – after her mother died of breast cancer.

Mrs Petrie had previously been reprimanded for an incident in Clevedon last October when she offered to give a small, home-made prayer card to an elderly, male patient, who had happily accepted it.

On this occasion, the patient's carer, who was with him, raised concerns over the incident.

In the letter, Mrs Petrie, who qualified as a nurse in 1985, was asked to attend an equality and diversity course and warned: "If there is any further similar incident it may be treated as potential misconduct and the formal disciplinary procedure could be instigated."

It is the second incident – the offer to pray for a patient – that led to the disciplinary action. She was suspended from her part-time job, without pay, on December 17.

She faced an internal disciplinary meeting last Wednesday and expects to learn the outcome this week.

At last week's hour-long meeting, Mrs Petrie says she was told the patient had said she was not offended by the prayer offer but the woman argued that someone else might have been.

Mrs Petrie, who has worked for the trust since February last year, has already taken legal advice from the Christian Legal Centre, which seeks to promote religious freedom and, particularly, to protect Christians and Christianity.

(Alderson, A. 2013)

One problem is that most physicians haven't been taught how to address spirituality at the bedside -- except for palliative care experts, who are well versed at tackling this topic. Palliative care guidelines even list spiritual suffering as one

of the symptoms clinicians need to assess and address. According to James Tulsky, a palliative care specialist at Duke University, "Spiritual issues are central to patients' experience of illness, particularly when they are really sick. To ignore spirituality is to ignore a central piece of what it means for many people to be a patient." Tulsky thinks physicians can address spirituality without unduly coercing patients, by asking them about spirituality without inviting them to pray.

The end result of this inquiry is that it opens up an important line of communication, and helps physicians better understand their patients' values and needs." Sometimes that line of inquiry leads to joint prayer. More often, it simply helps doctors understand their patients better, while giving patients license to talk about what is on their minds.

It was wrong for that neurosurgeon to preach at his patient's bedside without first inquiring about his patient's spirituality. It is equally wrong for physicians to act as if patients' spiritual beliefs have no relevance in their medical care. **(Ubel, P. 2013)**

Religion, for many years, was not seen as a typical or practical part of healing in conventional medicine. Medical schools are now trying to do a better job teaching future doctors to take into account a patient's ethnicity and cultural ties when discussing care and treatment options. This does not mean that prayer

itself is taught as a therapeutic modality. Rather, it is more likely that many physicians may still feel quite shy when approaching patients about questions of spirituality and prayer. Prayer itself may be much more a tool and comfort to patients than is currently being practiced right now.

Prayer is often a prominent aspect of one's spirituality. In times of illness, prayer is often a source of comfort and inner strength. We may never fully clarify when, why and how prayer works for a scientific journal, but many now feel that spirituality has a place in medicine. Nor should we discount the power of prayer for those wanting to pursue it. Hospitals now take extra efforts to ask religious or spiritual affiliations when someone is admitted to a hospital. Now may also be the time that both doctors and patients open channels of communication of preferences on spirituality and prayer in efforts to help both mind and body. **(PureHealthMD, 2013)**

Nurses may be asked by patients to pray with them or for them. Whether nurses should pray with patients has been a matter of longstanding controversy. Yet decades of research show that many of our patients want nurses to pray with them **(DiJoseph & Cavendish, 2005; Taylor, 2003)**. Prayer may benefit both the nurse and the patient; both may find comfort in prayer. Prayer may also help patients and their families adjust emotionally to their illness or life events and support the patients' spiritual health.

Unfortunately, nurses may not know prayers of different faiths. We offer practical prayers from different faith traditions for patients and nurses wanting to pray.

When a patient asks to pray, we recommend talking with patient's to determine their prayer preference before starting to pray. Some patients will want to pray silently. Some patients will want the nurse to be present while they say a prayer out loud. Others will want the nurse to lead them in prayer. Some will want to pray now, others may want the nurse to keep them in their prayers.

Short, Non-denominational Prayers. Sometimes a short prayer is the best. In her book, *Traveling mercies: Some thoughts on faith* **Lamont (2000)** argues that the two most common prayers are "*Please, please, please...*" and "*Thank-you, Thank-you, Thank-you...*" Patients and nurses who wish can add "*God*" or "*Lord*" to the beginning of any of these prayers, or "*In Jesus' name we pray*" to the end. A calming prayer is "*Calm my fears and anxieties as I go through this day.*" Some wish to say a prayer in the morning. One is "*This is another day, O Lord. I do not know what the day will bring, but help me be ready to face the day.*" A similar prayer is "*Please give me strength and courage to get through this day.*" Or "*Help me Lord to be loving and kind to all I meet today.*" A prayer for both the patient and nurse is "*God of compassion, source of life and health, give strength and new abilities to __ (insert name) __, and give your power of*

healing for those who minister to __(insert name)__ needs.” One nurse was often asked by the prisoners she cared for to pray with them. She has found that “Lord, please give __(insert name)__ what he/she needs today” is very calming. Some say the prayer that never fails is, “Thy will be done.”

Patients may request a prayer for forgiveness, or a prayer to forgive someone else. Both the “*Our Father*” and the Buddhist prayers in the preceding paragraphs ask for forgiveness. The following short prayer also may be effective in helping a patient forgive someone else. “*Lord, __(insert name)__ treated me badly, they __(briefly state what they did)__, and I forgive them.*” Encourage patients and families to say this prayer every time the wrong doing comes into their head. They may find they are no longer obsessed with negative thoughts.

The following prayer was written for patients who ask to pray to be released from pain: “*Dear Lord, I am facing this pain situation and it makes it difficult to work towards recovery. I don’t know what it takes to bear this pain. Be near me in my time of weakness and pain. Give me the strength and courage to do what I need to do. Help me believe I can find comfort and rest. Thank you for your abundant grace. Amen.*”

The following can be said with patients who ask for a prayer to help them sleep. “*Heavenly Father, grant __(insert name)__ the gift of sleep for the refreshing of __(insert name)__ body and soul.*”

Nurses can also personalize prayers for patients through the use of prayer prompts. **Joni Eareckson Tada (2008)** offers prayer prompts, which we have modified for nurses to use with patients who are overwhelmed by their current situation.

Lord, __(insert name)__ is facing __(describe the situation)__ Trying to handle this alone makes __(insert name)__ feel overwhelmed (express fears/weaknesses)

Give __(insert name)__ your strength, joy, patience, and wisdom to face __(the situation)__ Thank you, God for the abundant grace You provide for __(insert name)__ . Amen

Nurses may be asked by patients to pray with them or for them. Whether nurses should pray with patients has been a matter of longstanding controversy. Yet decades of research show that many of our patients want nurses to pray with them (**DiJoseph & Cavendish, 2005; Taylor, 2003**). Prayer may benefit both the nurse and the patient; both may find comfort in prayer. Prayer may also help patients and their families adjust emotionally to their illness or life events and support the patients' spiritual health.

Unfortunately, nurses may not know prayers of different faiths. In this article, we offer practical prayers from different faith traditions for patients and nurses wanting to pray.

When a patient asks to pray, we recommend talking with patient's to determine their prayer preference before starting to pray. Some patients will want to pray silently. Some patients will want the nurse to be present while they say a prayer out loud. Others will want the nurse to lead them in prayer. Some will want to pray now, others may want the nurse to keep them in their prayers.

Regardless of the faith tradition or practices of the patient, family, or nurse; the moments taken to pray may provide comfort and renewal for all present. We encourage you to adapt these prayers and take the time to pray today.

(Hubbartt, B. 2013)

When a nurse has many patients to attend to and too little time to spend on each one, communication can be reduce to answering questions, and telling a patient what to expect and what to do. From a holistic point of view, communicating in this way inhibits rather than aids in the healing process.

Holistic communication is the art of sharing emotional as well as factual information. It involves letting go of judgements and appreciating the patient's point of view. It begins with attentive nonverbal communication (i.e., warm, accepting eye contact, and facing the patient with arms uncrossed and an inviting facial expression). It follows with a willingness to listen to the patient's inner experience. Simply hearing what patients think and feel has a beneficial effect on their physical healing and well being. The basics for good communication are

simple to learn, do not take up a lot of time, and can significantly change the quality of the patient's experience (as well as that of the nurse).

The most basic form of holistic communication is "Active listening". Active listening is a specific way of hearing what a person says and feels, and reflecting that information back to the speaker. Its goal is to listen to the whole person and provide her with empathic understanding. It is the skill of paying gentle, compassionate attention to what has been said or implied. When you listen in this way to patients, you just try to reflect the other person's feelings and deeper meanings, which helps them feel heard and understood. You don't analyze, interpret, judge, or give advice. When patients are listened to in this way, they are less anxious, complain less about their caregivers, and are more likely to comply with their treatment plan. (Klagsbrun, J. 2012)

Example

A cardiac patient might be angry and complaining. As the nurse, you may try to avoid his room, and, when you have to be there, move in and out as quickly as possible. Avoidance is one solution, but there might be a different approach:

Patient: *Where's the doctor? She said she'd be here this morning. And it took you twelve minutes to answer my call button. I wasn't pressing it for fun, you know.*

***Nurse:** I can hear you're feeling very impatient today, and really conscious of how slowly things seem to move here. It must be difficult. I can imagine how frustrated you must be.*

***Patient:** Damn right it's frustrating! I feel as if I'm just a number around here.*

***Nurse:** So it feels like the delays reflect our not caring about you.*

***Patient:** Well, there are a few good nurses like you. (Pauses. He thinks for a while.) But I do feel frustrated. And having to lie here in bed makes me feel pretty helpless.*

***Nurse:** Can you think what might help that frustrated, helpless feeling when you do have to wait?*

***Patient:** Actually, as long as I have something good to read I'm not so aware of how slowly things happen around here. And it helps to have you drop by once in a while.*

***Nurse:** Well, let's make sure you have some absorbing reading. And I'll stop in again to check on you before the end of my shift. I know it can be very frustrating to be left waiting.*

Active listening is a non-intrusive way of sharing a patient's thoughts and feelings. In its most simple form, you hear what the patient is saying, repeat what you heard, and then check with the patient to make sure the reflection is correct. In a more complete listening response, you don't just listen to the words, you try to reflect the feeling or intent *behind* the words. (Klagsbrun, J. 2012)

Typical Dialogue:

Patient: *I'm very frightened about the procedure tomorrow.*

Nurse: *Oh, you'll be fine. The doctor does hundreds of these every year.*

Active Listening Response:

Patient: *I'm very frightened about the procedure tomorrow.*

Nurse: *So, you're frightened about the procedure. Can you say more about what's so frightening for you?*

Active listening helps patients clarify and articulate their inner process. For a patient, being carefully listened to can be a moving and profound experience, one that transforms the relationship between patient and nurse. Active listening is particularly relevant in a hospital setting, where patients often report

that they feel isolated and invisible. It can make a difference in rebuilding a patient's sense of self. It can also be rewarding for the nurse.

Words can be used to hide feelings and meanings; active listening helps reveal those meanings. In that sense, it engages the speaker and listener in true communication. **(Klagsbrun, J. 2012)**

Listening and focusing are invaluable skills for communicating and for reducing stress. They provide new opportunities for nurses to take better care of patients as well as themselves. While at first these new skills may seem awkward or time-consuming, with practice, you will find they are efficient and effective tools for nursing. Active Listening allows you to hear your patients' concerns in an empathetic way, allaying their anxiety and building trust between you. Focusing allows you to go beneath words and rational explanations, and attain new levels of awareness within your body. It is on this level - new and uncharted territory for most of us - that real change occurs. As Gendlin says, "One step in the body is worth a thousand steps in the mind".

It is with empathy that we can engage and empower our patients. With empathy and heart we can help our patients feel good, valued and respected. Empathy allows us to engage and empower our patients to take charge of their health and well-being.

With empathy, we can connect with our patients, we have an understanding of what it is they are going through, and by acknowledging their emotional state and listening attentively, we can engage our patients and empower them to be proactive and in charge of their health care.

Often patients want to feel that you are there for them. Sometimes they are not looking for lengthy discussions and overly involved detailed information. They want simple, accurate and informative information that is pertinent to them and presented in a genuine manner. They want to feel that they matter, and any questions they may have are not insignificant. They want to feel valued and respected.

On occasion, patients may only need a “look” or an unspoken word that says you care. Body language is essential in engaging with patients. It’s how you make them feel, that’s important.

Patients want to feel trust, a connection, and comfort with their health professionals. When doctors and nurses recognize how patients feel, it will help enhance the doctor/patient and nurse/patient relationship; it will facilitate a connection with their patient, which is essential.

If doctors and nurses are not genuine, if they are unengaged, cold, stilted, and do not sense how patients feel; communication may be hindered and patients

will miss out on the opportunity to become engaged and empowered patients.
(Ficarra, B., 2010)

Patient wellness outcome

Many illnesses are curable and may have only a temporary effect on health. Others, such as diabetes, are not curable but can be managed with proper eating, physical activity, and sound medical supervision. It should be noted that those possessing manageable conditions may be more at risk for other health problems, so proper management is essential. For example, unmanaged diabetes is associated with high risk for heart disease and other health problems. **(National Health Goals 2010)**

Death, disease, illness, and debilitating conditions are negative components that detract from optimal health. Death is the ultimate opposite of optimal health. Disease, illness, and debilitating conditions obviously detract from optimal health. Wellness has been recognized as the positive component of optimal health as evidenced by a sense of well-being reflected in optimal functioning, a good quality of life, meaningful work, and a contribution to society. Wellness allows the expansion of one's potential to live and work effectively and to make a significant contribution to society.

The dimensions of health and wellness include the emotional (mental), intellectual, physical, social, and spiritual. A positive total outlook on life is essential to wellness and each of the wellness dimensions. A “well” person is satisfied in his/her work, is spiritually fulfilled, enjoys leisure time, is physically fit, is socially involved, and has a positive emotional-mental outlook. This person is happy and fulfilled. Many experts believe that a positive total outlook is a key to wellness. **(National Health Goals 2010)**

The way one perceives each of the dimensions of wellness affects total outlook. Researchers use the term self-perceptions to describe these feelings. Many researchers believe that self-perceptions about wellness are more important than actual ability. For example, a person who has an important job may find less meaning and job satisfaction than another person with a much less important job. Apparently, one of the important factors for a person who has achieved high level wellness and a positive life’s outlook is the ability to reward himself/herself. Some people, however, seem unable to give themselves credit for their life’s experiences. The development of a system that allows a person to positively perceive the self is important. Of course, the adoption of positive perceive lifestyles that encourage improved self-perception is also important.

A person with emotional health is free from emotional-mental illness or debilitating conditions such as clinical depression and possesses emotional wellness. **(National Health Goals 2010)**

Emotional wellness is a person's ability to cope with daily circumstances and to deal with personal feelings in a positive, optimistic, and constructive manner. A person with emotional wellness is generally characterized as happy, as opposed to depressed.

A person with intellectual health is free from illnesses that invade the brain and other systems that allow learning. A person with intellectual health also possesses intellectual wellness.

Intellectual wellness is a person's ability to learn and to use information to enhance the quality of daily living and optimal functioning. A person with intellectual wellness is generally characterized as informed, as opposed to ignorant.

A person with physical health is free from illnesses that affect the physiological systems of the body such as the heart, the nervous system, and the like. A person with physical health possesses an adequate level of physical fitness and physical wellness.

Physical wellness is a person's ability to function effectively in meeting the demands of the day's work and to use free time effectively. Physical wellness includes good physical fitness and the possession of useful motor skills. A person with physical wellness is generally characterized as fit versus unfit.

A person with social health is free from illnesses or conditions that severely limit functioning in society, including antisocial pathologies. **(National Health Goals 2010)**

Social wellness is a person's ability to successfully interact with others and to establish meaningful relationships that enhance the quality of life for all people involved in the interaction (including self). A person with social wellness is generally characterized as involved as opposed to lonely.

Spiritual health is the one component of health that is totally comprised of the wellness dimension; for this reason, spiritual health is considered to be synonymous with spiritual wellness.

Spiritual wellness is a person's ability to establish a values system and act on the system of beliefs, as well as to establish and carry out meaningful and constructive lifetime goals. It is often based on a belief in a force greater than the individual that helps one contribute to an improved quality of life for all people. A

person with spiritual wellness is generally characterized as fulfilled as opposed to unfulfilled. **(National Health Goals 2010)**

In reality, health and its positive component (wellness), is an integrated state of being that is best depicted as many threads that can be woven together to produce a larger, integrated fabric. Each specific dimension relates to each of the others and overlaps all others. The overlap is so frequent and so great that the specific contribution of each thread is almost indistinguishable when looking at the total. The total is clearly greater than the sum of the parts.

Each individual is different from all the others. Health and wellness depend on each person's individual characteristics. Making comparisons to other people on specific individual characteristics may produce feelings of inadequacy that detract from one's profile of total health and wellness. Each of us has personal limitations and personal strengths. Focusing on strengths and learning to accommodate weaknesses are essential keys to optimal health and wellness.

All people can benefit from enhanced wellness. Wellness and an improved quality of life are possible for everyone, regardless of disease states. Evidence is accumulating to indicate that people with a positive outlook are better able to resist the progress of disease and illness than those with a negative outlook. Thinking positive thoughts has been associated with enhanced results from

various medical treatments and better results from surgical procedures. **(National Health Goals 2010)**

Because self-perceptions are important to wellness, positive perceptions of self are especially important to the wellness of people with disease, illness, and disability. The concepts of wellness and optimal health must be considered in light of one's heredity and personal disabilities and disease states.

Optimal health includes many areas, thus the term *holistic* (total) is appropriate. In fact, the word *health* originates from a root word meaning "wholeness".

Physical fitness is the body's ability to function efficiently and effectively. It is a state of being that consists of at least five health-related and six skill-related, physical fitness components, each of which contributes to total quality of life. Physical fitness is associated with a person's ability to work effectively, enjoy leisure time, be healthy, resist hypokinetic diseases, and meet emergency situations. It is related to, but not different from, health and wellness. Although the development of physical fitness is the result of many things, optimal physical fitness is not possible without regular physical activity. **(National Health Goals 2010)**

Possessing a moderate amount of each component of health-related fitness is essential to disease prevention and health promotion, but it is not essential to have exceptionally high levels of fitness to achieve health benefits. For example, moderate amounts of strength are necessary to prevent back and posture problems, whereas high levels of strength contribute most to improved performance in activities such as football and jobs involving heavy lifting.

The components of skill-related physical fitness are agility, balance, coordination, power, reaction time, and speed. They are called skill-related because people who possess them find it easy to achieve high levels of performance in motor skills, such as those required in sports and in specific types of jobs. Skill-related fitness is sometimes called sports fitness or motor fitness.

Research studies show that health benefits often occur even without dramatic improvements in traditional health-related physical fitness measures. Metabolic fitness is a state of being associated with lower risk of many chronic health problems, but not necessarily associated with high performance levels of health-related physical fitness. Examples of non-performance indicators of reduced risk are lowered blood pressure, lowered fat levels in the blood, and better regulation of blood sugar. Moderate physical activity has been shown to enhance metabolic fitness. Conventional wisdom classifies body composition as a component of health-related physical fitness, but some consider it to be a part of

metabolic fitness because it is a non-performance measure, and it is highly related to nutrition as well as physical activity. **(National Health Goals 2010)**

Traditional definitions do not include bone integrity as a part of physical fitness, but some experts feel that it should be. Like metabolic fitness, bone integrity cannot be assessed with performance measures as can most health-related fitness parts. There is little doubt that strong healthy bones are important to optimal health and are associated with regular physical activity and sound diet.

Good physical fitness contributes directly to the physical component of good health and wellness, and indirectly to the other four components. Good fitness has been shown to be associated with reduced risk of chronic diseases such as coronary heart disease and has been shown to reduce the consequences of many debilitating conditions. In addition, good fitness contributes to wellness by helping us look our best, feel good, and enjoy life. Other physical factors can also influence health and wellness. For example, having good physical skills enhances quality of life by allowing us to participate in enjoyable activities such as tennis, golf, and bowling. While fitness can assist in performing these activities, regular practice is necessary. Another example is the ability to fight off viral and bacterial infections. While fitness can promote a strong immune system, other physical factors can influence our susceptibility to these and other conditions.

For optimal health and wellness it is important to have good physical fitness and physical wellness. It is also important to strive for good emotional (mental), social, spiritual, and intellectual health and wellness. **(National Health Goals 2010)**

Historically, outcome measures can be traced back to Florence Nightingale, who devised a system for comparing death rates by diagnostic category during the Crimean war **(Pynsent et al 1993 as cited by Kneale, J. 2009)**.

An outcome is described by **Bulstrode 1993 as cited by Kneale, J. 2009** as a measure of change, the endpoint being compared to the situation prior to the intervention. Additionally **Bulstrode (1993)** describes an outcome as having relative value rather than being an absolute.

There are several methods of measuring outcomes as used, for example, following joint replacement surgery **(Bowling 1997 as cited by Kneale, J. 2009)**.

- Physical tests of function, such as assessment of the range of movement, stability of the joint or radiological evidence. However, these do not measure the impact of a disease such as osteoarthritis or an intervention such as surgery, on the individual patient

- Direct observation of patient behaviours is useful but can be intrusive for patients and very time consuming for the clinician

Interviewing patients enables practitioners to ascertain the patients' perceptions of the outcomes following an intervention. This approach is affirmed by **Garland 1988 as cited by Kneale, J. 2009** who suggests that quality of life measures focus on health as perceived by the patient, rather than on the status of the prosthesis or other technical concerns that are not directly related or relevant to patients. For instance, attainment of 90° or more knee flexion following a knee replacement is of little importance to a patient if they are in pain free and can function within their lives as they wish to. The problems of patients self-reporting outcomes include individual reactions to apparently similar levels of physical impairment, which in turn is dependent on their expectations, priorities and prior experiences (**Bowling 1997 as cited by Kneale, J. 2009**). Changes in patients' perceptions of their functional ability will also vary with time so a one-off snapshot will not give an accurate picture. Additionally patients' memories can be poor, especially when comparing pain prior to a procedure to that afterwards (**Pynsent et al 1993 as cited by Kneale, J. 2009**).

Health is a very individual, subjective concept; we each have our own perception of what being healthy is. This dynamic changeable state requires an ability to adapt to circumstances, including changes in quality of life and the

interplay of attitudes, emotions, thoughts, and feelings. **Kiger 1995 as cited by Kneale 2009** discusses four dimensions of health: physical, social, mental, and spiritual. These need to be in a state of balance; if one is upset, it can lead to an imbalance in one or more of the others. For example, a rugby player with a knee injury (physical health imbalance) is unable to play as part of a team (social imbalance); the resultant lack of social interaction can cause withdrawal or depression (mental imbalance) and if immobility affects his ability to take part in all the rites and practices of his religion, a spiritual imbalance may occur.

Being healthy reflects a person's definition of health, their personal goals, expectations, age, circumstances, environment and ability to live healthily in their own terms. Other factors affecting health include lifestyle, genetics, the available health services, political and economic factors and personal health benefits **(Bright 1997 as cited by Kneale, J. 2009)**

Kiger 1995 as cited by Kneale, J. (2009) views health as a continuum ranging from ill health due to disease to optimal health as evident in a sense of well-being. We move along this continuum in either direction at different times. The health professionals' role is to enable patients to move along the continuum within the confines of their particular health expectations and potential, to achieve an optimal health state. Hence a client who is mentally well adjusted, independent, physically and socially active but who happens to have had a below-

knee amputation can still achieve their optimal health despite the physical disability. Having an insight into how patients view their health is essential for understanding healing and health promotion and maximising the benefits of health education.

Holistic nursing is the most complete way to incorporate these aspects into the art and science of nursing. Holistic nursing practice draws on holistic knowledge, holistic theories, expertise, and the intuition of the practitioner to assist the patient during the healing-caring process. The healing process is a continual personal journey of changing and evolution through life, as well as the awareness of patterns that support or act as challenges/barriers to health and healing (**Dossey & Keegan, 2008**). The interconnectedness of the bio-psycho-social-cultural-spiritual human dimensions and integration of caring-healing modalities can reduce the devastating effects of disease and illness and assist the nurse and patient in their personal journeys toward wholeness and healing. The recognition by holistic nurses of the interrelationships of the bio-psycho-social-cultural-spiritual elements will impact how the patient distinguishes the holistic nurse's involvement and how the nurse recognizes his or her own involvement. The intent to practice holistically, to bring a sense of calmness and understanding of the patient's needs, leads to an improved and enhanced healing process for the patient and the Holistic Nursing practitioner.

Ageing is a normal and continual process occurring throughout life. Although it is generally accepted that there is some decline in the function of the organs and tissues of the body, ageing is not inevitably accompanied by disease or biological malfunction. Some of the decline is due to the progressive loss of body cells. This need not be significant in health terms since most body systems have considerable spare capacity. For example, we possess two kidneys when the body can adequately function with only one healthy kidney.

Demographic trends are resulting in an increasingly aged population and the present UK government is initiating standards for elderly care through the National Service Framework (**DoH 2001 as cited by Kneale, J 2009**). Within this, the 6th standard focuses on falls and the risk of osteoporotic fractures. Monitoring this group of the population will inevitably involve the orthopaedic nurse.

The normal ageing process need not limit movement. Mobility is, to some extent, affected by personal lifestyle and the degree of activity that the individual has maintained throughout their life, although some limitation of mobility may occur as a result of fear, such as the fear of falling. Ageing, does, however, lead to changes in balance, cartilage, and bone tissue.

The maintenance of balance relies on integrating responses from the visual system, vestibular system in the inner ear and the proprioceptors in muscles and

joints. Older people require greater angular movement in joints for proprioception to be achieved. **(Kneale, J. 2009)**

Gait disorders are not usually a feature of ageing but are more likely to be an indicator of underlying pathology such as stroke, peripheral neuropathy, or vitamin B12 deficiency.

Local Studies

Orthopaedic Nursing

The nurse cares for the patient, carries out procedures ordered by the doctor and, in collaboration with the doctor and other team members, assesses the patient and treats his or her problems. Nurses act as caregiver, communicator, counsellor, client advocate, educator, change agent, leader, coordinator, manager, researcher, and entrepreneur. **(Pajaro, 2012)**

Orthopaedic nursing is focus on the prevention and treatment of musculoskeletal disorders. Orthopaedic issues range from acute problems such as fractures or hospitalization for joint replacement, broken bones, strained muscles, torn ligaments and tendons, and other traumatic injuries to deal with a wide range of acquired and congenital skeletal deformities and with the effects of degenerative diseases such as osteoarthritis to chronic systemic disorders such as

loss of bone density or lupus erythematosus. Orthopaedic nurses have specialized skills such as use of splints, cast and traction, utilizes bone grafts, and artificial plastic joints for the hip and other bones damaged by disease, as well as artificial limbs, special footwear, and braces to return mobility to disabled patients' neurovascular status monitoring, continuous passive motion therapy and care of patients with external fixation. Also, orthopaedic nursing uses the techniques of physical medicine and rehabilitation and occupational therapy in addition to those of traditional medicine and surgery. **(Orellosa, Panay, Pausal, Potencia, Pua, & Reyes, 2011)**

In terms of their demographic data, according to age only caring behaviour 2 (hope) remained a significant change through the pretest and posttest. This indicated that regardless of the respondent's age there were still increase concerns in giving hope to patients in an orthopaedic institution. In their gender, caring behaviour 1 (humanism) and 6 (problem solving) showed a significant change. This explained that regardless of gender, there was an increase concern of humanism and they really knew how to solve problems concerning about providing caring to patients. Caring behaviour 8 (environment) was the only one that had a significant change in terms of the personal history. This indicated that they knew how to protect their patients from getting injured from the environment and provide supportive care. **(Palon, D., Oquendo, R., Pangasinan, J., & Queyquep, I., 2011)**

COMPOSURE Behaviors

Divinagracia (2001) conducted a study to determine the effects of COMPUSRE behaviours of the advanced practitioner on the recovery of selected patients at the Philippine Heart Center. Behaviours include competence, presence and prayer, open-mindedness, understanding, respect, and empathy.

Competence is an in depth knowledge and clinical expertise demonstrated in caring for patients. Presence and prayer is a form of nursing measure which means being with another person during times of need. This includes therapeutic communication, active listening, and touch. It is also a form of nursing measure which is demonstrated through reciting a prayer with the patient and concretized through the nurse's personal relationship and faith in God. Open-mindedness is a form of nursing measure which means being receptive to new ideas or to reason. It conveys a manner of considering patient's preferences and opinions related to his current health condition and practices and demonstrate the flexibility of the nurse to accommodate patient's views. Moreover, stimulation is a form of nursing measure demonstrated by means of providing encouragement that conveys hope and strength, guidance in the form of giving explanation and supervision when doing certain procedures to patient, use of complimentary words or praise and smile whenever appropriate. Appreciation of what patient can do is reinforced through positive encouraging remarks and this is done with kind and approving

behavioural approach. Understanding, according to her conveys interest and acceptance not only of patient's condition but also his entire being. This is manifested through concerned and affable facial approach; this is a way of making the patient feel important and unique. Respect is acknowledging the patient's presence. Use of preferred naming in addressing the patient, po and opo, is a sign of positive regard. It is also shown through respectful nods and recognition of the patient as someone important. Relaxation entails a form of exercise that involves alternate tension and relaxation of selected group of muscles. And lastly, empathy senses accurately other person's inner experience. The empathic nurse perceives the current positive thought and feelings and communicates by putting himself in the patient's place. Through the COMPOSURE behaviours of the nurse, holism is guaranteed to the patient.

Furthermore, **Divinagracia (2001)** stated that nursing is a profession that surpasses time and aspects of the individual as one of its clients. From the time the nurse admits a patient to the time of his discharge, the nurse's presence becomes a meaningful occasion for the two parties to develop mutual trust, acceptance, and eventually satisfying relationship.

A definition of nursing derived from staff nurses' experiences can reflect indigenous practice values, which in turn act as a rich source of ideas and inventiveness in developing a relevant knowledge base to inform practice.

However, a local study that deals with the perception of nursing by hospital staff nurses is still lacking. In this period when nursing enrolment in the Philippines is at its highest number and many have the goal of going abroad in mind, nursing needs to be clear for every Filipino nurse. It is difficult to clarify the characteristics of the nursing profession and the problems that exist within this field. Gaining, therefore, an understanding of the nurses' perception regarding their profession can improve knowledge on this subject.

At present, Filipino nurses must obtain a 4-year bachelor's degree from any nursing education institution duly recognized by the government, then pass the national licensure examination for nurses conducted by the Philippine Professional Regulations Commission (PRC). The Philippine Nurses Association (PNA) is the major national organization for Filipino nurses and has 92 local chapters and 7 international chapters. The Commission on Higher Education (CHED) is a government institution that regulates both nursing curriculum education institutions. It is responsible for school accreditation and reinforcement of rules and regulations and the setting of minimum standards for each institution.

The three main themes that emerged from the analyses were: (1) Nursing as defined as performing tasks that alternate between caring and using a medical-technical approach; (2) Nursing as defined as a health care profession, and (3) nursing as defined within the boundaries of high cultural appraisal and challenged

socio-institutional status. The first theme refers to the tasks nurses perform and how this routine approach differed from the caring approach. Three clusters supported the first theme, namely: the caring approach, medical approach and technical approach. The next theme, however, pertains to the meanings and goals of nursing that are reference-based and reflective of being a body of knowledge in health care. Book-based meaning of nursing and goals of nursing were the two initial clusters under this theme. Lastly, the third theme refers to the external circumstances that may influence their perception about their profession. Three clusters namely: social circumstance, cultural circumstance, and institutional circumstance, supported the last theme.

Caring has been the major theme in the answers of the respondents, reflecting Filipino culture and tradition. This, therefore, together with the high social regard for the profession, should be maintained or even enhanced by nursing leaders as well as by mentors in the academe and in the clinical areas. Instilling Filipino values further and molding nurses in line with this tradition will help exemplify the caring attributes of Filipino nurses in their workplaces. **(Rivera, A. F., 2011)**

Caring is the most central and unifying focus of the nursing practice. There were five (5) categories/themes of caring behaviour demonstrated by the respondent staff nurses to terminally ill patients, namely: acceptance of

uniqueness of patients as individuals, using emphatic communication, respecting patients, providing physical care, and offering emotional support.

Similar themes emerged based from the interviews and observations among the respondent cancer patients as to how the respondent staff nurses treated them.

The framework of the caring behaviour of Filipino nurses emerged which is indicative of the patients' compliance with the treatment regimen to cancer.

Accepting uniqueness of patients and using emphatic communication are significant predictors of patients' compliance with the treatment regimen to cancer. **(Delos Reyes, T. M., 2011)**

Divinagracia (2001) as cited by **Leocadio (2009)** concluded that through the COMPOSURE behaviours of the nurse, holism is guaranteed to the patient. In the post test score, what demonstrated as significant differences is when it is compared with the pretest or on the behavioural aspects of the physical, emotional, intellectual, social, and spiritual aspect of human wellness. Results show that there is a better result to all the dimensions of the patient when COMPOSURE behaviours were observed.

Patient Wellness Outcome

A study in the carative score levels of nursing students exposed to the orthopaedic center was conducted at a top performing university which provides a Bachelor of Science in Nursing program which also has their 4th year nursing students have their orthopaedic clinical exposure to an orthopaedic hospital itself with a total sample of 30 respondents, which are 7 male while the remaining are 23 females. The researchers used a non-probability sampling specifically purposive in selecting the participants. Their study wants to demonstrate the carative score of nursing students in caring behaviours and their demographic profile.

Caring behaviour also referred as characteristics of concern for the well-being of a patient, such as sensitivity, comforting, attentive listening, honesty and nonjudgmental acceptance of the 4th year nursing students in rendering care to orthopaedic patients that coincides with Watson's 10 Carative factors. Likert type of questionnaire were used which was formulated using Jean Watson's 10 Carative factors as a tool and was given before they undergo their clinical exposure. It composed of 10 carative factors which were humanism, hope, sensibility, helping relationship, expression of emotions, problem solving, teaching, environment, needs, and spirituality.

The researchers had given a pre-test in level IV students that will measure the caring behaviour of nursing students in giving concern to their patients. The results showed that in their first exposure the respondents had a very high score in Caring behaviour 1 (Humanism), 7 (teaching), and 8 (environment). The researchers also indicated the relationships of demographic data of the respondents to the carative score. It revealed that in their demographic data which were age, gender, personal and family history only caring behaviour 1 (humanism) and 9 (needs) had a very high score. **(Palon, D., Oquendo, R., Pangasinan, J., & Queyquep, I., 2011)**

Guerrero, J (2011) stated that there is a significant difference in the nursing care practices of the spinal ward nurses to immobilize patient confined in the Philippine Orthopedic Center. Age, gender, and years of experience of the nurse respondents do not relate to their nursing care practices to orthopaedic patients.

Leocadio (2009) conducted a study to create an enlightened model of Lydia Hall's Care, Core, Cure using perspectives of ARUGA for Holistic Nursing need of Filipino patients. Holistic nursing needs includes are the dimensions of physical, psychological, emotional, social, and spiritual needs of patients. The ARUGA Model describes nursing interventions practiced in the Philippines according to the needs of their Filipino patients.

Furthermore, **Leocadio's (2009)** study recommended that nurses must continually see the client as a holistic entity that requires satisfaction of all those dimensions related to holism. Interventions of nurses to their clients must always be based on the fact that all people have body, mind, and spirit. Needs of patients and practices of the nurses must be continuously evaluated and revised to analyze the changes of needs and practice through time. Further, **Leocadio (2009)** discussed that nurses must have the responsibility to analyze and synthesize nurse scientist's work, generate new ideas and continue theory development and application.

Furthermore, **Abaquin (1999)** as cited by **Leocadio (2009)** conducted a study using a quasiexperimental randomized block, split plot-factorial design. The study group received PREPARE ME – Nurses' presence, values clarification, reminiscence therapy, breathing relaxation and meditation. The study group is terminally ill and is cancer patients. Results of the study stated that happiness and degree of satisfaction toward life considering the holistic perspective (physical, psychological, social relationship, independence, environment, and spirituality) are important aspects to consider when caring for adult patients with advanced progressive cancer.

The interactions of the nurse with the patient create the meaning-based approach. The nurse as the giver of nursing care to patients with pain and discomfort affects the behavioural, affective, and cognitive domain. The nurse

shows skills in the behavioural domain while giving temporal nursing acts. A non-meaning based approach to care will result to gaps in care and self learned approaches as the patient's response to pain and discomfort. The patient's responses start from worry to tolerance while learning these of self help interventions, faith, expression of life situations and contentment with care.

On the other hand, the meaning-based approach to nursing comprises both the cognitive and affective domain of the nurses' role. A prompt response on a complaint of pain fosters the communication between the patient and the nurse. Nurses who show efficiency in rendering care are seen as service oriented. This in turn encourage reciprocity as patients would want to participate in their own care based from the rapport established by nurses. Furthermore, this would progress to the affective domain as assimilation of both cognitive and behavioural aspects of nursing care is appreciated through the nurse-patient interaction. The nurse is seen by the patient as a trustworthy partner in health care. The patient fully entrusts her/his body, mind, and soul to the care of the nurse. The nurse in turn shows virtue by being genuine to give goodness and care for the patient. The nurse conveys concern with her works, deeds, and actions. The self is used therapeutically with treatments afforded by the nurse to her patients. The constant presence of the nurse acts as a reminder that the patient will be cared for. This generates a feeling of comfort and induces ease, rest, and sleep.

The meaning-based approach to nursing care facilitates improvement as several patients attest to feelings of comfort after receiving it. The nurse in turn is seen as a special being that heals the patient. The nurse is included in the patient's prayer as a sign of gratitude to her.

The holistic nurse is an embodiment of the care she renders. The nurse creates the calm environment in any setting that facilitates treatment, healing and recovery from any pain or discomfort. **(Cuevas, P.E., 2009)**

Transcultural nursing is needed today more than ever because of the growing diversity that characterizes out national and global populations. As part of the nursing curriculum, student nurses during the Related Nursing Experiences are exposed to different hospital to experience different clinical situations that will enhance their critical nursing skills.

After a thorough survey, it was found out that majority of the subjects are female, 18-25 years old, Roman Catholic, earning a monthly income of below Php5,000 and mostly college graduate. The findings also found out that age is significantly related to personal beliefs alone; religion is highly significant to personal beliefs and spirituality; and that educational attainment is fairly related to personal beliefs. However, gender and monthly income are not related to any cultural factor under consideration.

Pertaining to their spirituality, community folks hold on the belief that their religion together with their religious items such as rosaries, scapulars, and “anting-anting” are enough to give them strength without the need for any medical intervention; and their perception of illness as a will of God which should be accepted relatively affects them in their health choices as reflected in the findings.

Personal beliefs is highly significantly related to age and religion and fairly correlated to educational attainment; while spirituality is greatly connected only to a person’s religion; whereas traditions and health practices shows no significant relationship to any of the profile variables under consideration. **(Garcia, P.R., 2010)**

Based on the findings of the study, the nurse respondents are not poor in giving spiritual care to their patients and this can be attributed to the fact that Philippines is the only Christian country here in Asia and Filipinos are also known for being spiritually inclined. The nurse respondents faired well from all the statements about spirituality except joining the patient and their family in praying. The nurse respondents got extremely high ratings in allowing their patients to make their own decisions in maintaining a non judgmental attitude towards their beliefs and in permitting their patient to express their feelings and concerns about spiritual beliefs.

Based on the findings also, the researchers found out that spiritual care is an area too often overlooked. Based from interview of the respondents' lack of education and training into the spiritual dimension of nursing were major concerns. The provision of spiritual care was seen as a part of the nurse's role. However, staff nurses did not feel that they had a monopoly over the situation. It must be emphasized that nurses do have a key role to play in the identification assessment and planning of spiritual care because of their continuous presence in wards. Therefore, there is a need for providers of health care to develop a team approach in the provision of spiritual care.

The spiritual dimension needs to be placed firmly within existing nursing curricula. Nurses should perceive spirituality as a universal concept which they feel is relevant to all individuals. Nurses should be always be prepared to participate in the provision of spiritual care emphasizing the need for a team approach. No individual member of the multidisciplinary team should have a monopoly in respect to this aspect of care. There should be more research investigating nurses and patients perceptions of spirituality in order to validate existing findings and to generate new knowledge and understanding of spirituality. Without intruding into their personal beliefs and the rule regarding confidentiality in research nurse respondents religion and involvement to religious activities be factors to considered in future studies of this kind. **(Coral, L.O. 2009)**

Foreign Studies

Orthopaedic Nursing

Most patients admitted in the hospital requiring skilled nursing care are at risk for adverse events or complications from their conditions and treatments. They require close observation during their hospital stays, and care providers must be prepared to detect and intervene quickly when complications occur. Orthopaedic patients are a unique surgical patient population in that their underlying physical conditions, operative locations, and comorbidities can place them at higher risk for complications or adverse events than many other surgical patients. Orthopaedic patients are usually admitted to general acute care surgical units where there are no monitoring devices and the staffing ratios are less intense. In the event that a higher level of surveillance is needed, current practice is to transfer the patient to a care area with telemetry or hardwired monitoring capability, which can result in deviation from the orthopaedic care pathway.

The changes to the care model on this unit have improved the overall care of the orthopaedic patients by reducing patient transfers for monitoring purposes, helping patients remain on the orthopaedic care pathway, and reducing readmissions to the orthopaedic unit. This change has empowered staff to provide excellent care to higher risk orthopaedic patients by including them in the care

planning through strategically timed preoperative and discharge education, and the automation of vital signs monitoring and alert notifications that allow staff the opportunity to respond faster to critical changes. These changes have improved nursing competence by encouraging autonomy, building confidence, and reinforcing accountability. The decision to monitor patients is a collaborative nursing function rather than a purely medical management decision, as it is in traditional telemetry units. In addition, by using their critical thinking skills, nurses are able to identify early signs of distress and intervene appropriately, thus avoiding transfers to a higher level of care. The ability to reduce costly intensive and intermediate care admissions, even in the face of our increasing patient acuity, became an achievable goal.

In conclusion, implementation of best practices for orthopaedic inpatient care at our medical center included a multidisciplinary approach to preoperative patient and family education that aims to improve their transition from hospital to community. The program also included a knowledgeable nursing and rehabilitative staff, as well as staffing patterns that allowed the providers sufficient time to spend with each patient. Finally, the new care model not only promoted nursing autonomy to intercede when appropriate but also included technology that could expand the reach of the nurse by alerting nurses to changing trends in vital signs and allowing the necessary intervention to be implemented in

a timely fashion. The process has led to a decreased hospital LOS and significantly lower hospital readmission rates in our patient population. **(Esoga, P.I. et al, 2012)**

Filipino nurses are the favourite among nurses abroad because of their tender, loving care, their facility with the language, their generally pleasant and well-scrubbed appearance and their cheerful and uncomplaining nature. Cheerful, smiling, respectful, and caring for elders, hospitable, almost treated like “idols” by their elderly clients, Filipino caregivers, despite their language and cultural challenges, are breaking barriers and demonstrating the universal practice of care. **(Balleascas et al, 2008)**

Orthopaedic nurses are a specialised group with unique skills and knowledge. In a rapidly changing healthcare environment some traditional Orthopaedic nursing skills may be required less frequently. However, Orthopaedic nurses still possess unique skills that ensure their patients receive the care that best matches their unique needs. Threats to the speciality exist and have the potential to expose the speciality to erosion. It is important then that the group should identify what is inherent about being an orthopaedic nurse and best prepare the group and its members to protect what it values and advocates for the Orthopaedic patient. **(McLeish, P., 2013)**

COMPOSURE Behaviors

Conceptualization of the nurse-patient relationship began with Peplau (1952/1988) and was expanded by interactional nurse theorists (King, 1981; Paterson & Zderad, 1988; Travelbee, 1971). Peplau's (1989) *Interpersonal Relations in Nursing* theory focuses attention on the critical therapeutic value of the nurse-patient encounter. Her collaborative capacity-building interpersonal process includes "presencing" with patients to address unique health needs effectively. Consequently, the teaching-learning of therapeutic relationships was replaced by a skills-based, stimulus-response approach. (Porr, C., 2009)

Rhodes, M.K., Morris, A. H., Lazenby, R. B., (2011) concluded that students overwhelmingly acknowledged *Intelligence* as a major factor in nursing competence. Three distinct areas describing *Intelligence* included saving lives, understanding disease processes and preventing mistakes, and patient surveillance. Students depicted saving lives in comments such as "knowledge saves lives." Fifteen students used the words "life or death" in describing the importance of competence in nursing. Respondents acknowledged that nursing "mistakes can be fatal" indicating that knowledge is required to prevent untoward patient outcomes. Students explained the importance of *Intelligence* regarding patient surveillance in explaining that nurses "make assessments" and "use the

knowledge and expertise for a positive outcome.” Several stated “critical thinking” was required to “make decisions” and “provide care.”

Eight respondents addressed the need for competence with regard to *Skills*. Several added the need to understand or use their critical thinking abilities to “perform skills and tasks well.” Two included the need for documenting patient care “accurately.” Some remarked that competence was “required to be professional;” others stated that nurses need to be accountable for their competence, both in “practicing skills” and “maintaining currency.”

Students responded with contrasting themes regarding *Self* as it refers to competence. Several responded “with competence comes confidence,” indicating that once a nurse was competent in critical thinking, clinical judgment, and performing skills, the nurse would become confident. Others responded that experience and confidence preceded competence. Two suggested that competence is required for success in effectively providing care as well as success in one’s career.

The final theme in this category involved being *Other focused*. Students identified competence as prerequisite to establishing trust with others. One wrote that competence is important because “it makes patients want you to take care of them.” Another student stated “patients and health professionals trust competent

nurses.” Still others discussed the role of competence in the ability to understand holistic care, adding, for example that competence “addresses patients holistically - in all dimensions.”

American Academy of Orthopedic Surgeons or AAOS (2011), psychological methods can be effective as an additional treatment for pain control. These methods can reduce or eliminate the need for medication. Some of oldest and best documented psychological methods include:

- Relaxation techniques
- Guided imagery
- Medical hypnosis

In 18 medical research studies, medical hypnosis, guided imagery, or relaxation techniques were used to improve recovery after surgery. In 16 of the studies (4 were orthopaedic surgeries), researchers documented improvements in both the physical and emotional recoveries of the patients.

These results demonstrated that psychological methods are effective as an additional treatment for pain management, postsurgical recovery (physical and emotional), and orthopaedic rehabilitation.

These methods appear to have potential in orthopaedic surgery that could reduce pain, enhance treatment outcomes, and contain or even reduce medical costs.

Both doctors and patients seem to realize that there is a missing component to patient care. 75% of more than a thousand physicians surveyed agree that religion and spirituality are important in helping patients cope and in giving them a positive state of mind. Studies also show that patients similarly place a high value on spirituality, especially during a time of illness. Statistics show that 50% of patients want to pray with their physician and not just a chaplain. Other studies show that on routine doctor visits patients would like to pray with their doctors. Praying brings people together. Forgiveness helps with the healing process and it has well documented health benefits. Forgiveness is also a process, but it helps people recover joy. **(Levy, D. 2011)**

The power of healing: Medicine and religion have both had their day, and they haven't always been able to coexist. But as today's medical treatment becomes more holistic, doctors are increasingly taking spirituality into account. Studies show a majority of patients want their spirituality recognized, and most med schools now have classes related to the topic. In general, the new thinking asks doctors to note their patients' spiritual leanings and open doors to expression, especially when life is at risk. Studies show 60 to 80 percent of patients want their

beliefs noted — not as affirmation but as a sign that the doctor actually cares. But fewer than 20 percent of doctors bring it up. **(Ramirez, M. 2013)**

Patient Wellness Outcome

“Can caring be reduced to behavioural task?” Morse et al, noted that scholars are in disagreement about this, obviously the proponents of perspectives seeing caring as a human trait, an affect, a moral imperative, or interpersonal relationships believe that caring is more than just skill or proficiency **(O’Lynn, 2007)**, though compassion and empathetic feelings of the nurse are requisite for clients to feel cared for. Clinical competence was the most important nurse caring behaviour **(Wysong & Driver, 2009)**. Also they noted that a nurse should be knowledgeable, skilled, competent in order to have high-quality care and they want nurses to have caring and humane attitude and make them feel comfortable – “cared well” as well as “cared for”. **(Henderson, 2007)**

Caring behaviours displayed toward nurses by nurse managers and nurse peers play a significant role in establishing relationships that promote a healthy work environment **(Longo, 2011)**. Nurses demonstrate caring behaviours toward their colleagues by coming to know them on both a professional and a personal

level they found categories through these: caring through helping and supporting, caring through appreciating, and acknowledging unappreciated caring.

Relevance to the Present Study

Orthopedic nurses have to achieve the knowledge, skills and attitude to provide nursing care that is unique in orthopaedic nursing. Thus, an orthopaedic nurse must be able to supply the needs of the surgical team (pre and post op care), the patient and the patient's relative all at the same time.

They are specialized in the treatment, care and prevention of people with musculoskeletal disorders or muscle and bone problems. These musculoskeletal problems usually included bone fractures, joint displacements, back pains, arthritis/ rheumatism, congenital malformations, musculoskeletal injuries and chronic disorders such bone density losses.

Since health is an essential right of every individual, the Filipino registered nurses believe the worth and dignity of each human being recognizes the most important responsibility to safeguard health at all cost. This responsibility encompasses promotion of health, prevention of illness, alleviation of suffering, and restoration of health.

To assume this responsibility, registered nurses have to increase knowledge and understanding of man's cultural, social, spiritual, psychological, and ecological aspects of illness, utilizing the therapeutic process.

Thus, the science and art of nursing have also evolved. The art of nursing is exemplified in the interaction between the nurse and the patient. Good relationships are based on interpersonal and communication skills, and knowing when to stay quiet, sit and listen to a patient. These attributes facilitate the nurse to judge when to act and when to give power to patients to take control of their own health and care. The science of nursing involves the application of knowledge and skills to particular patients' needs. Nurses necessitate keeping pace with changes in nursing and medical knowledge and adapting to the technology involved in care. Additionally, they require expert knowledge of the patient's orthopaedic condition, to comprehend how their needs can be met and complications are prevented.

As Dr. Divinagracia (2001) conceptualized forty statements that represented the dimensions of wellness which include the physical, emotional, intellectual, and spiritual domain, the COMPOSURE behaviors of nurses has born. Physical domain involves muscle strength, mobility, posture, gait exercise, and activity tolerance and cardio-respiratory endurance. Emotional domain includes awareness, orientation, understanding of own and other personal feelings

and ability to control and cope with emotions. Intellectual domain refers knowledge and perception of a healthy self and ability to recognize the presence of risk factors and preventive measures and spiritual domain is defined as development of inner self or one's soul through a relationship with God and others.

The focal point on holism in nursing is consequently fundamental to its humanistic practice and an important ethical aspect of care. Without it, patients become objects of care rather than partners with care providers. In orthopaedic nursing practice, holistic approaches to care support the person to be viewed as a human being with numerous physical and psychological issues contributing to their nursing needs rather than viewing the individual as, for example, an isolated limb injury or condition.

As a matter of fact, health and wellness is an integrated condition of being that is finest depicted as several threads that can be woven jointly to create a larger, integrated framework. Each detailed dimension relates to each of the others and overlaps all others. The overlap is so numerous and so great that the specific contribution of each thread is almost indistinguishable when looking at the total. The total is clearly greater than the sum of the parts.

More so, majority of the literatures found in this research stated that certain behaviours of nurses towards patients definitely affect their wellness. These literatures are highly related to this research.

This research discovered that there is a relationship and difference between patient's profile and wellness if the advanced beginner nurses' COMPOSURE behaviour will be taken as part of the nursing care given to selected orthopaedic patients.

Chapter 3

Methodology

This chapter presents the methodology used in the study. Specifically, it discusses the research design, population, sampling technique used, the research instrument, data gathering procedure, and statistical tools used in analyzing the data.

Research Design

The study used quasi-experimental 2-group pretest posttest design. According to **Bordens & Abbott (2007)**, quasi-experimental designs are those that resemble experimental designs. One advantage of it is that they allow you to evaluate the impact of a quasi-independent variable under naturally occurring conditions. In those cases in which you manipulate the independent variable or even simply take advantage of a naturally occurring event, you may be able to establish clear causal relationships among variables.

In addition to the 2-group pretest posttest design, it includes a pretest of participants on a dependent measure before the introduction of a treatment, followed by a posttest after the introduction of the treatment.

Pretest-posttest designs are used to evaluate the effects of some change in the environment (including interventions such as COMPOSURE behaviours of advanced beginner nurses) on subsequent performance.

Population, Sample and Sampling Technique

There were 12 advanced beginner nurse participants that attended the COMPOSURE behaviours and there were 25 selected orthopaedic patients in each group for a total of 50 patients as respondents.

The study used purposive sampling technique. According to **Berion et al (2005)**, in purposive sampling, the researcher uses sound judgment. He handpicks those whom he/she believes have the roles that meet the criteria set in the study.

Inclusion criteria for selected orthopaedic patients, male or female, are as follows: (1) with an uncomplicated diagnosis of fracture, (2) with baseline CBC test, (3) conscious at the time of study, (4) oriented to person, place, and time, (5) no hearing defect, (6) has the willingness to participate, and (7) able to communicate, understand, and follow English language or Filipino language.

Exclusion criteria for selected orthopaedic patients are as follows: (1) orthopaedic patients with tubes like endotracheal, tracheostomy and chest drainage, (2) with difficulty of communication, and (3) with hearing difficulty.

Research Instruments

The various parts of the research instrument are as follows: patient's demographic profile, physiologic and biobehavioral patient wellness status assessment tool for pretest and posttest to be answered by the respondents.

The researcher used the adapted 40-item Patient Wellness Status Assessment Tool of Dr. Divinagracia's theory of COMPOSURE behaviours.

The researcher patterned her instrument with the original tool but made some revisions in the format scales originally given in the tool, as:

5 = strong agree (talagang sang-ayon)

4 = agree (sang-ayon)

3 = neutral (di-tiyak)

2 = disagree (di sang-ayon)

1 = strongly disagree (talagang di sang-ayon)

The next instruments that were used by the researcher and trained research assistants are as follows: the advanced beginner nurse profile tool and the physiologic response assessment tool.

Data Gathering Procedure

First and foremost, a letter of intent and asking for permission to use the COMPOSURE behaviour theory of Dr. Divinagracia was sent to her last January 11, 2013 by the researcher and it was approved last January 13, 2013.

After the research proposal, the researcher sent letter of permission to the Medical director thru the chief nurse of the research locales. The Ethics Board Committee approval of the hospitals obtained. After that, the researcher distributed informed consent to the selected orthopaedic patients.

Right after the patient give their consent as the respondents of this study, respondents were assigned at random and had a pretest of patient wellness outcome. Experimental manipulation was done on the study group (Group A) while the control group (Group B) did not receive the experimental manipulation.

The variation of nursing care that has been given to the respondents are as follows: The respondents of Group A (Experimental group) received the complete package of COMPOSURE behaviour such as competence, presence & prayer, open-mindedness, stimulation, understanding, relaxation, and empathy every shift (AM-PM-N) for consecutive 5 days. Meanwhile, the respondents of Group B (Control group) received the routine nursing actions and behaviour given by the advanced beginner nurses.

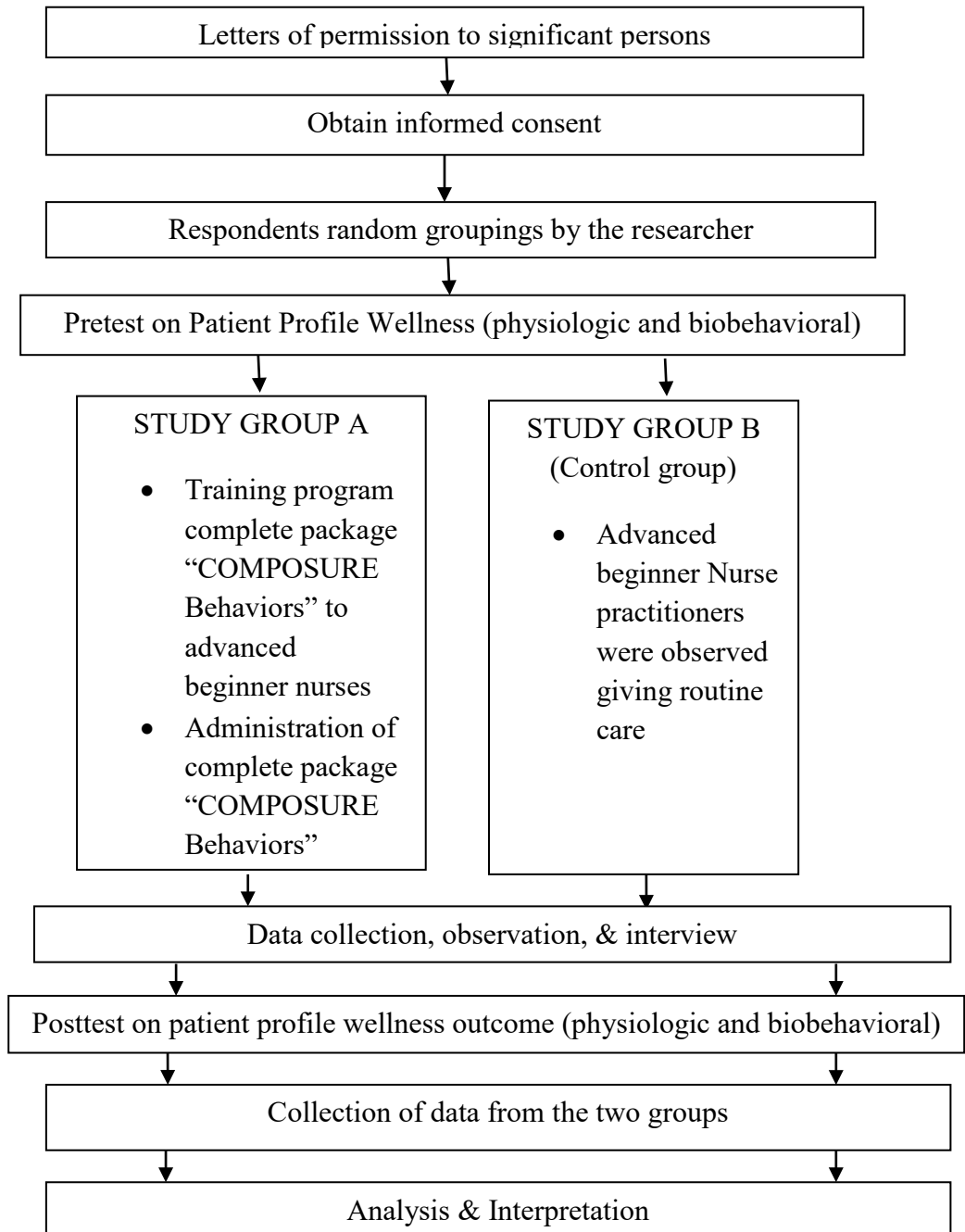
The 2 groups both have their posttest on their 6th day after they received their respective nursing care according to their groupings. In order to minimize bias and contamination, the blind method was used wherein the research assistants who participated in observing and monitoring the respondents did not have any previous knowledge to which group they belong (study group A, or study group B). Likewise, the respondents did not also have any knowledge as to whether they belong to study or control group.

The wellness status of the respondents was monitored by the researcher and trained research assistants after interventions to evaluate differences in outcome among the 2 groups.

After their posttest, the researcher did the data gathering, analysis, and interpretation of the results and findings.

A copy of the completed study has been given to the research locales and to Dr. Divinagracia.

Research Protocol Flowchart



Statistical Treatment of Data

For Problem No.1 to No.3, frequency distribution and percentages were used in the computation of the demographic profile, physiologic wellness outcome of selected orthopaedic patients.

Percentage

$$P = \frac{x}{n} (100\%)$$

where,

n = total number of respondents/population

x = frequency

Weighted Mean

$$\bar{x} = \frac{\sum_{i=1}^n w_i x_i}{n}$$

where,

\bar{x} = weighted mean

x_i = observation

w_i = weighted factor

n = total number of respondents

For Problem No. 4 and 5, Pearson r and chi square test were used to determine if there is a significant relationship between demographic profile and wellness outcome of selected orthopaedic patients.

Pearson r

$$r = \frac{\sum XY - \frac{(\sum X)(\sum Y)}{n}}{\sqrt{\left(\sum X^2 - \frac{(\sum X)^2}{n}\right) \left(\sum Y^2 - \frac{(\sum Y)^2}{n}\right)}}$$

Where

r = Pearson correlation coefficient

x = Values in first set of data

y = Values in second set of data

n = Total number of values

Chi-square

$$\chi^2 = \sum \frac{(O - E)^2}{E}$$

Where:

χ^2 = the value for chi square

Σ = the sum

O = the observed frequency

E = the expected frequency

For Problem No. 6 to 8, t-test was used to determine if there is a significant difference in the wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of novice nurses.

T-test

$$t = \frac{\bar{X}_1 - \bar{X}_2}{\sqrt{\frac{(n_1 - 1)(s_1)^2 + (n_2 - 1)(s_2)^2}{n_1 + n_2 - 2}} \sqrt{\frac{1}{n_1} + \frac{1}{n_2}}}$$

Where:

\bar{x}_1 = mean of the first group

\bar{x}_2 = mean of the second group

n_1 = total number of the first group

n_2 = total number of the second group

s_1^2 = variance of the first group

s_2^2 = variance of the second group

For Problem No.9, ANOVA was used to determine if there is a significant difference among the two groups in the wellness outcome before and after the COMPOSURE behaviours of advanced beginner nurses.

One-Way ANOVA Table

<i>SV</i>	<i>SS</i>	<i>DF</i>	<i>MSS</i>	<i>F</i>
<i>Between</i>	SS_{bet}	DF_{bet}	MSS_{bet}	F_c
<i>Within</i>	SS_{wit}	DF_{wit}	MSS_{wit}	
<i>Total</i>	SS_{tot}	DF_{tot}		

where

$$SS_{bet} = \sum \frac{(\sum x_{A_i})^2}{n_{A_i}} - \frac{(\sum x_1)^2}{N}$$

$$SS_{tot} = \sum x_1^2 - \frac{(\sum x_1)^2}{N}$$

$$SS_{wit} = SS_{tot} - SS_{bet}$$

$$DF_{bet} = c - 1$$

$$DF_{wit} = N - c$$

$$DF_{tot} = N - 1$$

$$MSS_{bet} = \frac{SS_{bet}}{DF_{bet}}$$

$$MSS_{wit} = \frac{SS_{wit}}{DF_{wit}}$$

$$F_c = \frac{MSS_{bet}}{MSS_{wit}}$$

where

x = observed value

i = individual observation or cell

A = the given factor or category

n = number of samples in a particular category

N = total samples

c = number of categories

F = f-statistic

F_c = computed value of f-statistic

CHAPTER 4

DATA PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

This study aims to determine the effect of the COMPOSURE behaviours of advanced beginner nurses on the wellness outcome among selected orthopaedic patients. The results of the data obtained by the researcher are presented in this chapter with subsequent discussion. The discussion is guided by the theoretical framework based on Dr. Carmelita C. Divinagracia's Theory of COMPOSURE Behaviours.

PROBLEM #1: What is the demographic profile of the orthopaedic patients in terms of:

1.4 age,

1.5 gender, and

1.6 religion?

Table 1 describes the frequency and percentage distribution of the demographic profile of the selected orthopaedic patients in terms of their age.

Table 1
Summary of Values Showing the Frequency and Percent Distribution of the Demographic Profile of the Orthopaedic Patients in terms of their Age

Age	Frequency	Percentage
10 – 14 years old	3	6%
15 – 19 years old	4	8%
20 – 24 years old	3	6%
25 – 29 years old	3	6%
30 – 34 years old	3	6%
35 – 39 years old	4	8%
40 – 44 years old	7	14%
45 – 49 years old	1	2%
50 – 54 years old	3	6%
55 – 59 years old	5	10%
60 – 64 years old	9	18%
65 and above	5	10%
Total	50	100%

Average grade: 43.25

Standard deviation: 18.42

Reflected from the figured data shown above, the majority of the respondents belong to the age group of **60 – 64 years old**, having the **18%** of the sample. It was then followed by the respondents who fall under the ranges of **40 – 44 years old** with **14%** as second, **55 – 59 years old** and **65 and above** with **10%** as third, **15 – 19 years old** and **35 – 39 years old** with **8%** as fourth, **10 – 14 years old**, **20 – 24 years old**, **25 – 29 years old**, **30 – 34 years old**, and **50 – 54 years old** with **6%** as fifth, and **45 – 49 years old** with **2%** as the lowest. The average grade was **43.25** with a standard deviation of 18.42.

As an individual grows and age increases, the incidence of hip fractures continues to augment. The old people have weaker bone that can be cause by osteoporosis and are more expected to fall due to poorer balance, medication side

effects, and difficulty moving around environmental hazards. Healthcare professionals in many fields are concerned in caring for patients with hip fractures and should be recognizable with the basic assessment and management of these injuries.

Some of the causes of fracture among young adults and middle-aged are occupational hazards and motor vehicular accidents.

Human bones develop as age increases. From infancy to adulthood, bones grow and their relative sizes change as well. Nonetheless, from young adulthood to old age, movement becomes more restricted due to bone margin and projections' gradual changes (**Untalan, 2009**). Before the age of 40, usually after puberty, is when human bones are strongest. However, at 40 years old and beyond, human bones undergo demineralization and the loss of collagen fibers which in turn makes it less flexible and more brittle (**Bonifacio, 2010**). In physiologic aging, connective tissues lose some of their elasticity and resilience. Muscles lose bulk, tone, and strength. Bone resorption happens faster than bone growth (**Udan, 2009**).

It has also been said that many elderly patients may experience significant morbidity due to delayed healing, poor health and disease, and undernutrition. Older adults are also at greater risk to be having other complications brought about by their injury. These complications include infection, skin breakdown, neurovascular compromise, and problems brought about by immobility such as

stasis pneumonia, thrombophlebitis, pressure ulcers, urinary infection and calculi, and constipation (**Nettina, 2010**).

Age advancement brings about metabolic diseases or disorders of bone remodelling. These are more commonly known as degenerative musculoskeletal conditions. Osteoarthritis is the most common one. Osteoporosis, on the other hand, is another common but more serious problem faced by aging people wherein there is a reduction of total bone mass, which is usually caused by decreasing levels of estrogen or testosterone, inadequate intake of calcium or Vitamin D, lack of physical activity, and other factors. Other common musculoskeletal conditions are osteomalacia and Paget's disease which are also known to affect older adults (**Rothrock, 2011**). The gait also becomes unsteady due to declining muscle strength and coordination. All these contribute to a person's susceptibility to falls and fractures (**Udan, 2009**).

Table 2 describes the frequency and percentage distribution of the demographic profile of the selected orthopaedic patients in terms of their gender.

Table 2
Summary of Values Showing the Frequency and Percent Distribution of the Demographic Profile of the Orthopedic Patients in terms of their Gender

Gender	Frequency	Percentage
Male	26	52%
Female	24	48%
Total	50	100%

Majority of the respondents are **male**, having **52%** of the total sample. It was then followed by **female** respondents with **48%**.

Male and female skeletons have several differences. Male bones are larger and heavier than of the females. The female pelvis is shallow and broad and with a wider pubic arch, whereas a male's pelvis tends to be deeper, funnel-shaped, and has a narrow pubic arch (**Untalan, 2009**). Calcium is lost from the bones especially in post-menopausal women due to more rapid bone reabsorption than bone growth, which may mean a greater risk for brittle and porous bones (**Udan, 2009**). Women lose more bone mass than men usually due to osteoporosis as estrogen withdraws and activity decreases (**Smeltzer, 2010**). However, statistics also show that males, particularly between the ages of 6 and 40 years, get more fractures as of their counterpart, supposedly due to more dangerous work and physical activity men engage in (**Bonifacio, 2010**).

Table 3 describes the frequency and percentage distribution of orthopaedic patient respondents in terms of their religion.

Table 3
Summary of Values Showing the Frequency and Percent Distribution of the Demographic Profile of the Orthopedic Patients in terms of their Religion

Religion	Frequency	Percentage
Catholic	42	84%
Non-catholic	8	16%
Total	50	100%

Based from the gathered data for the religion of the respondents, **84%** of selected orthopaedic patients are **Catholics** and there is **16% non-Catholic**.

The Philippines is the only predominantly Christian nation in Asia, where 84% are Roman Catholic, 11% belong to various Protestant groups and other denominations, and the remaining 5% are Muslims (**Daplas, 2012**). This may indirectly reflect common hospital admissions concerning the Catholic group. In a study conducted, results also showed that religion is highly significant to personal beliefs and spirituality (**Garcia, 2010**).

PROBLEM #2: What is the physiologic wellness outcome of selected orthopaedic patients in terms of:

2.4 vital signs,

2.5 bone pain sensation, and

2.6 complete blood count?

Table 4 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their vital signs in terms of their temperature.

Table 4
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Vital Signs in terms of their Temperature

Temperature	Frequency	Percentage
36.5 – 37.0	46	92%
37.1 – 37.5	1	2%
37.6 – 38.0	1	2%
38.1 – 38.5	2	4%
38.6 – 39.0	0	0%
39.1 – 39.5	0	0%
Total	50	100%

Average grade: 35.81

Standard deviation: 0.94

Based from the gathered results, **92%** of the respondents have a body temperature of **36.5 – 37.0 degree Celsius**. It was then followed by the respondents who have a body temperature of **38.1 – 38.5 degree Celsius with 4%** as second and a body temperature of **37.1 – 37.5 and 37.6 – 38.0 degree Celsius with 2%** as the lowest. The average grade was 35.81 with a standard deviation of 0.94.

Normal body temperature usually remains constant, ranging from 36.5 to 37.5 degrees Celsius in adults. Different factors may affect this such as circadian rhythms, ovulation, exercise, medications, and many more. Aging can also affect normal body temperature and its regulation. Fever or pyrexia is the term for an

increased body temperature which may indicate an infection. On the contrary, hypothermia is a core temperature of less than 36 degrees Celsius and may be due to aging or exposure to a cold environment (Smith, 2011). Regular assessment of skin temperature should be done because any abnormal change may indicate infection or circulatory impairment in the affected site (Untalan, 2009).

Table 5 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their vital signs in terms of their blood pressure.

Table 5
Summary of Values Showing the Frequency and Percent Distribution
of the Physiologic Wellness Outcome of Selected Orthopedic Patients
in terms of their Vital Signs in terms of their Blood Pressure

Blood Pressure	Frequency	Percentage
Normal	48	96%
Prehypertension	2	4%
Hypertension I	0	0%
Hypertension II	0	0%
Total	50	100%

Majority of the respondents have a **normal blood pressure**, having **96%** of the total sample. It was then followed by **prehypertension with 4%**.

Blood pressure is known as the force exerted by blood against the vessel walls. The systole is the peak pressure wherein the ventricles of the heart contract. On the other hand, diastole is the minimal pressure during which the ventricles relax. The most common method of taking the blood pressure is through auscultation with the use of a sphygmomanometer and a stethoscope. The unit for measurement is millimetres of mercury or mmHg. Blood pressure can be

classified for adults having the age of 18 years and older. A normal blood pressure has a systolic pressure of less than 120mmHg and a diastolic pressure of less than 80mmHg. Pre-hypertension is when one's systolic pressure is between 120-139mmHg or has a diastolic pressure of 80-89mmHg. Two stages of hypertension are present. Stage 1 included a systolic pressure of 140-159mmHg or a diastolic pressure of 90-99mmHg, while Stage 2 shows a systolic pressure greater than 160mmHg or a diastolic pressure of more than 100mmHg. Diagnosis of hypertension is done with two or more blood pressure readings in two or more different visits after an initial screening (Perry, 2010).

Table 6 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their vital signs in terms of their pulse rate.

Table 6
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Vital Signs in terms of their Pulse Rate

Pulse Rate	Frequency	Percentage
Normal	50	100%
Bradycardia	0	0%
Tachycardia	0	0%
Total	50	100%

Reflected from the figured data shown above, **100%** of the total sample has a **normal pulse rate**.

Checking the pulse is an important assessment which can provide information about the heart's rate and pumping power. The pulse is felt as a wave

of pressure that occurs as each heart beat causes a surge of blood to circulate to the arteries into the different organs. A pulse can be felt and taken in the surface of the body where an artery is close. The most common site is the radial artery. Pulse rate can be affected by several factors such as medication, exercise, or any abnormality in the hearts contraction. Still, in taking the pulse rate, it is still important to check the actual heart rate, or the apical pulse, in order to observe for any discrepancies. The normal resting pulse rate is from 60-100 beats per minute. Increased and decreased pulse rates are termed tachycardia and bradycardia respectively (Smith, 2011).

Table 7 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their vital signs in terms of their respiratory rate.

Table 7
Summary of Values Showing the Frequency and Percent Distribution
of the Physiologic Wellness Outcome of Selected Orthopedic Patients
in terms of their Vital Signs in terms of their Respiratory Rate

Respiratory Rate	Frequency	Percentage
Normal	30	60%
Bradypnea	0	0%
Tachypnea	20	40%
Total	50	100%

Majority of the respondents have a **normal respiratory rate**, having **60%** of the total sample. It was then followed by **40%** of the respondents with **tachypnea**.

The most sensitive and significant indicator when taking vital signs is the respiratory rate. Counting the number of breaths per minute as the chest rises and falls should be done properly. In adults, the normal respiratory rate in one minute ranges from 12 to 20 breaths, but may still depend on several factors. During the assessment of this vital sign, it is also important to take note and observe for the depth, rhythm, and the symmetry of the chest which may signify other important conditions of the client (**Smith, 2011**).

It is also important to watch out for complications involving respiration especially the occurrence of emboli which may be observed with signs like severe chest pain, dyspnea, pallor, and diaphoresis (**Untalan, 2009**).

Table 8 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their vital signs in terms of their bone pain sensation.

Table 8
Summary of Values Showing the Frequency and Percent Distribution of
the Physiologic Wellness Outcome of Selected Orthopedic Patients in
terms of their Vital Signs in terms of their Bone Pain Sensation

Bone Pain Sensation	Frequency	Percentage
0	3	6%
1	9	18%
2	10	20%
3	9	18%
4	6	12%
5	1	2%
6	4	8%
7	3	6%
8	4	8%
9	1	2%
10	0	0%
Total	50	100%

Based from the gathered results, 20% of the respondents experience **pain scale of 2/10**. It was then followed by the **18%** of the respondents who fall under the ranges of **1/10 and 3/10 pain scale** as second, 12% of the respondents experience **pain scale of 4/10** as third, 8% of the respondents experience **pain scale of 6/10 and 8/10** as fourth, 6% of the respondents experience **pain scale of 0/10 and 7/10** as fifth, and 2% of the respondents experience **pain scale of 5/10 and 9/10** as sixth, and none of the respondents experience **pain scale of 10/10** as the lowest.

Pain is experienced by most patients with conditions and diseases involving muscles, bones, and joints. Pain in the bone can be described as dull and deep that is “boring” in nature, while characteristically, muscle pain is felt as soreness or aching, typically known as muscle cramps. Pain during fractures is

usually described as sharp, piercing, and relieved by absence of movement. This kind of pain can also be caused by muscle spasm or sensory nerve pressure. Still, rest relieves most of the musculoskeletal pain, whereas steadily increasing pain may indicate another problem. It is of great importance that the patient's pain be addressed and managed successfully as prolonged pain can be exhausting and can make the patient very dependent (**Smeltzer, 2010**).

Pain and discomfort are the most frequent reasons why an individual chooses to receive health care, which is why proper assessment of pain is necessary to provide appropriate nursing care. A significant concept in pain assessment is when nurses should assess. Pain assessment should be done regularly and repeatedly, usually at the request of the patient, or when the pain is expected or anticipated. Different problems and dilemmas are usually faced in healthcare when it comes to pain assessment. Healthcare providers must identify if the pain is acute or chronic, but the more serious dilemma is when patients and healthcare providers do not agree on what the real pain score is (**Parsons, 2010**). Doubts usually may arise especially if the reported pain score is different from objective data gathered. According to **Pasero (2011)**, "*Clinicians are not required to believe a patient but are required to accept what a patient says, convey acceptance to the patient, and take the appropriate action.*" It is also important to understand that each individual has his or her own experience of pain. Pain threshold is defined as the point at which a stimulus is felt as painful. Pain

intensity, duration, and other characteristics also vary. Pain tolerance, on the other hand, is the duration of pain that a person is willing to endure and may vary from person to person depending on several factors such as coping skills and energy levels. It has also been said that society places a high value on a high pain tolerance. The results of a study suggest that nurses do not like patient who are coping poorly with their pain. However stoic it may seem, patients have a right to determine their own pain tolerance. Behavioural adaptation or suppression of pain may occur as a result of stoic responses so more thorough assessment is needed to obtain a valid pain data.

As the American Pain Society challenges healthcare systems to consider pain as the fifth vital sign, it is very relevant to have good assessment of your patient when it comes to pain. Complete data collections would include the type, severity, location, onset, duration, and history of the pain. It is also important to consider that the pain is very subjective for the patient and his perspective is the most important source for assessment. Considering other sources may lead to inability to relieve pain (**Laccetti, 2009**).

Relieving the pain in musculoskeletal problems is one of the most important aspects of orthopaedic nursing care. Aside from maintaining proper alignment and pull of the necessary orthopaedic equipment, other pain-relieving measures can be done such as backrubs, soft light, and soft tranquil music. Patient controlled analgesia and medications can also be provided. Informing the patient

of techniques to avoid discomfort while moving will also benefit the patient's pain, which includes supporting injured area and practicing gentle position changes (Nettina, 2010).

Managing pain may be complex and challenging especially because of its subjectivity, but all measures should be done to relieve pain as continuously experiencing pain has been shown to affect morbidity. Nurses must understand the physiology of pain and decide on appropriate treatments of choice, may it be pharmacological or non-pharmacological methods (Bench, 2011).

Table 9 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their red blood cells.

Table 9
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Complete Blood Count in terms of Red Blood Cells

Red Blood Cells	Frequency	Percentage
Below Normal	10	20%
Normal	11	22%
Above normal	29	58%
Total	50	100%

Reflected from the figured data shown above, the majority of the respondents have **above normal level of red blood cells**, having **58%** of the total sample. It was then followed by **normal level of red blood cells** with **22%** as second, **below normal red blood cells** with **20%** as the lowest.

Red blood cells (RBC) are the most numerous of the formed elements of the blood. RBCs are elegantly designed, biconcave disks with no nuclei, to fulfil major functions which are to deliver oxygen to the peripheral tissues and to transport carbon dioxide for elimination through respiration (Aster, 2011). The number of RBCs a person has varies with age, gender, and general health. The red blood cells produce hemoglobin. RBCs are also buffers and help maintain acid-base balance. The RBC count measures circulating RBCs in 1mm^3 of blood. Decreased levels indicate possible anemia or hemorrhage while increased levels indicate possible chronic hypoxia or polycythemia vera (Ignatavicius, 2010).

Table 10 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their white blood cells.

Table 10
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Complete Blood Count in terms of White Blood Cells

White Blood Cells	Frequency	Percentage
Below Normal	0	0%
Normal	28	56%
Above normal	22	44%
Total	50	100%

Based from the gathered data for the white blood cells of the respondents,

56% of the sample has a **normal level of white blood cells** and there is **44%** who has **above normal white blood cells**.

White blood cells (WBC) or leukocytes are responsible for protection through inflammation and immunity. Many WBCs are formed in the bone marrow and are differentiated to perform different functions. These include eosinophils, basophils, neutrophils, monocytes, and lymphocytes. The WBC count measures circulating WBCs in 1mm^3 of blood. Increased levels are associated with infection, inflammation, autoimmune disorders, and leukemia. Decreased levels may indicate prolonged infection or bone marrow suppression (**Ignatavicius, 2010**).

Table 11 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their eosinophils.

Table 11
Summary of Values Showing the Frequency and Percent Distribution
of the Physiologic Wellness Outcome of Selected Orthopedic Patients
in terms of their Complete Blood Count in terms of Eosinophils

Eosinophils	Frequency	Percentage
Below Normal	0	0%
Normal	44	88%
Above normal	6	12%
Total	50	100%

Reflected from the figured data shown above, the majority of the respondents have a **normal level of eosinophils**, having **88%** of the sample. It was then followed by the respondents who have **above normal level** of eosinophils with **12%**.

Eosinophils are cells with two nuclear lobes and abundant red cytoplasmic granules. They are a type of granulocyte who has an important role in certain chronic immune responses, especially the associated with helminthic worm infections, asthma, and certain types of allergic reactions (**Aster, 2011**).

An increased percentage of eosinophils may be due to allergic reaction, cancer, collagen vascular disease and parasitic infection (**The New York Times 2013**)

Table 12 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their monocytes.

Table 12
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopaedic Patients in terms of their Complete Blood Count in terms of Monocytes

Monocytes	Frequency	Percentage
Below Normal	3	6%
Normal	44	88%
Above normal	3	6%
Total	50	100%

Majority of the respondents have **normal level of monocytes**, having **88%** of the total sample. It was then followed by **below normal level** and **above normal level of monocytes**, both have **6%**.

Monocytes measure from 12 to 20 micrometers, being the largest among the white blood cells. They are highly phagocytic like neutrophils and differentiate into relatively long-lived macrophages upon emigration into tissues.

They are capable of detecting “danger” signals produced by infection or tissue injury (Aster, 2011). They are also responsible for the destruction of bacteria and cellular debris (Ignatavicius, 2010).

An increased percentage of monocytes may be due to chronic inflammatory disease, parasitic infection, tuberculosis, and viral infection (for example, infectious mononucleosis, mumps, measles). (Dugdale, D.C. 2011)

Low monocyte counts generally do not cause specific symptoms. It is most likely that the signs of some type of an infection will be noticed by someone suffering from a low monocyte blood count. Frequent signs of these types of infections include flu-like symptoms, coughing, sore throat, chills and fever, and frequent urination. (Larson, C. 2013)

Table 13 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their lymphocytes.

Table 13
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Complete Blood Count in terms of Lymphocytes

Lymphocytes	Frequency	Percentage
Below Normal	28	56%
Normal	20	40%
Above normal	2	4%
Total	50	100%

Majority of the respondents have a **below normal level** of lymphocytes with **56%** of the total sample. It was then followed by respondents who have

normal level of lymphocytes with **40%** as second, **above normal level** of lymphocytes with **4%** as the lowest.

Lymphocytes are the key components of the adaptive immune system. They may be circulating B cells, T cells, or natural killer cells. Some B and T cells may live for years and is the basis for the immune system's ability to "remember" exposures to pathogens (Aster, 2011).

There are many possible causes for an abnormally high lymphocyte count (known as lymphocytosis). A lymphocyte level that is more than 40% is considered to be abnormally high. Some basic causes of a high lymphocyte count are the flu and the chickenpox. Other causes of a high lymphocyte level include tuberculosis, mumps, rubella, varicella, whooping cough, brucellosis, and herpes simplex. For an abnormally low lymphocytes (less than 15%) also known as lymphocytopenia, the possible causes are aplastic anemia, AIDS, multiple sclerosis, myasthenia gravis, Guillain-Barre syndrome, and use of steroids. (Carone, D., 2011)

Table 14 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their platelet count.

Table 14
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Complete Blood Count in terms of Platelet Count

Platelet Count	Frequency	Percentage
Below Normal	3	6%
Normal	39	78%
Above normal	8	16%
Total	50	100%

Reflected from the figured data shown above, the majority of the respondents have **normal level of platelet count**, having **78%** of the sample. It was then followed by respondents who have **above normal level of platelet count** with **16%** as second, and **below normal level of platelet count** with **6%** as the lowest.

Platelets or thrombocytes are small cell fragments from megakaryocytes in the bone marrow. They play a critical role, together with the clotting factors, in the regulation of hemostasis (Aster, 2011). Increased levels may indicate polycythemia vera or malignancy, while decreased levels may indicate bone marrow suppression, autoimmune disease, or hypersplenism (Ignatavicius, 2010).

Table 15 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their haemoglobin.

Table 15
Summary of Values Showing the Frequency and Percent Distribution
of the Physiologic Wellness Outcome of Selected Orthopedic Patients
in terms of their Complete Blood Count in terms of Hemoglobin

Haemoglobin	Frequency	Percentage
Below Normal	43	86%
Normal	7	14%
Above normal	0	0%
Total	50	100%

Based from the gathered data for haemoglobin level, **86%** of the respondents have **below level of haemoglobin**, and **14%** who have **normal level of haemoglobin**.

Hemoglobin is produced by the red blood cells. Each normal mature RBC contains thousands of hemoglobin molecules. However, only when the heme molecule is complete with iron can it transport up to four molecules of oxygen. The most significant feature of hemoglobin is its ability to combine loosely with oxygen. Some problems modify the speed and amount of oxygen released to the tissues. Erythropoiesis helps meet the body's need for tissue perfusion by ensuring adequate delivery of oxygen. When tissue oxygenation decreases, the kidney releases erythropoietin to stimulate the bone marrow to produce more red blood cells. The hemoglobin level is the amount of hemoglobin in the blood. Decreased levels indicate possible anemia or hemorrhage while increased levels indicate possible chronic hypoxia or polycythemia vera (**Ignatavicius, 2010**).

Complete blood count test should be considered especially if there is blood loss and extensive muscle damage from the musculoskeletal injury to see if there is decreases hemoglobin (**Bonifacio, 2010**).

Table 16 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their hematocrit.

Table 16
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Complete Blood Count in terms of Hematocrit

Hematocrit	Frequency	Percentage
Below Normal	31	62%
Normal	19	38%
Above normal	0	0%
Total	50	100%

Based from the gathered results, majority of the respondents have **below normal level** of hematocrit, having **62%** of the sample. It was then followed by respondents who have **normal level** of hematocrit with **38%**.

Blood tests, primarily a complete blood count may show decreased hematocrit levels especially when loss of blood and muscle damage is present (**Bonifacio, 2010**). The hematocrit is calculated as the percentage of RBCs in the total blood volume. Decreased levels indicate possible anemia or hemorrhage while increased levels indicate possible chronic hypoxia or polycythemia vera (**Ignatavicius, 2010**).

Table 17 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their mean corpuscular volume (MCV).

Table 17
Summary of Values Showing the Frequency and Percent Distribution
of the Physiologic Wellness Outcome of Selected Orthopedic Patients
in terms of their Complete Blood Count in terms of their
Mean Corpuscular Volume (MCV)

MCV	Frequency	Percentage
Below Normal	7	14%
Normal	32	64%
Above normal	11	22%
Total	50	100%

Based from the gathered data pertaining to their level of MCV, **64%** of the respondents have a **normal level**. It was then followed by respondents who have **above normal level** of MCV with **22%** as second, and **below normal level** of MCV with **14%** as the lowest.

Mean Corpuscular Volume measures the average volume r size of a single RBC and is useful for classifying anemias. Increased levels indicate macrocytic cells, possible anemia, while decreased levels indicate microcytic cells, possible iron-deficiency anemia (**Ignatavicius, 2010**).

Table 18 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their mean corpuscular hemoglobin (MCH).

Table 18
Summary of Values Showing the Frequency and Percent Distribution of the
Physiologic Wellness Outcome of Selected Orthopedic Patients
in terms of their Complete Blood Count in terms of
Mean Corpuscular Haemoglobin (MCH)

MCH	Frequency	Percentage
Below Normal	13	26%
Normal	33	66%
Above normal	4	8%
Total	50	100%

Reflected from the figured data shown above, majority of the respondents have **normal level** of MCH with **66%** of the total sample. It was then followed by **below normal level** of MCH with **26%** as second, and **above normal level** of MCH with **8%** as lowest.

The Mean Corpuscular Hemoglobin is the average amount of hemoglobin by weight in a single RBC. Increased levels indicate macrocytic cells, possible anemia, while decreased levels indicate microcytic cells, possible iron-deficiency anemia (**Ignatavicius, 2010**).

Table 19 describes the frequency and percentage distribution of the physiologic wellness outcome of selected orthopaedic patients in terms of their complete blood count in terms of their Mean Corpuscular Hemoglobin Concentration (MCHC).

Table 19
Summary of Values Showing the Frequency and Percent Distribution of the Physiologic Wellness Outcome of Selected Orthopedic Patients in terms of their Complete Blood Count in terms of Mean Corpuscular Hemoglobin Concentration (MCHC)

MCHC	Frequency	Percentage
Below Normal	1	2%
Normal	42	84%
Above normal	7	14%
Total	50	100%

Majority of the respondents with **84%** have **normal level of MCHC** followed by **above normal level of MCHC** with **14%** and **below normal level of MCHC** with **2%** as the lowest.

The Mean Corpuscular Hemoglobin Concentration measures the average amount of hemoglobin by percentage in a single RBC. When the MCHC is decreased the cell has a hemoglobin deficiency and is hypochromic, as in iron deficiency anemia. Increased levels may indicate spherocytosis or anemia, while decreased levels may indicate iron deficiency anemia or a hemoglobinopathy (Ignatavicius, 2010).

PROBLEM #3: What is the COMPOSURE behaviours of advanced beginner nurses in terms of:

3.8 competence,

- 3.9 presence and prayer,
- 3.10 open-mindedness,
- 3.11 stimulation,
- 3.12 understanding,
- 3.13 respect and relaxation, and
- 3.14 empathy?

Table 20 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of competence.

Table 20
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms Competence

Competence	Mean	Verbal Interpretation
1. Examines patient by obtaining a thorough history, systems review, and administering selected test and applying appropriate nursing measures	4.25	Always
2. Assesses the patient as to level of understanding and level of consciousness	3.83	Often
3. Provides skin care such as sponging of the affected extremity	3.75	Often
4. Changes the patient's bed linen	3.33	Sometimes
5. Provides bedpan as needed and serves bedpan on the unaffected side, provides pillow at the back and provides privacy.	3.42	Often
6. Provides perineal care	3.25	Sometimes
7. Provides ROM exercises with the use of trapeze	3.67	Often
8. Assists the patient doing deep breathing exercises, static quadriceps exercises, and toes pedal exercises	3.58	Often
9. Prepares equipment for balance skeletal traction application, hardware, and gadgets	3.83	Often
10. Performs application of balance skeletal traction efficiently and competently	4.00	Often
11. Manifests good interpersonal and communication skills in dealing with patients and able to extract significant information to aid in planning and delivery of effective nursing care	4.50	Always
12. Develops health education plan based on the assessed and anticipated needs of the patients	2.27	Rarely
13. Knowledgeable in different usage of various hardware and gadgets and establishes mechanism to ensure proper functioning of equipment	3.08	Sometimes
14. Maintains accurate and updated documentation of client care and observes legal imperatives in record keeping	4.00	Often
15. Establishes collaborative relationship with colleagues and other members of the health care team to improve patient care	4.17	Often
16. Identifies nursing problems of the patient and gathers data in order to render quality nursing intervention	4.17	Often
17. Generates good clinical care to maximize patient outcome	3.58	Often
18. Explains the scientific principles behind patients' condition, nursing management, and principles of traction, hardware, and gadgets application	3.75	Often
19. Knowledgeable on the curative and harmful effects of drugs and other therapeutics and exhibits satisfactory aptitude in stating nursing responsibilities	4.08	Often
20. Evaluates nursing intervention based on the extent to which goals are achieved and formulate alternative nursing intervention needed	3.83	Often
21. Reports to duty on time in appropriate uniform and paraphernalia	4.25	Always
22. Shows enthusiasm, diligence, initiative and tactfulness in dealing with others and able to respond to patients' needs promptly and appropriately	4.17	Often
23. Shows adherence to institution's guidelines and policies	3.92	Often
Overall Mean	3.77	Often

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely
 1 = Never

Reflected from the figured data shown above, the specific competence that has the **highest mean of 4.50** with a verbal interpretation of **“Always”** is

“Manifests good interpersonal and communication skills in dealing with patients and able to extract significant information to aid in planning and delivery of effective nursing care”. However, the **lowest mean 2.27** with the verbal interpretation of **“Rarely”** is *“Develops health education plan based on the assessed and anticipated needs of the patients”*. Overall, Table 20’s enumerated responses that garnered an overall mean of **3.77**, **“Often”** being its current corresponding verbal interpretation.

Competence is defined by the American Nurses’ Association (ANA) as *“an expected and measurable level of nursing performance that integrates knowledge, skills, abilities, and judgment based on established scientific knowledge and expectations for nursing practice.”* The Emergency Nurses’ Association (ENA) defines competence as *“the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.”* Both definitions aim for personal and professional practice advancements. The ANA’s Code of Ethics also states that the nurse has a duty to herself, which includes professional competence and keeping the contract between the nursing profession and society by protecting the public while ensuring the integrity of the nursing profession (**Harding, 2013**). Also, to be considered in law as competent, a nurse must have undertaken a training program provided by an institution or by the employer (**Smith, 2011**).

In the orthopaedic field, competence can be best seen especially during application of orthopaedic equipment. Application of tractions, may it be skeletal or skin traction, including nursing assessment and interventions, prevention of complications, and patient education is expected from a competent nurse. One must consider weights for balance and counterbalance, proper alignment, line of pull, and aseptic conditions during application. Nursing assessment should focus on preventing complications like infection, skin breakdown, neurovascular compromise, and problems of immobility. It is also important to always assess for the equipment for safety and effectiveness. Interventions should also be done to address the patient's needs in all aspects. Performing active exercises of uninvolved muscles, encouraging deep breathing, fluid intake and high fiber diet, establishing bowel routine, preventing pressure, monitoring vital signs, cleaning the sites, and reporting promptly any changes in neurovascular status; there are all important nursing care to be provided to an orthopaedic patient (**Nettina, 2010**).

Table 21 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of prayer.

Table 21
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms of Prayer

Prayer	Mean	Verbal Interpretation
1. Encourages the patient to pray.	2.50	Rarely
2. Touches the patient and demonstrate sensitivity and sincerity.	2.50	Rarely
3. Allows some moment of silence.	4.50	Always
4. Prays with the patient.	1.83	Rarely
Overall Mean	2.83	Sometimes

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely
 1 = Never

According to the gathered data pertaining to prayer, the **highest mean score** in Table 21 was **4.50** for the statement *“Allows some moment of silence”*, with a verbal interpretation of **“always”**. The **lowest mean score** of **1.83** and a verbal interpretation of **“Rarely”** was for the statement, *“Prays with the patient.”* Overall, the mean score is **2.83** with a verbal interpretation of **“Sometimes”**.

Prayer offers an opportunity to renew personal faith and belief in a higher being in a specific, focused way that is either highly ritualized and formal or quite spontaneous and informal. It is an effective coping resource for physical and psychological symptoms. Nurses are supportive of prayer by giving clients privacy, by suggesting prayer when they know clients use it as a coping resource, and by participating in prayer with clients. If prayer is not suitable, listening to music, reading a book, poetry, or other inspirational texts can be alternatives (Potter, 2011).

Prayer is a spiritual practice for many and is defined as “human communication with divine and spiritual entities.” While meditational and colloquial prayer experiences have been found to be associated with spiritual wellbeing and quality of life in healthy adults, ritual and petitionary prayer experiences may be most comforting and appropriate for those who are ill and unable to concentrate. Patients may need uninterrupted quiet time during which they have prayer books, rosaries, malas, or other icons available to them **(Berman, 2012)**.

Prayer involves a sense of love and connection, as well as reaching out. It has many health benefits and healing properties. A recent Cochrane review of the evidence from several randomized experiments that investigated the efficacy of intercessory prayer, that is, having a person unknown to the client pray for the client’s physical healing, however, concluded that the findings equivocally suggest no clear positive or negative effects. When it is assessed to be ethical and desired, the nurse who shares a belief in prayer may find praying with a client to be an inwardly powerful experience **(Berman, 2012)**.

In addition, a study published in a medical journal, showed a connection between religion and medicine and opened the door for further research on prayer and spirituality. Prayer frequently is considered a complementary therapy. It is an effective therapeutic intervention and many patients desire prayer. Reasons for prayer is when people think more about God during illnesses but some may find it

difficult to pray. Also, because prayer is intimate, it may bring the person in touch with either physical or emotional pain. Praying with patients is a privilege and a responsibility. Assess the patient, use appropriate spiritual care, and when the nurse sees an open door, offer to pray (Sweat, 2009).

Table 22 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of presence.

Table 22
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms of Presence

Presence	Mean	Verbal Interpretation
1. Establishes the purpose of the interaction.	3.83	Often
2. Displays interest to the patient.	3.83	Often
3. Encourages expression of feelings.	3.75	Often
4. Focuses completely on the interaction by suppressing prejudice, bias, assumptions, preoccupying personal concerns, and other distractions.	3.33	Sometimes
5. Displays an awareness of and sensitivity to emotions.	3.42	Often
6. Spends time with patient even in silence.	3.08	Sometimes
7. Demonstrates awareness of physical stance conveying nonverbal messages.	3.33	Sometimes
8. Listens for the unexpressed message and feelings as well as content of the conversation.	3.33	Sometimes
9. Demonstrates sensitivity and awareness of which words are avoided, as well as nonverbal messages that accompany the expressed words.	3.33	Sometimes
10. Observes appropriate tone, tempo, volume, pitch, and inflection of the voice.	3.67	Often
11. Determines the meaning of the message by reflecting on attitudes, past experiences, and the current situation.	3.42	Often
12. Avoids barriers to active listening (e.g., minimizing feelings, offering easy solutions, interrupting, talking about self, and premature closure).	3.50	Often
Overall Mean	3.49	Often

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely

1 = Never

In Table 22, the **highest mean scores are 3.83** with a verbal interpretation of **“Often”** for statements *“Establishes the purpose of the interaction”* and *“Displays interest to the patient”*. The **lowest mean is 3.08** with a verbal interpretation of **“Sometimes”** for statement *“Spends time with patient even in silence.”* The overall mean is **3.49** with a verbal interpretation of **“Often”**.

Providing presence conveys closeness and a sense of caring between two persons. It involves “being there” and “being with”. It is not only a physical presence but also includes communication and understanding. In this way, the nurse offers support, comfort, encouragement, reassurance, and the diminishing of unwanted feelings. The nurse makes herself available and at the patients’ disposal. The client will then accept the nurse to see, share, and touch their vulnerability and suffering. Establishing presence with the client enhances the nurse’s ability to learn from the client and to provide appropriate nursing care. Giving reassurance, remaining at the client’s side, and helping the client go through the experience is invaluable to the patient’s wellbeing (**Potter, 2011**).

Therapeutic presence starts even from assessment. It is when the nurse projects an air of caring concern. During assessment, it is important for the nurse to establish presence for clients do not often share information with a professional whom they see as distracted or uninterested (**Laccetti, 2009**).

Table 23 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of their open-mindedness.

Table 23
Summary of Values Showing the Mean and Verbal Interpretation of the COMPOSURE Behaviours of Advanced Beginner Nurses in terms of Open-mindedness

Open-mindedness	Mean	Verbal Interpretation
1. Creates an environment of trust and rapport.	4.00	Often
2. Encourages openness to patient's feelings.	3.67	Often
3. Listens attentively to patient.	3.33	Sometimes
4. Allows the patient to have some degree of control over himself/herself.	3.75	Often
5. Respect the rights and opinion of patient and others.	3.92	Often
Overall Mean	3.73	Often

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely
 1 = Never

The **highest mean score** for Table 23 is **4.00** with a verbal interpretation of "**Often**" for statement "*Creates an environment of trust and rapport.*" The **lowest mean score is 3.33** with a verbal interpretation of "**Sometimes**" for statement "*Listens attentively to patient.*" The overall mean is **3.73** with a verbal interpretation of "**Often**".

Knowing the client is the first step to be open-minded and to accept his individuality and condition. Knowing develops over time as a nurse learns the clinical conditions within a specialty and the behaviours and physiological

responses of clients. Intimate knowing helps the nurse respond to what really matters to the client. A nurse must avoid assumptions, focus on the client, and engage in a caring relationship that reveals information and cues that facilitates critical thinking and clinical judgment. By establishing a caring relationship, the nurse knows the client as a unique individual and can choose the most appropriate and efficacious nursing therapies. To know the client is to enter in a social process that results in “bonding” which then sets the client to be more involved in his or her care and accept help when needed (**Potter, 2011**).

Nurses should also show positive regard, which refers to the warmth, caring, interest, and respect for the person, seeing the person unconditionally or non-judgmentally. This is an act of open-mindedness. Positive regard does not mean that the nurse accepts all aspect of a person’s behaviour. The underlying assumption is that the person is worthwhile, has value and dignity, and should then be accepted (**Udan, 2009**).

Active listening is a primary source of communication for nurses. What patients say about themselves is very important. In order to listen, the nurse must be actively engaged in receiving and decoding messages that patients send. The nurse listens to the patient with two purposes in mind: to comprehend the message and evaluate its meaning. (**Sherman, K., 2009**)

Table 24 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of stimulation.

Table 24
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms of Stimulation

Stimulation	Mean	Verbal Interpretation
1. Shows genuine interest through gentle touch and smile	4.08	Often
2. Provides guidance and encouragement in doing activities of daily living.	4.17	Often
3. Tells patient what he can do, what he is suppose to do, and how to do it.	4.33	Always
4. Provides praise and complimentary words.	4.25	Always
5. Encourages goal setting by asking patient to decide on the type of change needed.	3.92	Often
6. Encourages decisions by asking the patient to make a choice among options.	3.83	Often
7. Encourages patient to evaluate his action.	3.67	Often
Overall Mean	4.04	Often

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely
 1 = Never

For Table 24, the **highest mean score is 4.33** with a verbal interpretation of “**Always**” for statement “*Tells patient what he can do, what he is suppose to do, and how to do it.*” The **lowest mean score is 3.67** with a verbal interpretation of “**Often**” for statement “*Encourages patient to evaluate his action.*” The overall mean is **4.04** with a verbal interpretation of “**Often**”.

Stimulation is through the use of touch, a comforting approach where the nurse reaches out to clients communicate concern and support. It is relational and leads to a connection between nurse and client. The skilful and gentle performance of a nursing procedure conveys security and a sense of competence.

Caring touch is a form of non-verbal communication which successfully influences a client's comfort and security, enhances self-esteem, and improves reality orientation. Stimulation can also be given through sharing hope. Appropriate encouragement and positive feedback are important in fostering hope and self-confidence and for helping people achieve their potential and reach their goals. Sharing a vision of the future and reminding others of their resources and strengths can give hope and stimulate personal growth (Potter, 2011).

Table 25 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of understanding.

Table 25
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms of Understanding

Understanding	Mean	Verbal Interpretation
1. Encourages the patient to feel comfortable in the nurse-patient relationship.	4.08	Often
2. Takes time to a response so that it reflects understanding of the received message.	3.83	Often
3. Clarifies the message through the use of question and feedback.	3.75	Often
Overall Mean	3.89	Often

Legend: 5 = Always
4 = Often
3 = Sometimes
2 = Rarely
1 = Never

For Table 25, the **highest mean score is 4.08** with a verbal interpretation of **“Often”** for statement *“Encourages the patient to feel comfortable in the*

nurse-patient relationship.” The **lowest mean score is 3.75** with a verbal interpretation of **“Often”** for statement *“Clarifies the message through the use of question and feedback.”* The overall mean is **3.89** with a verbal interpretation of **“Often”**.

Caring involves an interpersonal interaction wherein the nurse establishes trust, open lines of communication, and listens to what the client has to say. It includes “taking in” what a client says, as well as interpreting and understanding what the client is saying and giving back that understanding to the person talking. Listening and understanding helps create a mutual relationship, and truly knowing and responding to what really matters to the client and family. It is important to remain intentionally silent and to concentrate on what the client has to say, paying attention to the individual’s words and tones of voice and entering his or her frame of reference to truly have understanding (**Potter, 2011**).

Table 26 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of respect.

Table 26
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms of Respect

Respect	Mean	Verbal Interpretation
4. Calls the patient by his/her preferred name.	4.67	Always
5. Provides privacy whenever certain part of the body has to be examined.	4.17	Always
6. Provides respect for whatever decisions made regarding patient's own preferences.	3.92	Often
7. Provides options before making decisions.	3.83	Often
8. Utilizes "po" and "opo" when being asked.	4.67	Always
Overall Mean	4.25	Always

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely
 1 = Never

In Table 26, the **highest mean score is 4.67** with a verbal interpretation of **"Always"** for statements *"Calls the patient by his/her preferred name"* and *"Utilizes "po" and "opo" when being asked"*. The **lowest mean score is 3.83** with a verbal interpretation of **"Often"** for the statement of *"Provides options before making decisions."* The overall mean is **4.25** with a verbal interpretation of **"Always"**.

One of the qualifications and abilities of a professional nurse is to have respect for human dignity (Udan, 2009). Respect is one of the things most patients expect from healthcare providers. Without it, depersonalization can occur. This is when the client perceives that he is not valued or respected as a person. It is also the feeling that he is not being listened to or is not invited to be used in planning his care. Another one of the very important aspect of respect is

for patient's privacy. Information revealed during assessment is personal and not easily shared in comfortable circumstances. To respect the patient is to maintain confidentiality too. **(Laccetti, 2009).**

Every patient, especially the vulnerable, has the right to be treated with respect and dignity. All health care professionals must treat their patients with respect and dignity by listening to their concerns and acting on their behalf. There should be no discrimination on the grounds of age, disability, race, gender, sexual orientation, religion or beliefs. This can be done by avoiding all forms of abuse, treating each person as an individual, enabling people to maintain the maximum possible level of independence, listening and supporting people to express their needs, assist people to maintain confidence and a positive self-esteem, and to act on alleviating people's loneliness and isolation. Treating each patient with respect and dignity is included as an essential benchmark and is central to care delivery **(Smith, 2011).**

Nurses promote a client's self-esteem and dignity by respecting him or her as a whole person with feelings, accomplishments, and passions independent of the illness experience. Giving importance to the things that a client cares about validates the person, at the same time strengthening communication among the client, family members, and the nurse **(Potter, 2011).**

Table 27 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of relaxation.

Table 27
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms of Relaxation

Relaxation	Mean	Verbal Interpretation
1. Asks the patient to empty his/her bladder before the start of the intervention.	4.00	Often
2. Assists the patient in finding a comfortable position.	4.08	Often
3. Describes progressive relaxation, its rationale, and benefits.	3.92	Often
4. Considers the patient's willingness to participate, preferences, past experiences, contraindications, and fears before starting with the procedure.	3.92	Often
5. Asks the patient to close his/her eyes.	4.00	Often
6. Instructs the patient to do deep breathing and relax	3.75	Often
7. Sets goals with the patient. For example, reduction of pain, tension, and anxiety.	3.67	Often
8. Have patient quantify level of parameters to be changed. For example, "my pain level sensation is at this moment."	3.33	Sometimes
9. Takes note of facial expression and unnecessary body movements.	3.08	Sometimes
10. Guides through progressive relaxation technique.	3.67	Often
11. Provides undisturbed time because patient may fall asleep.	3.92	Often
12. Regularly evaluates reports of the individual's feedback about relaxation achieved.	3.58	Often
13. Periodically monitors vital signs and muscle tension.	4.17	Often
14. Plans to provide regular reinforcement for the use of relaxation.	3.75	Often
15. Praises patient's effort and acknowledge possible outcomes.	3.75	Often
16. Evaluates and document the patient's response to the intervention.	4.25	Always
17. Observes his breathing. Ask if he is feeling relaxed.	4.25	Always
18. Asks the patient to describe the technique and assess whether your patient is able to understand the technique well.	4.17	Often
19. Asks whether the technique was helpful for reducing the tension and pain sensation.	3.75	Often
20. If the technique increases your patient's comfort level, explores whether the benefits was significant to him.	4.00	Often
Overall Mean	3.85	Often

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely

1 = Never

For Table 27, the **highest mean score is 4.25** with a verbal interpretation of “**Always**” for statements “*Evaluates and document the patient’s response to the intervention*” and “*Observes his breathing. Ask if he is feeling relaxed.*” The **lowest mean is 3.08** with a verbal interpretation of “**Sometimes**” for statement “*Takes note of facial expression and unnecessary body movements*”. The overall mean is **3.85** with a verbal interpretation of “**Often**”.

Restorative and continuing care are all part of a nurse’s therapy under which is the promotion of relaxation. Meditation effectively creates a relaxation response that reduces daily stress and blood pressure, reduces pain, and enhances the immune system. Nurses often use guided imagery to help clients learn meditation. When clients use meditation with their spiritual beliefs, they often report an increased spirituality that they commonly describe as experiencing the presence of a power, force or energy, or what was perceived as God (**Potter, 2011**).

Non-pharmacological interventions can also provide relaxation for patients, especially those who are in need for relief of pain. Massage, including rubbing of the skin using heat and cold can promote comfort because it produces

muscle relaxation. Thermal therapies may also be effective for pain relief. Distraction helps relieve both acute and chronic pain because it involves focusing the patient's attention on something other than the pain, and may be the mechanism responsible for other effective cognitive techniques. Watching tv, listening to music, physical and mental exercises, and visits from family and friends can be effective in alleviating pain and promotion relaxation. Another simple relaxation technique consists of breathing at a slow and rhythmic rate. Regular relaxation periods may help combat the fatigue and muscle tension that occur with increasing pain. Guided imagery, hypnosis, and music therapy are other techniques as well (Smeltzer, 2010).

Table 28 describes the mean and verbal interpretation of the COMPOSURE behaviours of advanced beginner nurses in terms of empathy.

Table 28
Summary of Values Showing the Mean and Verbal Interpretation
of the COMPOSURE Behaviours of Advanced Beginner
Nurses in terms of Empathy

Empathy	Mean	Verbal Interpretation
1. Encourages expression of feelings; focus on verbal and nonverbal behaviour.	4.33	Always
2. Leans forward with head and body turned toward the patient.	3.75	Often
3. Displays an awareness of and sensitivity to emotions.	3.67	Often
4. Provides verbal responses to the patient's previous comments.	3.75	Often
5. Provides verbal responses that focus on patient's strengths and limitations.	3.75	Often
6. Maintains a good tone of voice consistent with facial and verbal response. The tone should be similar with that of the patient.	4.00	Often
7. Formulates responses of empathy in a language and manner that are most easily understood by the patient.	3.75	Often
8. Provides continuous feedback.	3.50	Often
9. Explores feelings toward termination of relationship.	3.58	Often
10. Encourages sharing of feelings and emotions.	3.75	Often
Overall Mean	3.78	Often

Legend: 5 = Always
 4 = Often
 3 = Sometimes
 2 = Rarely
 1 = Never

For Table 28, the **highest mean** is **4.33** with a verbal interpretation of **“Always”** for statement *“Encourages expression of feelings; focus on verbal and nonverbal behaviour.”* **The lowest mean** is **3.50** with a verbal interpretation of **“Often”** for statement *“Provides continuous feedback.”* The overall mean score is **3.78** with verbal interpretation of **“Often”**.

According to **Webster (2013)**, a cancer patient who has told of life story of celebration about the healing power of a nurse's empathy that nurses change lives through the power of envisioning, as she had felt from her nurse a sense of empathy that allowed her healing at its deepest level. Nurses can directly impact the care of patients and their families through the use of therapeutic communication. In addition, patients and families prefer the style of communication to include empathy and honesty, balanced with sensitivity and hope. By using this, the nurse is able to incorporate quality of life domains such as physical, psychological, social, and spiritual aspects, to address the patient's care needs (**Baer, 2013**).

Empathy is the ability to enter into another person's experience, to perceive it accurately and to understand how situation is viewed from the client's perspective. It includes the ability to respond receptively to the other person's experience while maintaining objectivity and ability to communicate to the person that he or she is understood. The nurse must feel secure enough not to be intimidated if the client experiences a situation differently. The nurse should also feel comfortable enough to imagine what a situation might be like for someone else while remaining outside that situation to maintain objectivity. Through this, the nurse conveys that she perceives the client's feelings accurately. Empathy is a strong component in therapeutic relationship. Simple actions such as touch,

kindness, attentiveness, and information also signify empathy (Udan, 2009). To express empathy, the nurse reflects understanding of the importance of what the other person communicated on a feeling level. Such empathic understanding requires the nurse to be both sensitive and imaginative, especially if the nurse had not yet had a similar experience (Potter, 2011).

PROBLEM #4: What is the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses?

Table 29 describes the mean and verbal interpretation of the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses in terms of physical.

Table 29
Summary of Values Showing the Mean and Verbal Interpretation of the
Biobehavioral Wellness Outcome of Selected Orthopedic Patients
Before and After the COMPOSURE Behaviors
of Advanced Beginner Nurses in
terms of Physical

Physical	Before		After	
	Mean	Verbal Interpretation	Mean	Verbal Interpretation
1. I feel alright. (Magaan ang aking pakiramdam.)	3.47	Agree	3.80	Agree
2. I have enough energy to carry out my activities of daily living. (May sapat akong lakas para gampanan ang aking mga gawain.)	3.22	Neutral	3.29	Neutral
3. I can take care of myself. (Kaya kong alagaan ang aking sarili.)	2.80	Neutral	3.10	Neutral
4. I can walk without difficulty. (Nakakalakad ako ng walang kahirap-hirap.)	2.20	Disagree	2.43	Disagree
5. Walking exercise is good for me. (Nakakabuti sa akin ang paglalakad.)	3.43	Agree	3.53	Agree
6. I exercise every day. (Nag-eehersisyo ako araw-araw.)	3.27	Neutral	3.88	Agree
7. I have no difficulty sleeping. (Hindi ako nahihirapan sa pag tulog.)	3.31	Neutral	3.45	Agree
8. I feel rested when I wake up in the morning. (Nakakaramdam ako ng ginhawa paggising ko sa umaga.)	3.59	Agree	3.88	Agree
9. I feel bone pain on the affected area when I perform physical activities. (Nakakaramdam ako ng pananakit ng buto sa hita kung ako ay gumagawa ng pampisikal na gawain.)	3.76	Agree	3.47	Agree
10. I have difficulty doing my activities of daily living. (Nahihirapan akong gawin ang mga pang-araw-araw kong mga gawain.)	3.47	Agree	3.57	Agree
Overall Mean	3.25	Neutral	3.44	Agree

Legend: 5 = strong agree (talagang sang-ayon)
4 = agree (sang-ayon)
3 = neutral (di-tiyak)
2 = disagree (di sang-ayon)
1 = strongly disagree (talagang di sang-ayon)

For Table 29, the **highest mean** among the biobehavioral wellness outcome in terms of **physical before** the COMPOSURE behaviours of the advanced beginner nurses is **3.76** with a verbal interpretation of **“Agree”** for statement *“I feel bone pain on the affected area when I perform physical activities. (Nakakaramdam ako ng pananakit ng buto sa hita kung ako ay gumagawa ng pampisikal na gawain.)”*. The **lowest mean score is 2.20** with a verbal interpretation of **“Disagree”** for a statement *“I can walk without difficulty. (Nakakalakad ako ng walang kahirap-hirap.)”*. The overall mean score is **3.25** with a verbal interpretation of **“Neutral”**.

After the COMPOSURE behaviors of advanced beginner nurses, the **highest mean score is 3.88** with a verbal interpretation of **“Agree”** for statements *“I exercise every day. (Nag-eehersisyo ako araw-araw.)”* and *“I feel rested when I wake up in the morning. (Nakakaramdam ako ng ginhawa paggising ko sa umaga.)”*. The **lowest mean score is 2.43** with a verbal interpretation of **“Disagree”** for statement *“I can walk without difficulty. (Nakakalakad ako ng walang kahirap-hirap.)”*. The overall mean score is **3.44** with a verbal interpretation of **“Agree”**.

Physical fitness is the body's ability to function efficiently and effectively. It is a state of being that consists of at least five health-related and six skill-related, physical fitness components, each of which contributes to total quality of life. Physical fitness is associated with a person's ability to work effectively, enjoy leisure time, be healthy, resist hypokinetic diseases, and meet emergency situations. It is related to, but not different from, health and wellness. Although the development of physical fitness is the result of many things, optimal physical fitness is not possible without regular physical activity.

The five components of health-related physical fitness are body composition, cardiovascular fitness, flexibility, muscular endurance, and strength. Each health related fitness characteristic has a direct relationship to good health and reduced risk of hypokinetic disease. **(National Health Goals 2010)**

Exercise is unlikely to pop into our mind as an important way to accelerate fracture healing – yet it is. In general, bone tissue responds to patterns of loading by increasing matrix synthesis, altering composition, organization, and mechanical properties. Evidence indicates that the same holds true for bone under repair. Further, fracture healing requires good circulation and an adequate flow of nutrient – replenishing blood to the fracture site – both of which are enhanced by exercise. To avoid stress on the broken bone, joint loading, range of motion, and

specific tendon-gliding exercises are employed to accelerate healing and assure return of function post fracture. For example, in the case of a broken forearm, exercises would involve movements of the fingers and hand, as well as the elbow and shoulder joints. **(Brown, S. 2013)**

Cells damaged from the trauma of fracture release large amounts of inflammatory prostaglandins at the site of fracture. The ensuing inflammation causes pain and the natural tendency is to want to block the painful reaction. **(Brown, S. 2013)**

The orthopaedic patient faces a lot of physical setbacks. These are often seen as impaired physical mobility, risk for injury, risk for skin integrity, constipation, altered nutritional status, and many more. Patients are also challenged by further complications such as shock, fat or pulmonary embolism, compartment syndrome, deep vein thrombosis, thromboembolism, pressure ulcers, stasis pneumonia, muscle atrophy, infection, and others **(Untalan, 2009)**.

Physiologically, there are generally many signs and symptoms for musculoskeletal disorders, depending on their locations, severity, and causes. Still, nursing care is to address all physical aspects of a patient. This would include minimizing the effects of immobility and encouraging mobility,

maintaining skin integrity, avoiding infection, promoting tissue perfusion, maintaining intact neurovascular status, monitoring for shock and hemorrhage, promoting effective breathing pattern, relieving pain, providing adequate nutrition, promoting adequate hygiene, and other needs presented by the patient (Nettina, 2010).

Table 30 describes the mean and verbal interpretation of the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses in terms of intellectual.

Table 30
Summary of Values Showing the Mean and Verbal Interpretation of the Biobehavioral
Wellness Outcome of Selected Orthopedic Patients Before and After the
COMPOSURE Behaviors Of Advanced Beginner Nurses
in terms of Intellectual

Intellectual	Before		After	
	Mean	Verbal Interpretation	Mean	Verbal Interpretation
1. I am alert and aware of what is happening around me. (Alam ko ang nangyayari sa aking paligid.)	3.92	Agree	4.08	Agree
2. I am oriented to time. (Nalalaman ko ang oras ngayon.)	4.18	Agree	4.33	Strongly Agree
3. I can recognize the people around me. (Nakikilala ko ang mga tao sa aking paligid.)	4.29	Strongly Agree	4.37	Strongly Agree
4. I know where I am right now. (Nalalaman ko kung saan ako naroroon ngayon.)	4.43	Strongly Agree	4.47	Strongly Agree
5. I know exercise is good for my bones. (Alam kong ang ehersisyo ay mabuti sa mga buto.)	4.29	Strongly Agree	4.51	Strongly Agree
6. I verbalize my feelings to others. (Sinasabi ko ang aking nararamdaman sa iba.)	4.16	Agree	4.31	Strongly Agree
7. I know fruits and vegetables should always part of my daily diet. (Alam kong dapat bahagi ng aking pang-araw-araw na pagkain ang mga prutas at gulay.)	4.65	Strongly Agree	4.33	Strongly Agree
8. Smoking is bad for my health. (Masama sa kalusugan ang paninigarilyo.)	4.51	Strongly Agree	4.44	Strongly Agree
9. Drinking alcoholic beverages is not good. (Hindi nakakabuti ang pag-inom ng mga inuming may alcohol.)	4.35	Strongly Agree	4.16	Agree
10. I think carefully before making decisions. (Nag-iisip ako ng mabuti bago gumawa ng desisyon.)	4.20	Agree	4.47	Strongly Agree
11. I ask for doctor's advice regarding health condition. (Humihingi ako ng payo sa doktor ukol sa aking kalusugan.)	4.33	Strongly Agree	4.49	Strongly Agree
12. I keep an open mind about new things in life. (Pinananatili kong bukas ang aking isipan sa mga pagbabagong nangyayari sa buhay.)	4.27	Strongly Agree	4.47	Strongly Agree
Overall Mean	4.30	Strongly Agree	4.37	Strongly Agree

Legend: 5 = strong agree (talagang sang-ayon)
4 = agree (sang-ayon)
3 = neutral (di-tiyak)
2 = disagree (di sang-ayon)
1 = strongly disagree (talagang di sang-ayon)

In Table 30, the **highest mean** among the **intellectual** biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour is **4.65** with a verbal interpretation of “**Strongly Agree**” for statement “*I know fruits and vegetables should always part of my daily diet. (Alam kong dapat bahagi ng aking pang-araw-araw na pagkain ang mga prutas at gulay.)*.” The **lowest mean is 3.92** with a verbal interpretation of “**Agree**” for statement “*I am alert and aware of what is happening around me. (Alam ko ang nangyayari sa aking paligid.)*”. The overall mean score is **4.30** with a verbal interpretation of “**Strongly Agree**”.

After the COMPOSURE behaviors of advanced beginner nurses, the **intellectual** biobehavioral patient wellness outcome of the selected orthopaedic patients, the **highest mean is 4.51** with a verbal interpretation of “**Strongly Agree**” for statement “*I know exercise is good for my bones. (Alam kong ang ehersisyo ay mabuti sa mga buto.)*”. The **lowest mean score is 4.08** with a verbal interpretation of “**Agree**” for statement “*I am alert and aware of what is happening around me. (Alam ko ang nangyayari sa aking paligid.)*”. The overall mean score is **4.37** with a verbal interpretation of “**Strongly Agree**.”

Mental status of patients, may it or may it not be caused by pain, can be a barrier for development. In the early days of hospitalization it is quite common for patients to experience anxiety, especially when accompanied by pain, can reduce comprehension, memory, and the ability to communicate. Confusion may also

interfere with assessment and nursing interventions. The elderly and the young are more at risk to be confused when removed from familiar routines and environment. Acknowledging and addressing the causes can promote improvement for the patient (**Lacceti, 2009**).

To promote intellectual wellness, it is of great help to offer patient education. Teaching the patient the purpose of the therapy, delineating limitations of activities, use of patient aids and activities that will minimize development of complications, reporting changes in sensations, pain, and movement, can be beneficial to the patient. This not only promotes understanding but also prevents anxiety and confusion for the patient (**Nettina, 2010**).

Good nutrition is required for proper bone growth and healing throughout life, as bones go through a constant process of breaking down old bone and replacing it with new bone. Nutrition needs are even greater after an injury or if living with a condition such as osteoporosis, which causes the bones to become brittle. While a balanced diet is necessary there are particular foods that aid with bone healing that should be consumed every day.

Yogurt and milk are both good sources of calcium, which can help bones heal. Adequate intake of calcium is an important step in helping bones to stay strong. Calcium is also needed for many other functions in the body, which means if not enough is eaten, calcium is taken from the bones to meet those other needs.

Fish such as salmon, tuna and mackerel and fish oils are the best dietary sources of vitamin D, which is important for bone health. Getting enough vitamin D is necessary because vitamin D must be present to help the bones absorb calcium claims the Centers for Disease Control and Prevention. Inadequate intake of vitamin D can lead to rickets or a softening of the bones.

Protein is also essential for bone health and healing and a lack of protein can contribute to hip fractures in the elderly, warns the International Osteoporosis Foundation. Lean red meat and poultry are the best sources of dietary protein; however, it can also be found in legumes, soy products, tofu, grains, nuts and seeds.

Eating a variety of green leafy vegetables every day is also good for your bones. Green leafy vegetables are often high in calcium as well as vitamin K. According to the International Osteoporosis Foundation, vitamin K is essential for bone metabolism. While more research is needed to determine a link, inadequate vitamin K intake may contribute to the development of osteoporosis.

Magnesium is required for many functions in the body and up to 50 percent of the magnesium stored in the body is in your bones. Nuts and whole grains supply this essential mineral that helps to regulate calcium metabolism in the bones, states the Office of Dietary Supplements website. Daily needs are based on age, gender, and overall health. (Newell, L. 2010)

Table 31 describes the mean and verbal interpretation of the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses in terms of emotion.

Table 31
Summary of Values Showing the Mean and Verbal Interpretation
of the Biobehavioral Wellness Outcome of Selected Orthopedic
Patients Before and After the COMPOSURE Behaviors
of Advanced Beginner Nurses in terms of Emotional

Emotional	Before		After	
	Mean	Verbal Interpretation	Mean	Verbal Interpretation
1. I love and take care of myself. (Mahal ko at inaalagaan ko ang aking sarili.)	4.31	Strongly Agree	4.41	Strongly Agree
2. I know how to relax at the end of the day. (Alam ko kung paano magpahinga pagkatapos ng maghapon.)	4.37	Strongly Agree	4.27	Strongly Agree
3. I take time to go on rest and vacation. (Naglalaan ako ng oras sa pahinga at bakasyon.)	4.00	Agree	4.16	Agree
4. Enough or sufficient time for sleeping is good. (Ang sapat na oras ng pagtulog ay nakagagaling.)	4.35	Strongly Agree	4.31	Strongly Agree
5. I get angry easily. (Madali akong magalit.)	3.08	Neutral	3.10	Neutral
6. I feel a sense of connectedness to other people. (Nakakaramdam ako ng pagiging malapit sa ibang tao.)	4.20	Agree	3.96	Agree
7. I don't think ill of others. (Hindi ako nag-iisip ng masama sa iba.)	4.21	Agree	4.12	Agree
8. I do not care about others especially if they do not affect me. (Hindi ako nakikialam sa iba lalo na kung hindi sila nakakaapekto sa akin.)	4.23	Strongly Agree	4.41	Strongly Agree
9. My values guide my daily life. (Ang pagpapahalaga ko sa aking sarili ang siyang gabay ko sa pang-araw-araw na buhay.)	4.30	Strongly Agree	4.41	Strongly Agree
Overall Mean	4.12	Agree	4.13	Agree

Legend: 5 = strong agree (talagang sang-ayon)
4 = agree (sang-ayon)
3 = neutral (di-tiyak)
2 = disagree (di sang-ayon)
1 = strongly disagree (talagang di sang-ayon)

Reflected from the figured data shown above, the **highest mean** among the **emotional** biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour is **4.37** with a verbal interpretation of “**Strongly Agree**” for statement “*I know how to relax at the end of the day. (Alam ko kung paano magpahinga pagkatapos ng maghapon.)*.” The **lowest mean score** is **3.08** with a verbal interpretation of “**Neutral**” for statement “*I get angry easily. (Madali akong magalit.)*”. The **overall mean score** is **4.12** with a verbal interpretation of “**Agree**”.

After the COMPOSURE behaviors of advanced beginner nurses, the emotional biobehavioral patient wellness outcome of the selected orthopaedic patients, the **highest mean score** is **4.41** with a verbal interpretation of “**Strongly Agree**” for statements “*I love and take care of myself. (Mahal ko at inaalagaan ko ang aking sarili.)*”, “*I do not care about others especially if they do not affect me. (Hindi ako nakikialam sa iba lalo na kung hindi sila nakakaapekto sa akin.)*”, and “*My values guide my daily life. (Ang pagpapahalaga ko sa aking sarili ang siyang gabay ko sa pang-araw-araw na buhay.)*”. The **lowest mean score** is **3.10** with a verbal interpretation of “**Neutral**” for statement “*I get angry easily. (Madali akong magalit.)*”. The **overall mean score** is **4.13** with a verbal interpretation of “**Agree**”.

Most of the time, depersonalization may be caused by the immersion of a client in the sick role. Usual emotions include hopelessness and powerlessness

and may inhibit the patient from participating in his self-care. It is vital to always assess the patient on his emotional needs by listening to the client, assessing for affect, unwillingness to participate, or history of conflicts with health providers to prevent negative feelings that may have a major impact on his emotional health **(Laccetti, 2009)**.

Most of the common emotional difficulties orthopaedic patients face involves nursing diagnoses of body image disturbance, fear, altered role performance, and self-care deficit brought upon by impairments in physical mobility **(Untalan, 2009)**.

Anxiety is more of an emotional problem than intellectual. Relieving anxiety in patients serves as emotional support most of the time. Reassuring the patient about tractions and fixators, emphasizing positive aspects of the treatment, encouraging verbalization, and involving the patient in their care can offer emotional development during times of crises. At times too, the patient may need more emotional support especially if faced with a need for acceptance of body image change. Avoiding unrealistic and misleading statements and explore more on the patient's perception. Accept patient's responses and encourage expression of fears and concerns. Encourage participation in rehabilitation therapy and make sure to assist in adaptation to changes in self-care. Also, minimizing the psychological effects of trauma by assisting the patient to move through different

phases of stress such as outcry, denial, intrusiveness, working through, and completion, would further help him emotionally (Nettina, 2010).

Table 32 describes the mean and verbal interpretation of the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses in terms of spiritual.

Table 32
Summary of Values Showing the Mean and Verbal Interpretation of the Biobehavioral Wellness Outcome of Selected Orthopedic Patients Before and After the COMPOSURE Behaviors of Advanced Beginner Nurses in terms of Spiritual

Spiritual	Before		After	
	Mean	Verbal Interpretation	Mean	Verbal Interpretation
1. I am satisfied with my spiritual life. (Nasisiyahan ako sa aking buhay ispiritwal.)	4.47	Strongly Agree	4.59	Strongly Agree
2. I feel a sense of connectedness with God. (Nakakaramdam ako ng pagiging malapit sa Diyos.)	4.46	Strongly Agree	4.39	Strongly Agree
3. I spend a portion of everyday in prayer and personal reflection. (Naglalaan ako ng oras sa aking pang-araw-araw na pagdarasal at pagninilay-nilay.)	4.42	Strongly Agree	4.61	Strongly Agree
4. I leave to God what I cannot take or change. (Ipinauubaya ko sa Diyos ang hindi ko makaya at mabago.)	4.60	Strongly Agree	4.65	Strongly Agree
5. I do not lose hope despite trials in life. (Hindi ako nawawalan ng pag-asa sa kabila ng mga pagsubok sa buhay.)	4.45	Strongly Agree	4.63	Strongly Agree
6. I reflect on my personal life and how I affect others. (Nagninilay ako sa aking sariling buhay at kung paano ako nakakaapekto sa iba.)	4.13	Agree	4.37	Strongly Agree
7. I feel a sense of inner peace. (Nakakadarama ako ng kapanatagan ng kalooban.)	4.27	Strongly Agree	4.41	Strongly Agree
8. My life has a positive purpose. (May positibong hangarin ang aking buhay.)	4.48	Strongly Agree	4.43	Strongly Agree
9. We are all connected with people and surroundings. (May pagkakaugnay tayo sa ibang tao at sa ating paligid.)	4.31	Strongly Agree	4.37	Strongly Agree
Overall Mean	4.40	Strongly Agree	4.49	Strongly Agree

Legend: 5 = strong agree (talagang sang-ayon)
4 = agree (sang-ayon)
3 = neutral (di-tiyak)
2 = disagree (di sang-ayon)
1 = strongly disagree (talagang di sang-ayon)

Reflected from the figured data shown above, the **highest mean score** among the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour is **4.60** with a verbal interpretation of “**Strongly Agree**” for statement “*I leave to God what I cannot take or change. (Ipinauubaya ko sa Diyos ang hindi ko makaya at mabago.)*”. The **lowest mean score** is **4.13** with a verbal interpretation of “**Agree**” for statement “*I reflect on my personal life and how I affect others. (Nagninilay ako sa aking sariling buhay at kung paano ako nakakaapekto sa iba.)*”. The **overall mean score** is **4.40** with a verbal interpretation of “**Strongly Agree**”.

After the COMPOSURE behaviors of advanced beginner nurses, the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients, the **highest mean score** is **4.65** with a verbal interpretation of “**Strongly Agree**” for statement “*I leave to God what I cannot take or change. (Ipinauubaya ko sa Diyos ang hindi ko makaya at mabago.)*.” The **lowest mean score** is **4.37** with a verbal interpretation of “**Strongly Agree**” for statement “*I reflect on my personal life and how I affect others. (Nagninilay ako sa aking sariling buhay at kung paano ako nakakaapekto sa iba.)*” and “*We are all connected with people and surroundings. (May pagkakaugnay tayo sa ibang tao at sa ating paligid.)*”. The **overall mean score** is **4.49** with a verbal interpretation of “**Strongly Agree**”.

Spiritual health is when a person finds balance between his or her own life values, goals, and belief systems and those of others. Research shows a link between spirit, mind, and body and one's beliefs and expectations do have effects on the person's physical wellbeing. Spirituality offers a sense of connectedness as well, interpersonally, intrapersonally, and transpersonally. With this, hope is mobilized for the client and the nurse, and illnesses are interpreted and understood that becomes acceptable to the client (**Potter, 2011**).

A recent nursing concept analysis concluded that spirituality was defined as *“that most human of experiences that seeks to transcend self and find meaning and purpose through connection with others, nature, and or a Supreme being, which may or may not involve religious structures or traditions.”* It generally involves a belief in a relationship with some higher power, creative force, divine being, or infinite source of energy. A person may believe in “God”, “Allah, the “Great Spirit”, or a “Higher Power”. It is pivotal to ethical nursing care that diverse views regarding spirituality be acknowledged and respected (**Berman, 2012**)

Spiritual nursing care is an intuitive, interpersonal, altruistic and integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life. It begins from a perspective of being with the

client in love and dialogue but may emerge into therapeutically oriented interventions that take direction from the client's spiritual reality. Four qualities were critical to spiritual care. Receptivity is being open and present; humanity is giving the client a sense of personhood and appreciating their uniqueness; competency is properly caring for the body concurrently; and positivity which is exuding a balanced amount of upbeat energy (**Berman, 2012**).

Spiritual health or wellbeing is manifested by a feeling of being "generally alive, purposeful, and fulfilled." It is a way of living, a lifestyle that views and lives life purposeful and pleasurable, which seeks life-sustaining and life-enriching options to be chosen freely at every opportunity. It can be enhanced through various spiritual disciplines such as prayer, meditation, service, fellowship with similar believers, learning from a spiritual mentor, worship, study, and fasting (**Berman, 2012**).

PROBLEM #5: Is there a significant relationship between demographic profile and physiologic wellness outcome of orthopaedic patients?

Table 33 describes the relationship between the demographic profile and physiologic wellness outcome of selected orthopaedic patients.

Table 33
Summary of Values Showing the Relationship between the Demographic profile and Physiologic wellness Outcome of Orthopaedic Patients

Physiological	Computed r	Computed t	T value	Level of Significance	Decision
Temperature	-0.196	-1.382	1.96	5%	Accept Ho
Pulse Rate	-0.133	-0.932	1.96	5%	Accept Ho
Respiratory Rate	-0.054	-0.375	1.96	5%	Accept Ho
Blood Pressure	0.040	0.275	1.96	5%	Accept Ho
Bone Pain	0.097	0.676	1.96	5%	Accept Ho
Red Blood Cells	-0.399	-3.011	1.96	5%	Reject Ho
White Blood Cells	0.005	0.346	1.96	5%	Accept Ho
Neutrophils	0.169	1.189	1.96	5%	Accept Ho
Eosinophils	0.130	0.907	1.96	5%	Accept Ho
Lymphocytes	0.054	0.372	1.96	5%	Accept Ho
Monocytes	-0.176	-1.237	1.96	5%	Accept Ho
Platelet Count	0.244	1.745	1.96	5%	Accept Ho
Haemoglobin	-0.132	-0.924	1.96	5%	Accept Ho
Hematocrit	0.110	0.769	1.96	5%	Accept Ho
MCV	-0.049	-0.339	1.96	5%	Accept Ho
MCH	-0.158	-1.110	1.96	5%	Accept Ho
MCHC	0.310	2.256	1.96	5%	Reject Ho

Results on Table 33 show *computed r* of red blood cells with the value of **-0.399** as well as its the *computed t* with the value of **-3.011**, with a level of significance at **0.05**. Therefore, the decision was to **reject the null hypothesis**. It implies that **there is a significant relationship between the demographic profile and physiologic wellness outcome of orthopaedic patients**.

Also, in particular to **mean corpuscular haemoglobin concentration or MCHC**, it shows the *computed r* with the value of **0.310**, as well as its *computed t* with the value of **2.256**, with a level of significance at **0.05**. Therefore, the decision was to **reject the null hypothesis**. It implies that **there is a significant relationship**

between the demographic profile and physiologic wellness outcome of orthopaedic patients.

Reflected from the figured data shown on Table 9, the majority of the respondents have above normal level of red blood cells, having 58% of the total sample. It was then followed by normal level of red blood cells with 22% as second, below normal red blood cells with 20% as the lowest.

The primary function of the **red blood cells**, or **erythrocytes**, is to carry oxygen from the lungs to body tissues and to transfer carbon dioxide from the tissues to the lungs. Oxygen transfer is accomplished via the hemoglobin contained in red blood cells. Hemoglobin combines readily with oxygen and carbon dioxide. Hemoglobin gives arterial blood its bright red color; because venous blood has a low oxygen content, it appears dark red. To enable the maximum amount of hemoglobin to be used, red cells are shaped like biconcave disks. This shape provides more surface area for the hemoglobin to combine with oxygen. Red blood cells are also able to change shape to permit passage through small capillaries that connect arteries with veins. **(Kennedy, R. 2011)**

According to Table 19 majority of the respondents with 84% have normal level of MCHC followed by above normal level of MCHC with 14% and below normal level of MCHC with 2% as the lowest.

Blood cells, which can be seen under a microscope, make up about 40% of the blood's volume. Blood cells are divided into three main types: Red

cells (erythrocytes). These make blood a red colour. One drop of blood contains about five million red cells. A constant new supply of red blood cells is needed to replace old cells that break down. Millions of red blood cells are made each day. Red cells contain a chemical called haemoglobin. This binds to oxygen, and takes oxygen from the lungs to all parts of the body. **(Kenny, T. 2012)**

Red blood cell (RBC) indices are part of the complete blood count (CBC) test. They are used to help diagnose the cause of anemia, a condition in which there are too few red blood cells. The indices include: average red blood cell size (MCV), hemoglobin amount per red blood cell (MCH), and the amount of hemoglobin relative to the size of the cell (hemoglobin concentration) per red blood cell (MCHC).

RBCs transport hemoglobin which, in turn, transports oxygen. The amount of oxygen tissues receive depends on the amount and function of RBCs and hemoglobin.

The MCV reflects the size of red blood cells. The MCH and MCHC reflect the hemoglobin content of red blood cells. These RBC measures are used to diagnose types of anemia. **(Gersten, T. 2012)**

PROBLEM #6: Is there a significant relationship between the demographic profile and biobehavioral wellness outcome of orthopaedic patients?

Table 34 describes the significant relationship between the demographic profile and biobehavioral wellness outcome of selected orthopaedic patients before the COMPOSURE behaviors of advanced beginner nurses.

Table 34
Summary of Values Showing the Relationship between the Demographic Profile and Biobehavioral Wellness Outcome of Selected Orthopaedic Patients before the COMPOSURE Behaviors of Advanced Beginner Nurses

Profile	Computed r	Computed t	T value	Decision
Age	0.310	2.258	1.96	Reject Ho
Gender	0.010	0.069	1.96	Accept Ho
Religion	0.244	1.741	1.96	Accept Ho

Results on Table 34 shows *computed r* of age with the value of **0.310** as well as the *computed t* with the value of **2.258**, with a level of significance at **0.05**. Therefore, the decision was to **reject the null hypothesis**. It implies that **there is a significant relationship between the demographic profile and biobehavioral wellness outcome of orthopaedic patients BEFORE the COMPOSURE behaviours of advanced beginner nurses**. However, gender and religion shown otherwise.

According to Table 1 the majority of the respondents belong to the age group of 60 – 64 years old, having the 18% of the sample. It was then followed by the respondents who fall under the ranges of 40 – 44 years old with 14% as second, 55 – 59 years old and 65 and above with 10% as third, 15 – 19 years old

and 35 – 39 years old with 8% as fourth, 10 – 14 years old, 20 – 24 years old, 25 – 29 years old, 30 – 34 years old, and 50 – 54 years old with 6% as fifth, and 45 – 49 years old with 2% as the lowest.

A hip fracture is a very common injury that affects mainly older people. It is one of the most common reasons for being admitted to an orthopaedic (bone) ward in a hospital. Around 75,000 hip fractures are treated each year in the UK. However, given the UK's ageing population, this number is predicted to double by 2050. About 8 in 10 people who fracture a hip are women. The average age of someone who fractures their hip is 80 years.

For most older people, a hip fracture happens after a fall, usually just a fall from standing. If you have osteoporosis you are more likely to fracture your hip when you fall. Osteoporosis is the leading cause of hip fracture. Osteoporosis means that you have lost some bone material. Your bones become less dense and more honeycombed. This makes them more prone to breaking.

A hip fracture can also occur in younger people. In these cases, it is more likely to be caused by trauma such as a car crash or a fall from a significant height. **(Kenny, T. 2011)**

According to Table 2 majority of the respondents are male, having 52% of the total sample. It was then followed by female respondents with 48%.

A hip fracture is another term for a broken hip. It is a common injury that mainly affects older women who often have underlying osteoporosis. Your hip can break in different places. A hip fracture can be intracapsular (within the joint capsule) or extracapsular (outside the joint capsule). Most people who have a hip fracture need an operation to fix the break in the bone. Whether your fracture is intracapsular or extracapsular will determine the exact treatment that the orthopaedic surgeon suggests. It is important that any underlying osteoporosis be treated after a hip fracture. **(Kenny, T. 2011)**

According to Table 3 based from the gathered data for the religion of the respondents, 84% of selected orthopaedic patients are Catholics. And there is 16% non-Catholic.

Although people in modern Western nations typically regard healing as a subject of medical science, it has traditionally played an important role in religion and religious experiences throughout the world. It has been common, for example, for religions to be the sole source of physical, mental, emotional, and psychological healing for adherents.

The connection between religion and healing may be difficult to perceive, but it does exist. Although religion isn't able to deliver the resources of modern medical science, it is able to alter the way people perceive and process their experiences. This, in turn, can alter the course of a disease because of the

significant influence our attitudes can have on our physical well-being. In traditional religious systems, it's normal to attribute physical improvement to the supernatural action.

Religious healings typically occur in a very ritualistic manner — indeed, it is likely that the rituals are a significant aspect of the healing power of religion. Ritual healings are more than just personal, however. Ritual healings also serve to heal social disorders and communal problems. Quite often, ritual healings occur with the full participation of the community because it is the relationship of the individual to the whole which requires the most repair. (Cline, A. 2011)

Table 35 describes the significant relationship between the demographic profile and biobehavioral wellness outcome of selected orthopaedic patients after the COMPOSURE behaviors of advanced beginner nurses.

Table 35
Summary of Values Showing the Relationship between the Demographic Profile and Biobehavioral Wellness Outcome of Selected Orthopaedic Patients after the COMPOSURE Behaviors of Advanced Beginner Nurses

Profile	Computed r	Computed t	T value	Decision
Age	0.149	1.045	1.96	Reject Ho
Gender	0.055	0.381	1.96	Accept Ho
Religion	0.083	0.575	1.96	Accept Ho

Results on Table 35 shows *computed r* of age with the value of 0.149 as well as the *computed t* with the value of 1.045, with a level of significance at 0.05. Therefore, the decision was to **reject the null hypothesis**. It implies that **there is a**

significant relationship between the demographic profile and biobehavioral wellness outcome of orthopaedic patients AFTER the COMPOSURE behaviours of advanced beginner nurses. However, gender and religion shown otherwise.

According to Table 1 the majority of the respondents belong to the age group of 60 – 64 years old, having the 18% of the sample. It was then followed by the respondents who fall under the ranges of 40 – 44 years old with 14% as second, 55 – 59 years old and 65 and above with 10% as third, 15 – 19 years old and 35 – 39 years old with 8% as fourth, 10 – 14 years old, 20 – 24 years old, 25 – 29 years old, 30 – 34 years old, and 50 – 54 years old with 6% as fifth, and 45 – 49 years old with 2% as the lowest.

Hip fracture represents the second leading cause of hospitalization for elderly people. Incidence increases substantially with age, rising from 22.5 and 23.9 per 100,000 population at age 50 to 630.2 and 1289.3 per 100,000 population by age 80, for men and women, respectively. Following a hip fracture, patients have increased health service utilization for at least 1 year, with much of health care costs attributable to subsequent long-term care. Identifying best practices for elderly hip fracture patients while using available health resources effectively and efficiently is relevant to both clinicians and policymakers. **(Beaupre, L. A. et al 2005)**

According to Table 2 majority of the respondents are male, having 52% of the total sample. It was then followed by female respondents with 48%.

Bone is living tissue, and its an easy thing for many people to forget. Until, of course, something goes wrong. Most of the time, our bodies work very well at keeping the right proportion of new bone growth and old bone resorption (breakdown) in balance but not always. Sometimes, due to age, weak bone structure, physical activity, and pH imbalances, we build up areas of what is essentially “dead calcium”, which results in painful bone spurs (also called osteophytes) or kidney stones. Conventional treatment is risky and unnecessary, especially when the right nutrients can help put your body back on track naturally. **(Lemerond, T. 2012)**

According to Table 3 based from the gathered data for the religion of the respondents, 84% of selected orthopaedic patients are Catholics. And there is 16% non-Catholic.

Spiritual health is the one component of health that is totally comprised of the wellness dimension; for this reason, spiritual health is considered to be synonymous with spiritual wellness.

Spiritual wellness is a person's ability to establish a values system and act on the system of beliefs, as well as to establish and carry out meaningful and constructive lifetime goals. It is often based on a belief in a force greater than the individual that helps one contribute to an improved quality of life for all people. A person with spiritual wellness is generally characterized as fulfilled as opposed to unfulfilled. **(National Health Goals 2010)**

PROBLEM #7: Is there a significant difference in the physiologic wellness outcome of orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses?

Table 36 describes the significant difference in the physiologic wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses.

Table 36
Summary of Values Showing the Difference in the Physiologic Wellness
Outcome of Orthopaedic Patients before and after the
COMPOSURE behaviours of Advanced
Beginner Nurses

Physiologic wellness	Computed t	T value	Level of Significance	Decision
Temperature	1.247	1.96	5%	Accept Ho
Pulse Rate	1.186	1.96	5%	Accept Ho
Respiratory Rate	-0.143	1.96	5%	Accept Ho
Blood pressure	0.715	1.96	5%	Accept Ho
Bone pain	-0.311	1.96	5%	Accept Ho
Red blood cells	2.127	1.96	5%	Reject Ho
White blood cells	0.46	1.96	5%	Accept Ho
Neutrophils	0.736	1.96	5%	Accept Ho
Eosinophils	0.656	1.96	5%	Accept Ho
Lymphocytes	0.972	1.96	5%	Accept Ho
Monocytes	0.164	1.96	5%	Accept Ho
Platelet Count	-1.874	1.96	5%	Accept Ho
Haemoglobin	-0.478	1.96	5%	Accept Ho
Hematocrit	1.001	1.96	5%	Accept Ho
MCV	0.795	1.96	5%	Accept Ho
MCH	0.42	1.96	5%	Accept Ho
MCHC	-0.205	1.96	5%	Accept Ho

Results on Table 36 show the *computed t* of **red blood cells** with the value of **2.127**, with a **level of significance** at **0.05**. Therefore, the decision was to **reject the null hypothesis**. It implies that **there is a significant difference in the physiologic wellness outcome of orthopaedic patients BEFORE and AFTER the COMPOSURE behaviours of advanced beginner nurses**. However, most of the physiologic wellness outcome shows otherwise.

According to Table 9 reflected from the figured data shown above, the majority of the respondents have above normal level of red blood cells, having

58% of the total sample. It was then followed by normal level of red blood cells with 22% as second, below normal red blood cells with 20% as the lowest.

A doctor may complete blood count order for a variety of reasons. It may be a part of a routine check-up or screening, or as a follow-up test to monitor certain treatments. It can also be done as a part of an evaluation based on a patient's symptoms.

For example, a high WBC count (leukocytosis) may signify an infection somewhere in the body or, less commonly, it may signify an underlying malignancy. A low WBC count (leukopenia) may point toward a bone marrow problem or related to some medications, such as chemotherapy. A doctor may order the test to follow the WBC count in order to monitor the response to a treatment for an infection. The components in the differential of the WBC count also have specific functions and if altered, they may provide clues for particular conditions.

A low red blood cell count or low hemoglobin may suggest anemia, which can have many causes. Possible causes of high red blood cell count or hemoglobin (erythrocytosis) may include bone marrow disease or low blood oxygen levels (hypoxia).

A low platelet count (thrombocytopenia) may be the cause of prolonged bleeding or other medical conditions. Conversely, a high platelet count

(thrombocytosis) may point toward a bone marrow problem or severe inflammation. (Nabili, S. T. 2008)

PROBLEM #8: Is there a significant difference in the demographic profile to wellness outcome of the selected orthopaedic patients?

Table 37 describes the summary of the significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their age before COMPOSURE behaviours of advanced beginner nurses.

Table 37
Summary of ANOVA Values on the Significant Difference on Wellness Outcome of the Selected Orthopaedic Patients when Grouped According to their Age Before COMPOSURE Behaviours of Advanced Beginner Nurses

ANOVA					
<i>Source of Variation</i>	<i>Sum of Squares</i>	<i>Df</i>	<i>Mean Square</i>	<i>F</i>	<i>F crit</i>
Between Groups	1.700491	5	0.340098	1.353267	2.437693
Within Groups	10.55529	42	0.251316		
Total	12.25578	47			

Results on Table 37 show the ***F value of 1.353267*** which is lesser than the ***F critical value of 2.437693***, with a level of significance at **0.05**. Therefore, the decision was to **accept the null hypothesis**. It implies that **there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their age BEFORE COMPOSURE behaviours of advanced beginner nurses.**

According to Table 1 the majority of the respondents belong to the age group of 60 – 64 years old, having the 18% of the sample. It was then followed by the respondents who fall under the ranges of 40 – 44 years old with 14% as second, 55 – 59 years old and 65 and above with 10% as third, 15 – 19 years old and 35 – 39 years old with 8% as fourth, 10 – 14 years old, 20 – 24 years old, 25 – 29 years old, 30 – 34 years old, and 50 – 54 years old with 6% as fifth, and 45 – 49 years old with 2% as the lowest.

Researchers have unravelled crucial details of how aging causes broken bones to heal slowly, or not at all, according to study results published online today in the Journal of Bone and Mineral Research. The research team also successfully conducted preclinical tests on a potential new class of treatments designed to “rescue” healing capability lost to aging.

In the worst cases, an age-related delay in healing keeps the two sides of a fractured bone from ever rejoining (non-union), leaving many confined to wheelchairs, unable to walk or to live independently. Of the estimated 5.6 million fractures in the United States each year, between five and ten percent (up to 560,000) will heal slowly or incompletely. Researchers have known for 30 years that aging interferes with fracture healing, and have been filling in the details since on the complex web of biochemicals, stem cells and genes that bring about healing. The field is now reaching the point where precision designed drugs are in different stages of animal and human trials. **(Naik, A., et al, 2009)**

Table 38 describes the summary of the significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their profile before COMPOSURE behaviours of advanced beginner nurses.

Table 38
Summary of T-test Values on the Significant Difference on Wellness Outcome of the Selected Orthopaedic Patients when Grouped According to their Profile Before COMPOSURE Behaviours of Advanced Beginner Nurses

Profile	Computed t	T value	Level of Significance	Decision
Gender	-0.067	1.96	5%	Accept Ho
Religion	-2.473	1.96	5%	Reject Ho

Results on Table 38 show *computed t* of **gender** with the value of **-0.067**, with a **level of significance at 0.05**. Therefore, the decision was to **accept the null hypothesis**. It implies that **there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their gender BEFORE COMPOSURE behaviours of advanced beginner nurses**.

Moreover, results on Table 38 also show *computed t* of **religion** with the value of **-2.473**, with a **level of significance at 0.05**. Therefore, the decision was to **reject the null hypothesis**. It implies that **there is a significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their religion BEFORE COMPOSURE behaviours of advanced beginner nurses**.

According to Table 2 majority of the respondents are male, having 52% of the total sample. It was then followed by female respondents with 48%.

Clinically, gender and stability affect bone defect healing simultaneously. It is unclear whether gender and stability interact in some synergistic or independent effects of these factors might suggest a gender-related modification in the stability of clinical fracture devices that could possibly improve bone healing outcome. **(Mehta, M. 2011)**

According to Table 3 based from the gathered data for the religion of the respondents, 84% of selected orthopaedic patients are Catholics. And there is 16% non-Catholic.

Praying for one's spiritual healing is widely accepted. Emotional healing is closely linked with spiritual healing. **(Heron, B., 1997)**

Table 39 describes the summary of ANOVA on the significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their age after COMPOSURE behaviours of advanced beginner nurses.

Table 39
Summary of ANOVA Values on the Significant Difference on Wellness Outcome of the Selected Orthopaedic Patients when Grouped to their Age After COMPOSURE Behaviours of Advanced Beginner Nurses

ANOVA					
<i>Source of Variation</i>	<i>Sum of Squares</i>	<i>Df</i>	<i>Mean Square</i>	<i>F</i>	<i>F crit</i>
Between Groups	3.215851	4	0.803963	2.310615	2.588836
Within Groups	14.96156	43	0.347943		
Total	18.17741	47			

Results on Table 39 show the *F value of 2.310615* which is lesser than the *F critical value of 2.588836*, with a level of significance at **0.05**. Therefore, the decision was **to accept the null hypothesis**. It implies that **there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their age AFTER COMPOSURE behaviours of advanced beginner nurses.**

According to Table 1 the majority of the respondents belong to the age group of 60 – 64 years old, having the 18% of the sample. It was then followed by the respondents who fall under the ranges of 40 – 44 years old with 14% as second, 55 – 59 years old and 65 and above with 10% as third, 15 – 19 years old and 35 – 39 years old with 8% as fourth, 10 – 14 years old, 20 – 24 years old, 25 – 29 years old, 30 – 34 years old, and 50 – 54 years old with 6% as fifth, and 45 – 49 years old with 2% as the lowest.

Bones weaken during normal aging in a process called resorption. Bone resorption is the gradual loss of bone. As individuals age, whether male or female,

there is an average loss of 0.5% bone mass every year after age 50. The result is an increase in bone fractures, such as hip fractures. (Valenty J. 2013)

Table 40 describes the summary of T-test on the significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their profile after COMPOSURE behaviours of advanced beginner nurses.

Table 40
Summary of T-test Values on the Significant Difference on Wellness Outcome of the Selected Orthopaedic Patients when Grouped According to their Profile After COMPOSURE Behaviours of Advanced Beginner Nurses

Profile	Computed t	T value	Level of Significance	Decision
Gender	-0.382	1.96	5%	Accept Ho
Religion	-0.856	1.96	5%	Reject Ho

Results on Table 40 show *computed t* of gender with the value of **-0.382**, with a **level of significance** at **0.05**. Therefore, the decision was **to accept the null hypothesis**. It implies that **there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their gender AFTER COMPOSURE behaviours of advanced beginner nurses**.

Moreover, results on Table 40 also show *computed t* of religion with the value of **-0.856**, with a **level of significance** at **0.05**. Therefore, the decision was **to reject the null hypothesis**. It implies that **there is a significant difference on wellness outcome of the selected orthopaedic patients when grouped**

according to their religion AFTER COMPOSURE behaviours of advanced beginner nurses.

According to Table 2 majority of the respondents are male, having 52% of the total sample. It was then followed by female respondents with 48%.

Fractures from osteoporosis are about twice as common in women as they are in men. Although women are four times more likely than men to develop the disease, men also suffer from osteoporosis. Women start out with lower bone mass and tend to live longer, increasing their risk for developing osteoporosis. They also experience a sudden drop in estrogen at menopause that accelerates bone loss, as estrogen helps with bone formation. Slender, small-framed women are particularly at risk because they have relatively less bone mass to lose. Men who have low levels of the male hormone testosterone also are at increased risk. From age 75 years on, osteoporosis is as common in men as it is in women. **(Valenty J. 2013)**

According to Table 3 based from the gathered data for the religion of the respondents, 84% of selected orthopaedic patients are Catholics. And there is 16% non-Catholic.

Every person is different. For example, people who devote their lives to God and the practice of their religion. These individuals may strive their entire lives to achieve spiritual wellness, to become one with a higher power. This quest

alone may entirely fulfill them, and the other pillars may fall by the wayside or hold less importance. (Valenty J. 2013)

PROBLEM #9: Is there a significant difference among the two groups in the wellness outcome before and after the COMPOSURE behaviours of advanced beginner nurses

Table 41 describes the summary of T-test on significant difference in the biobehavioral wellness outcome of selected orthopaedic patients before and after COMPOSURE behaviours of advanced beginner nurses.

Table 41
Summary of T-test Values on Significant Difference in the Biobehavioral Wellness Outcome of Orthopedic patients Before and After COMPOSURE behaviours of Advanced Beginner Nurses

Areas	Computed t	T value	Level of Significance	Decision
Physical	-0.95192	1.96	5%	Accept Ho
Intellectual	-1.06423	1.96	5%	Accept Ho
Emotional	-0.05803	1.96	5%	Accept Ho
Spiritual	-1.54144	1.96	5%	Accept Ho

Results on Table 41 show *computed t* of **physical** aspect of biobehavioral wellness outcome of selected orthopaedic patients with the value of **-0.95192**, with a **level of significance** at **0.05**. Therefore, the decision was **to accept the null hypothesis**. It implies that **there is no significant difference on biobehavioral wellness outcome of the selected orthopaedic patients when**

grouped according to their physical aspect before and after COMPOSURE behaviours of advanced beginner nurses.

According to Table 29, the highest mean among the biobehavioral wellness outcome in terms of physical before the COMPOSURE behaviours of the advanced beginner nurses was the patient feels bone pain on the affected area when she/he perform physical activities. The lowest mean among them is the patient can walk without difficulty. After the COMPOSURE behaviors of advanced beginner nurses, the physical biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was the patients exercise every day and they feel rested when they wake up in the morning. The lowest mean among them is the patient can walk without difficulty.

Bone fractures may cause severe pain. Individuals should stay in close contact with their healthcare providers to ensure that their medications are properly managing the pain. In some cases, the medication or dosage may need to be changed.

Exercise can increase bone density at any age. Muscle pulling on bone builds bone, so weight-bearing exercise builds denser, stronger bones. Children who are physically active and consume adequate amounts of calcium-containing foods have the greatest bone density. (Valenty J. 2013)

Moreover, results on Table 41 also show *computed t* of **intellectual** aspect of **biobehavioral wellness outcome** of selected orthopaedic patients with the value of **-1.06423**, with a **level of significance at 0.05**. Therefore, the decision was to **accept the null hypothesis**. It implies that **there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their intellectual aspect before and after COMPOSURE behaviours of advanced beginner nurses**.

According to Table 30, the highest mean among the intellectual biobehavioral patient wellness outcome of the selected orthopaedic patients before the COMPOSURE behaviour is they know that fruits and vegetables should always be part of their daily diet. The lowest mean is they are alert and aware of what is happening around them. After the COMPOSURE behaviors of advanced beginner nurses, the intellectual biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was the patients know exercise is good for their bones. The lowest mean among them is they are alert and aware of what is happening around them.

Most people think of dairy when they think of foods good for bones and teeth. While it's true that dairy is an excellent source of bone-building calcium, it is not the only nor best source of this important mineral, according to the Harvard School of Public Health. Certain vegetables provide calcium as well as vitamin K, a nutrient equally important to bone health. Both vegetables and fruits promote

bone health by neutralizing blood, which helps reduce calcium excretion and related bone loss. **(Basilicato, L. 2013)**

Regular exercise helps build muscle, but it also helps maintain and increase bone strength. Exercise causes the muscle to contract against the bone. This action stresses or stimulates the bone and the bone becomes stronger and denser. **(Calvagna, M. 2008)**

Results on Table 41 show *computed t* of **emotional** aspect of **biobehavioral wellness outcome** of selected orthopaedic patients with the value of **-0.05803**, with a **level of significance at 0.05**. Therefore, the decision was to **accept the null hypothesis**. It implies that **there is no significant difference on biobehavioral wellness outcome of the selected orthopaedic patients when grouped according to their emotional aspect before and after COMPOSURE behaviours of advanced beginner nurses.**

According to Table 31, the highest mean among the emotional biobehavioral patient wellness outcome of the selected orthopaedic patients before the COMPOSURE behaviour is they know how to relax at the end of the day. The lowest mean is they get angry easily. After the COMPOSURE behaviors of advanced beginner nurses, the emotional biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was they love and take care of their selves, they do not care about others especially if it do not affect

them and their values guide their daily life. The lowest mean among them is they get angry easily.

Management of anger (and any other unreasonable emotional behaviour for that matter) and the stress that causes it, can only be improved if the person wants to change - acceptance, cognisance, commitment - so awareness is the first requirement. Some angry people take pride in their anger and don't want to change; others fail to appreciate the effect on self and others.

As with stress, the next anger management step is for the angry person to understand the cause of their angry tendency, which will be a combination of stressors and stress susceptibility factors. Angry people need help in gaining this understanding - the counsellor often won't know the reason either until rapport is established. If the problem is a temporary tendency then short-term acute stress may be the direct cause. Use one-to-one counselling to discover the causes and then agree necessary action to deal with them. Where the anger is persistent, frequent and ongoing, long-term chronic stress is more likely to be the cause. Again, counselling is required to get to the root causes. Exposing these issues can be very difficult, so great sensitivity is required. The counsellor may need several sessions in order to build sufficient trust and rapport. (**Chartered Management Institute, 2006**)

Moreover, results on Table 41 also show *computed t* of **spiritual** aspect of **biobehavioral wellness outcome** of selected orthopaedic patients with the value

of *-1.54144*, with a **level of significance at 0.05**. Therefore, the decision was to **accept the null hypothesis**. It implies that **there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their spiritual aspect before and after COMPOSURE behaviours of advanced beginner nurses**.

According to Table 32, the highest mean among the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients before the COMPOSURE behaviour is they leave to God what they cannot take or change. The lowest mean is they reflect on their personal life and how they affect others. After the COMPOSURE behaviors of advanced beginner nurses, the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was they leave to God what they cannot take or change. The lowest mean among them is they reflect on their personal life and how they affect others and they are all connected with people and surroundings.

“Care of the spirit” is an awesome responsibility and special privilege we are called to do. For years, the connection between spiritual well-being and physical health has been studied. Rev. Granger Westberg, Lutheran pastor and founder of the parish nurse legacy in 1984, taught jointly at the University of Chicago in the Divinity and Medical Schools. His conviction was that “You cannot look at just the body without looking at the human spirit.” Thus the evolution of parish nursing and health ministry took place. **(Martin, M. A. 2008)**

“Common to most descriptions of spirituality, as reflected in nursing literature, are the elements of love; compassion; caring; transcendence; relationship with God; and the connection of body, mind, and spirit,” according to Mary Elizabeth O’Brien in *Spirituality in Nursing, Standing on Holy Ground*. Whereas a person can go to their health care practitioner and receive excellent health care, the intentional care of the spirit is seldom, if ever, received there. We are taught to assess, diagnose, plan, implement and evaluate in all areas of nursing and spiritual assessment is included within the specialty of faith community nursing. Our interventions frequently address the spiritual realm—we listen, pray, offer compassion, love, hope, wisdom and bring God to the side of the hurting. What a gift we have been given and are able to give to our faith community members. **(Martin, M. A. 2008)**

CHAPTER 5

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter discusses the summary of findings, conclusions drawn from the findings and the recommendations made by the researcher based from the aforementioned categorized findings.

Summary

The study used quasi-experimental 2-group pretest posttest design. Selected orthopaedic patients from two medical centers in Quezon City were recruited. Data was collected using the questionnaires of Dr. Carmelita C. Divinagracia's Theory of COMPOSURE Behaviours that was modified and were correlated and differentiated accordingly. Statistical tools were used for the results followed by the researcher's insights and findings reinforced by the different authors and studies related to this.

Summary of Findings

1. In terms of the demographic profile of the orthopaedic patients.

a. Age

Generally, the age of the orthopaedic patients were found out mostly belong to the age group of 60 – 64 years old, having the 18% of the sample. It was then followed by the respondents who fall under the ranges of 40 – 44 years old with 14% as second, 55 – 59 years old and 65 and above with 10% as third, 15 – 19 years old and 35 – 39 years old with 8% as fourth, 10 – 14 years old, 20 – 24 years old, 25 – 29 years old, 30 – 34 years old, and 50 – 54 years old with 6% as fifth, and 45 – 49 years old with 2% as the lowest.

b. Gender

Majority of the respondents were male, comprising of 52% of the total sample. It was then followed by female respondents with 48%.

c. Religion

Furthermore, 84% of selected orthopaedic patients are Catholics and is 16% non-Catholic.

2. In terms of their physiologic wellness outcome of selected orthopaedic patients.

a. Vital Signs

- Based on the gathered results, 92% of the respondents have a body temperature of 36.5 – 37.0 degree Celsius. It was then followed by the respondents who have a body temperature of 38.1 – 38.5 degree Celsius with 4% as second and a body temperature of 37.1 – 37.5 and 37.6 – 38.0 degree Celsius with 2% as the lowest.
- Likewise, majority of the respondents have a normal blood pressure, having 96% of the total sample. It was then followed by prehypertension with 4%.
- Also, reflected from the figured data shown on Chapter 4, 100% of the total sample has a normal pulse rate.
- Moreover, most of the respondents have a normal respiratory rate, comprising 60% of the total sample. It was then followed by 40% of the respondents with tachypnea.

b. Bone Pain

- For the majority of the respondents, 36% of patients experience pain on a scale of scale of 1 – 2. It was then followed by the 28% of the respondents who experience pain with the ranges of 3 – 4 as the second, 18% of the respondents experience pain scale of 0 as third, 12% of the respondents experience pain scale of 7 – 8 as fourth, 4% of the respondents experience pain

scale of 5 – 6 as fifth, and 2% of the respondents experience pain scale of 9 – 10 as lowest.

c. Complete blood count

- The majority of the respondents have above normal level of red blood cells, having 58% of the total sample. It was then followed by normal level of red blood cells with 22% as second, below normal red blood cells with 20% as the lowest.
- Likewise, the white blood cells of the respondents with 56% of the sample have a normal level of white blood cells and there is 44% who has above normal white blood cells.
- Also, the greater parts of the respondents have a normal level of eosinophils, having 88% of the sample. It was then followed by the respondents who have above normal level of eosinophils with 12%.
- Similarly, most of the respondents have normal level of monocytes, having 88% of the total sample. It was then followed by below normal level and above normal level of monocytes, both have 6%.
- However, majority of the respondents have a below normal level of lymphocytes with 56% of the total sample. It was then followed by respondents who have normal level of

lymphocytes with 40% as second, above normal level of lymphocytes with 4% as the lowest.

- Furthermore, the majority of the respondents have normal level of platelet counts with 78% of the sample. It was then followed by respondents who have above normal level of platelet count with 16% as second, and below normal level of platelet count with 6% as the lowest.
- As for haemoglobin level, 86% of the respondents have below level of haemoglobin, and 14% have normal level of haemoglobin.
- Nonetheless, majority of the respondents have below normal level of hematocrit, having 62% of the sample. It was then followed by respondents who have normal level of hematocrit with 38%.
- On the other hand, the level of MCV with 64% of the respondents, have a normal level. It was then followed by respondents who have above normal level of MCV with 22% as second, and below normal level of MCV with 14% as the lowest.
- As well as, the majority of the respondents have normal level of MCH with 66% of the total sample. It was then followed by

below normal level of MCH with 26% as second, and above normal level of MCH with 8% as lowest.

- In addition, the mainstream of the respondents with 84% have normal level of MCHC followed by above normal level of MCHC with 14% and below normal level of MCHC with 2% as the lowest.

3. In terms of the COMPOSURE behaviours of advanced beginner nurses.

a. Competence

- They always manifest good interpersonal and communication skills in dealing with patients and able to extract significant information to aid in planning and delivery of effective nursing care. However, they rarely develops health education plan based on the assessed and anticipated needs of the patients.

b. Prayer

- The advanced beginner nurses always allows some moment of silence. But they rarely pray with the patients.

c. Presence

- Indeed, the advanced beginner nurses often establish the purpose of the interaction and often display interest to the

patient. Moreover, they sometimes spend time with patient even in silence

d. Open-mindedness

- The advanced beginner nurses often create an environment of trust and rapport. On the other hand, they sometimes listen attentively to patient.

e. Stimulation

- Likewise, the advanced beginner nurses always tell patient what he can do, what he is suppose to do, and how to do it. More so, they often encourage patient to evaluate his action.

f. Understanding

- The advanced beginner nurses to often encourage the patient to feel comfortable in the nurse-patient relationship. More so, they often clarify the message through the use of question and feedback.

g. Respect

- The advanced beginner nurses always call the patient by his/her preferred name and utilize “po” and “opo” when being asked and they also provide options before making decisions.

h. Relaxation

- They always evaluate and document the patient's response to the intervention, observe his/her breathing, and ask if he/she is feeling relaxed yet they sometimes take note of facial expression and unnecessary body movements.

i. Empathy

- Shows that they always encourage expression of feelings; focus on verbal and nonverbal behaviour and they often provide continuous feedback.

4. In terms of the biobehavioral wellness outcome of selected orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses.

a. Physical

- In particular, the highest mean in terms of physical **before** the COMPOSURE behaviours of the advanced beginner nurses was the patient feels bone pain on the affected area when she/he perform physical activities. However, the lowest mean among them is the patient can walk without difficulty.
- **After** the COMPOSURE behaviours of advanced beginner nurses, the physical biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was the patients exercise every day and they feel rested when they

wake up in the morning. Nevertheless, the lowest mean among them is the patient can walk without difficulty.

b. Intellectual

- The highest mean among the intellectual biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour was the patients know that fruits and vegetables should always be part of their daily diet. Nonetheless, the lowest mean is that they are alert and aware of what is happening around them.
- **After** the COMPOSURE behaviours of advanced beginner nurses, the intellectual biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was the patients know exercise is good for their bones. Although the lowest mean among them is they are alert and aware of what is happening around them.

c. Emotional

- In addition, the highest mean among the emotional biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour is they know how to relax at the end of the day. On the other hand, the lowest mean is they get angry easily.

- **After** the COMPOSURE behaviors of advanced beginner nurses, the emotional biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was they love and take care of their selves, they do not care about others especially if it do not affect them and their values guide their daily life. The lowest mean among them is they get angry easily.

d. Spiritual

- As for the highest mean among the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients **before** the COMPOSURE behaviour is they leave to God what they cannot take or change. However, the lowest mean is they reflect on their personal life and how they affect others.
- **After** the COMPOSURE behaviors of advanced beginner nurses, the spiritual biobehavioral patient wellness outcome of the selected orthopaedic patients, the highest mean was they leave to God what they cannot take or change. Still, the lowest mean among them is they reflect on their personal life and how they affect others and they are all connected with people and surroundings.

5. In terms of the significant relationship between demographic profile and physiologic wellness outcome of orthopaedic patients.

- There is a significant relationship between the demographic profile and physiologic wellness outcome of orthopaedic patients specifically their red blood cells and their mean corpuscular haemoglobin concentration or MCHC.

6. In terms of the significant relationship between demographic profile and biobehavioral wellness outcome of orthopaedic patients.

- In particular, **before** the COMPOSURE behaviours of advanced beginner nurses, age and biobehavioral wellness outcome of selected orthopaedic patients has a significant relationship. However, gender and religion shown otherwise.
- Likewise, **after** COMPOSURE behaviour, age and biobehavioral wellness outcome of selected orthopaedic patients has a significant relationship. However, gender and religion shown otherwise.

7. In terms of the significant difference in the physiologic wellness outcome of orthopaedic patients before and after the COMPOSURE behaviours of advanced beginner nurses.

- Furthermore, there is a significant difference in the physiologic wellness outcome, specifically the red blood cells, of orthopaedic

patients **before** and **after** the COMPOSURE behaviours of advanced beginner nurses. However, most of the physiologic wellness outcome shows otherwise.

8. In terms of the significant difference in the demographic profile to wellness outcome of the selected orthopaedic patients.

- On the other hand, there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their **age before** COMPOSURE behaviours of advanced beginner nurses.
- Furthermore, there is no significant difference on wellness outcome of the selected orthopaedic patients when grouped according to their **gender before** COMPOSURE behaviours of advanced beginner nurses.
- There is a **significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **religion** BEFORE COMPOSURE behaviours of advanced beginner nurses.
- More so, there is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **age after** COMPOSURE behaviours of advanced beginner nurses.

- Again, there is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **gender after** COMPOSURE behaviours of advanced beginner nurses.
- There is a **significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **religion AFTER** COMPOSURE behaviours of advanced beginner nurses.

9. In terms of the significant difference among the two groups in the wellness outcome before and after the COMPOSURE behaviours of advanced beginner nurses.

- Thus, there is **no significant difference** on biobehavioral wellness outcome of the selected orthopaedic patients when grouped according to their **physical aspect before and after** COMPOSURE behaviours of advanced beginner nurses.
- There is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **intellectual aspect before and after** COMPOSURE behaviours of advanced beginner nurses.
- There is **no significant difference** on biobehavioral wellness outcome of the selected orthopaedic patients when grouped according to their **emotional aspect before and after** COMPOSURE behaviours of advanced beginner nurses.

- There is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their spiritual aspect **before** and **after** COMPOSURE behaviours of advanced beginner nurses.

10. Actions plans (See Tables on pp. 340 - 365)

CONCLUSION

1. Generally, the **age** of the orthopaedic patients were found out mostly belong to the age group of **60 – 64 years old**. This result may suggest that the most common cause of their fracture is from fall. More than half of the respondents were **male**. In conclusion, most of the respondents of this study are construction workers and messengers that require them to ride a motorcycle. Most of the respondents are **Catholic** which is known to pray to God, saints, and other intercessors for healing, conception, transportation, and other developmental milestones in one's life in a ritualistic way.
2. The selected orthopaedic patients usually have a **normal body temperature** of 36.5 – 37.0 degree Celsius. Their **blood pressures** are dominantly **normal**. As for their pulse rate, **all** of them have a **normal heart beat**. Respectively, most of them have a **normal breathing pattern** as well. Normal vital signs measure the body's most basic

functions which may imply that our respondents' basic function is in good condition. Generally, the respondents experience **bone pain scale of 1 – 2 over 10** that can be categorized as **mild pain** which can be managed by mild painkillers such as paracetamol, ibuprofen, or celecoxib. As for their complete blood count, the respondents are generally have a **normal levels of white blood cells, eosinophils, monocytes, platelet counts, mean corpuscular volume, mean corpuscular haemoglobin, and mean corpuscular haemoglobin concentration**. However, their **lymphocytes, haemoglobin, and hematocrit have below normal levels** which may suggest of inflammation and anemia. Moreover, their **red blood cells** are generally **above normal level** which may imply chronic hypoxia.

3. In terms of **competence**, the advanced beginner nurses always manifests good interpersonal and communication skills in dealing with patient and able to extract significant information to aid in planning and delivery of effective nursing care. However, they rarely develops health education plan based on the assessed and anticipated needs of the patients. This may imply that the advanced beginner nurses may need to improve their ability to do health planning and health education that can increase the patient wellness outcome. As for **prayer**, the advanced beginner nurses always allows some moment of

silence. However, they rarely pray with the patients. This may imply that the advanced beginner nurses may have difficulty in initiating prayer with the patient since it is not usually included in the nursing activities in the hospital. When it comes to **presence**, the advanced beginner nurses often establish the purpose of the interaction and often display interest to the patient. However, they sometimes spend time with patient even in silence. This may suggest that they have lack of quality time with patients talking to them because of ineffective time management. In terms of the advanced beginner nurses' **open-mindedness**, majority of them often create an environment of trust and rapport. However, they sometimes listen attentively to patient. This may be because of weak follow through on the part of the nurses which can be traced back to nurse-patient ratio. As for **stimulation**, the advanced beginner nurses always tell the patient what he can do, what he is suppose to do, and how to do it. More so, they often encourage patient to evaluate his action. In terms of **understanding**, they often encourage the patient to feel comfortable in the nurse-patient relationship. Moreover, they often clarify the message through the use of question and feedback. When it comes to **respect**, the advanced beginner nurses always call the patient by his/her preferred name and utilize "po" and "opo" when being asked. Moreover, they

also provide options before making decisions. For **relaxation**, majority of the advanced beginner nurses always evaluate and document the patient's response to the intervention, observe his/her breathing, and ask if he/she is feeling relaxed. However, they sometimes take note of facial expression and unnecessary body movements. In the case of their **empathy**, the advanced beginner nurses always encourage expression of feelings and focus on verbal and nonverbal behaviour. Moreover, they often provide continuous feedback.

4. **Before** the COMPOSURE behaviours of the advanced beginner nurses, the highest mean among the biobehavioral wellness outcome in terms of **physical**, the overall mean score is **3.25** with a verbal interpretation of "**Neutral**". However, **after** the COMPOSURE behaviors of advanced beginner nurses, the **physical biobehavioral patient wellness outcome** of the selected orthopaedic patients, the overall mean score is **3.44** with a verbal interpretation of "**Agree**". Based on the gathered data, the overall mean score among the **intellectual biobehavioral patient wellness outcome** of the selected orthopaedic patients **before** the COMPOSURE behaviour is **4.30** with a verbal interpretation of "**Strongly Agree**". Similarly, **after** the COMPOSURE behaviors of advanced beginner nurses, the **intellectual biobehavioral patient wellness outcome** of the selected

orthopaedic patients, the overall mean score is **4.37** with a verbal interpretation of “**Strongly Agree.**” As for the **emotional biobehavioral patient wellness outcome** of the selected orthopaedic patients **before** the COMPOSURE behaviour, the **overall mean score** is **4.12** with a verbal interpretation of “**Agree**”. Similarly, **after** the COMPOSURE behaviors of advanced beginner nurses, the **emotional biobehavioral patient wellness outcome** of the selected orthopaedic patients, the **overall mean score** is **4.13** with a verbal interpretation of “**Agree**”. In addition, the overall mean score among the **spiritual biobehavioral patient wellness outcome** of the selected orthopaedic patients before the COMPOSURE behaviour is **4.40** with a verbal interpretation of “**Strongly Agree**”. Just the same, **after** the COMPOSURE behaviours, the overall mean score is **4.49** with a verbal interpretation of “**Strongly Agree**”.

5. There is a **significant relationship** between the **demographic profile** and **physiologic wellness outcome** of orthopaedic patients when it comes to **red blood cells** and **mean corpuscular haemoglobin concentration** is involved.
6. There is a **significant relationship** between the **demographic profile** and **biobehavioral wellness outcome** of orthopaedic patients **BEFORE** the COMPOSURE behaviours of advanced beginner nurses

when **age** is involved. However, gender and religion shown otherwise. Likewise, there is a **significant relationship** between the **demographic profile** and **biobehavioral wellness outcome** of orthopaedic patients **AFTER** the COMPOSURE behaviours of advanced beginner nurses when the **age** is concerned. However, gender and religion shown otherwise.

7. When it comes to **red blood cells**, there is a **significant difference** in the **physiologic wellness outcome** of orthopaedic patients **BEFORE** and **AFTER** the COMPOSURE behaviours of advanced beginner nurses. However, most of the physiologic wellness outcome shows otherwise.
8. There is **no significant difference** on **wellness outcome** of the selected orthopaedic patients when grouped according to their **age** **BEFORE** COMPOSURE behaviours of advanced beginner nurses. There is **no significant difference** on **wellness outcome** of the selected orthopaedic patients when grouped according to their **gender** **BEFORE** COMPOSURE behaviours of advanced beginner nurses. There is a **significant difference on wellness outcome** of the selected orthopaedic patients when grouped according to their **religion** **BEFORE** COMPOSURE behaviours of advanced beginner nurses. There is **no significant difference** on **wellness outcome** of the selected orthopaedic patients when grouped according to their **age**

AFTER COMPOSURE behaviours of advanced beginner nurses.

There is **no significant difference** on **wellness outcome** of the selected orthopaedic patients when grouped according to their **gender**

AFTER COMPOSURE behaviours of advanced beginner nurses.

There is **a significant difference** on **wellness outcome** of the selected orthopaedic patients when grouped according to their **religion**

AFTER COMPOSURE behaviours of advanced beginner nurses.

9. There is **no significant difference** on **biobehavioral wellness outcome** of the selected orthopaedic patients when grouped according to their **physical aspect before and after** COMPOSURE behaviours of advanced beginner nurses. There is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **intellectual aspect before and after** COMPOSURE behaviours of advanced beginner nurses. There is **no significant difference** on biobehavioral wellness outcome of the selected orthopaedic patients when grouped according to their **emotional aspect before and after** COMPOSURE behaviours of advanced beginner nurses. There is **no significant difference** on wellness outcome of the selected orthopaedic patients when grouped according to their **spiritual aspect before and after** COMPOSURE behaviours of advanced beginner nurses.

Recommendations

The following suggestions are recommended to improve the patient wellness outcome of selected orthopaedic patients through COMPOSURE behaviors of advanced beginner nurses:

11. Most of the respondents are elderlies that are prone for a fracture because of fall, may it be in households or occupation-related hazards, both for men and women. In response to this, the researcher may suggest that households, working areas and establishment may become oriented with fall prevention practices.
12. The results of the blood examinations showed that most of them had below normal level of lymphocytes, haemoglobin, and hematocrit which can be addressed by strengthening nutritional support for patients with fracture in a hospital and/or home setting to prevent nutritional deficiencies to speed up bone recovery. Malnutrition is common in the hospitalized elderly with hip fractures and has been linked to poorer recovery and increased complications.
13. Nurses may learn how to develop health education plan based on the assessed and anticipated needs of the patients. This may contain the following: Precautions before and after surgery, surgery preparation, medications before and after surgery, pain management, positioning before and after surgery, exercises before and after surgery, expectation

during hospital stay, expectation during rehabilitation, everyday activity after surgery, and nutritional build up guides.

14. It is highly recommended to implement prayer schedules (i.e., 3 o' clock habit) as often as possible all throughout the hospital via paging system. It will be very helpful also if there is a consistent schedule for a chaplain services or pastoral care that patients can avail anytime. Moreover, when a patient asks to pray, it is highly recommended for the nurse to recommend talking with patients to determine their prayer preference before starting to pray. Some patients will want to pray silently. Some patients will want the nurse to be present while they say a prayer out loud. Others will want the nurse to lead them in prayer. Some will want to pray now, others may want the nurse to keep them in their prayers.
15. It will be very helpful to provide training for nurses on how to listen attentively to patients such as active listening and focusing which will be very helpful both for patients and nurses.
16. Rehabilitation protocol is highly suggested to be strengthened as part of the routine care for the patients to promote speed recovery. This may include orthopaedic surgeons, registered nurses, physiotherapists, physical therapists, and occupational therapists.

17. Anger management, emotional support and/or referral to psychiatrists may be beneficial for the improvement of patients' mental health status. Apparently, fracture can be a life-changing event that often leads to depression, sadness, hopelessness and fear of the unknown. Support systems from family, friends, and health care professionals can be of great value at this moment.
18. To strengthen pain management protocol. This may include pain as part of their vital signs and may be monitored concurrent with other parameters every 4 hours. This intervention may highly increase the feeling of comfort to the patients.
19. Apparently, fracture is a life-changing event to patients that require them to have spiritual care available when needed.
20. Last but the least, it is highly suggested to conduct a similar study utilizing different research method and bigger sample of respondents from different nursing specialty to generate new knowledge for nursing profession.

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APPENDICES

TRINITY UNIVERSITY OF ASIA
Graduate School

January 10, 2013

DR. CARMELITA C. DIVINAGRACIA
Dean, UERMMMCM

Dear Dr. Divinagracia,

Good day!

I would like to respectfully submit to your good office my letter of intent to utilize your COMPOSURE behaviours theory as my theoretical framework to be used in my dissertation entitled “COMPOSURE Behaviors of Novice Nurses and Its Effect on the Wellness Outcome among Selected Orthopedic Patients in a Tertiary Hospital of Quezon City”.

If permitted, I would like to reassure you that proper acknowledgment will be done in the final paper as well as in the presentation of the research output. I am hoping for your favourable response.

Thank you.

Respectfully yours,

Bea-Gracia M. Cruz, RN, MAN
Doctor of Nursing Management (DNM) Candidate

Endorsed by:

Dr. Lydia A. Cabigao
DNM Adviser

Noted by:

Dr. Benjamin C. Dayrit
Dean, Graduate School

April 29, 2013

Luisito R. Maaño, MD, MHA, CESO V
Medical Center Chief II
Philippine Orthopedic Center
Ma. Clara St., Quezon City

Thru: Imelda Tiongson, RN, MAN, PhD
Philippine Orthopedic Center
Chief Nurse

Dear Dr. Maaño,

Good day!

I am a Doctor of Nursing Management (DNM) student of Trinity University of Asia – Graduate School who is presently on dissertation writing. The title of my research is “COMPOSURE Behaviors of Advanced Beginner Nurses and Its Effect on the Patient’s Wellness Outcome among Selected Orthopedic Patients”.

In this connection, may I request permission to allow me to conduct my study in your hospital, specifically the Female and Male Traction Ward between May and June of this year.

Herewith is the copy of my research proposal endorsed by the panel composed of: Dr. Eufemia Octaviano, Dr. Annabelle Borromeo, Dr. Maria Linda Buhat, Dr. Theophile Salcedo, and Dr. Jovita Pilar.

I am hoping for your favourable response on this request. Rest assured that the information gathered from this study will be treated with utmost respect and confidentiality. The result of the study will be shared to you and your staff.

Thank you very much.

Respectfully,

Bea-Gracia M. Cruz, RN, MAN
Doctor of Nursing Management Student

Endorsed by:

Dr. Lydia A. Cabigao
Dissertation Adviser

Noted by:

Dr. Benjamin Dayrit
Dean, TUA-GS

Dr. Roland L. Cortez
Medical Director
East Avenue Medical Center

Thru: Nora L. Diaz, RN, MAN
Chief nurse
Cynthia Tuazon, RN, MAN
Training Officer

Dear Dr. Cortez,

Good day!

I am a Doctor of Nursing Management (DNM) student of Trinity University of Asia – Graduate School who is presently on dissertation writing. The title of my research is “COMPOSURE Behaviors of Advanced Beginner Nurses and Its Effect on the Patient’s Wellness Outcome among Selected Orthopedic Patients”.

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Thank you very much.

Respectfully,

Bea-Gracia M. Cruz, RN, MAN
Doctor of Nursing Management Student

Endorsed by:

Dr. Lydia A. Cabigao
Dissertation Adviser

Noted by:

Dr. Benjamin Dayrit
Dean, TUA-GS

TRINITY UNIVERSITY OF ASIA
Graduate School

Dear _____,

Ako po ay isang nars na nagtuturo sa Trinity University of Asia at nag-aaral sa Graduate School ng Trinity University of Asia. Ako po ay nagsasagawa ng isang pag-aaral tungkol sa mga epekto ng mga pag-aalagang ginagawa ng mga nars sa pangkalahatang estado ng kalusugan ng mga Pilipinong may bali sa buto. Ang pag-aaral pong ito ay makakatulong upang mapabuti pa ang mga paraan ng aming ginagawang pag-aalaga sa mga katulad ninyong may karamdaman.

Sa inyo pong pagsali dito, kayo po ay makakatanggap ng pag-aalaga at pagtuturo mula sa mga narses na kasama dito sa pag-aaral na ito. Kayo po ay dadalawin namin, aalagaan, at tuturuan ng mga bagay na maaaring makadagdag ng inyong kaalaman sa pag-aalaga sa inyong sarili. Kasabay nito, nais ko pong hingin ang inyong pahintulot at kooperasyon sa pagsagot sa mga katanungan (questionnaire) na ibibigay namin sa inyo. Makakaasa po kayo na bibigyan namin ng pagpapahalaga at pangangalaga ang mga ibibigay ninyong kasagutan.

Kung kayo po ay mayroong mga katanungan na gusto ninyong linawin sa pag-aaral na ito, huwag po kayong mag-aatubili na magtanong o ipagbigay alam sa amin.

Maraming salamat po.

Lubos na gumagalang,

Bea-Gracia M. Cruz, RN, MAN

Informed Consent (Pag-Sang-ayon)

Ako ay si _____ ay sumasang-ayon na sumali sa gagawing pag-aaral sa akin.

Naipaliwanag sa akin ang mga layunin ng pag-aaral na ito. Naipaliwanag din na ako ay makakatanggap ng pag-aalaga at pagtuturo mula sa mga narses ukol sa mga bagay na makakaragdag kaalaman sa pag-aalaga sa aking karamdaman. Ako ay sumasang-ayon din na gawin ang mga bagay na makakatulong upang makamit ko ang pangkalahatang estado ng aking kalusugan. Sasagutin ko rin ang mga katanungan na ibibigay nila sa akin para sa pag-aaral na ito.

Kung sakali, at may gusto akong linawin, ako ay maluwag na makakapagtanong sa mga narses.

Pangalan at lagda ng pasyente: _____

Kasama o tagapag-alaga: _____

Petsa: _____ Lugar: _____ Oras: _____

Bea-Gracia M. Cruz, RN, MAN

Part I. Patient Demographic Profile Tool

Date: _____ Code: _____
 Age: _____
 Gender: Male ___ Female ___
 Religion: Catholic _____
 Non-catholic, pls specify: _____

Part II. Patient Wellness Status Assessment/Evaluation Tool

Date: _____ Code: _____

Direction: The following are statements that determine your present wellness status. Please put a check (√) mark on the boxes that correspond to your answer to the following:

- 5 = strong agree (talagang sang-ayon)
- 4 = agree (sang-ayon)
- 3 = neutral (di-tiyak)
- 2 = disagree (di sang-ayon)
- 1 = strongly disagree (talagang di sang-ayon)

Statements (Talata)					
PHYSICAL	5	4	3	2	1
1. I feel alright. (Magaan ang aking pakiramdam.)					
2. I have enough energy to carry out my work and activities. (May sapat akong lakas para gampanan ang aking mga gawain.)					
3. I can take care of myself. (Kaya kong alagaan ang aking sarili.)					
4. I can walk without difficulty. (Nakakalakad ako ng walang kahirap-hirap.)					
5. Walking exercise is good for me. (Nakakabuti sa akin ang paglalakad.)					
6. I exercise every day. (Nag-eehersisyo ako araw-araw.)					

7. I have no difficulty sleeping. (Hindi ako nahihirapan sa pag tulog.)					
8. I feel rested when I wake up in the morning. (Nakakaramdam ako ng pagkapahinga paggising ko sa umaga.)					
9. I feel bone pain on the affected area when I perform physical activities. (Nakakaramdam ako ng pananakit ng buto kung ako ay gumagawa ng pampisikal na gawain.)					
10. I have difficulty doing my activities of daily living. (Nahihirapan akong gawin ang mga pang-araw-araw kong mga gawain.)					
INTELLECTUAL	5	4	3	2	1
11. I am alert and aware of what is happening around me. (Maagap ako at alam ang nangyayari sa aking paligid.)					
12. I am oriented to time. (Nalalaman ko ang oras ngayon.)					
13. I can recognize the people around me. (Nakikilala ko ang mga tao sa aking paligid.)					
14. I know where I am right now. (Nalalaman ko kung saan ako naroroon ngayon.)					
15. I know exercise is good for my bones. (Alam kong ang ehersisyo ay mabuti sa mga buto.)					
16. I verbalize my feelings to others. (Sinasabi ko ang aking nararamdaman sa iba.)					
17. I know fruits and vegetables should always part of my daily diet. (Alam kong dapat bahagi ng aking pang-araw-araw na pagkain ang mga prutas at gulay.)					
18. Smoking is bad for my health. (Masama sa kalusugan ang paninigarilyo.)					
19. Drinking alcoholic beverages is not good. (Hindi nakakabuti ang pag-inom ng mga inuming may alcohol.)					
20. I think carefully before making decisions. (Nag-iisip ako ng mabuti bago gumawa ng desisyon.)					
21. I ask for doctor's advice regarding health condition. (Humihingi ako ng payo sa doktor ukol sa aking kalusugan.)					
22. I keep an open mind about new things in life.					

(Pinananatili kong bukas ang aking isipan sa mga pagbabagong nangyayari sa buhay.)					
EMOTIONAL	5	4	3	2	1
23. I love and take care of myself. (Mahal ko at inaalagaan ko ang aking sarili.)					
24. I know how to relax at the end of the day. (Alam ko kung paano magpahinga pagkatapos ng maghapon.)					
25. I take time to go on rest and vacation. (Naglalaan ako ng oras sa pahinga at bakasyon.)					
26. Enough or sufficient time for sleeping is good. (Ang sapat na oras ng pagtulog ay nakagagaling.)					
27. I get angry easily. (Madali akong magalit.)					
28. I feel a sense of connectedness to other people. (Nakakaramdam ako ng pagiging malapit sa ibang tao.)					
29. I don't think ill of others. (Hindi ako nag-iisip ng masama sa iba.)					
30. I do not care about others especially if they do not affect me. (Hindi ako nakikialam sa iba lalo na kung hindi sila nakakaapekto sa akin.)					
31. My values guide my daily life. (Ang pagpapahalaga ko sa aking sarili ang siyang gabay ko sa pang-araw-araw na buhay.)					
SPIRITUAL	5	4	3	2	1
32. I am satisfied with my spiritual life. (Nasisiyahan ako sa aking buhay ispiritwal.)					
33. I feel a sense of connectedness with God. (Nakakaramdam ako ng pagiging malapit sa Diyos.)					
34. I spend a portion of everyday in prayer and personal reflection. (Naglalaan ako ng oras sa aking pang-araw-araw na pagdarasal at pagninilay-nilay.)					
35. I leave to God what I cannot take or change. (Ipinaubaya ko sa Diyos ang hindi ko makaya at mabago.)					
36. I do not lose hope despite trials in life. (Hindi ako nawawalan ng pag-asa sa kabila ng mga pagsubok sa buhay.)					
37. I reflect on my personal life and how I affect others. (Nagninilay ako sa aking sariling buhay at kung paano ako nakakaapekto sa iba.)					
38. I feel a sense of inner peace. (Nakakadarama ako ng					

kapanatagan ng kalooban.)					
39. My life has a positive purpose. (May positibong hangarin ang aking buhay.)					
40. We are all connected with people and surroundings. (May pagkakaugnay tayo sa ibang tao at sa ating paligid.)					

Part III. Physiologic Assessment Tool

1. Vital Signs

Time	Date	Temperature	Pulse rate	Respiratory rate	Blood pressure
Pretest					
Post test					

2. Bone pain sensation

Time	Date	No pain 0	Mild 1-3	Moderate 4-6	Severe 7-10
Pretest					
Post test					

3. Complete blood count

Time	Date	Complete blood count
Pretest		
Post test		

Part IV. Checklist of COMPOSURE Behaviors

Date: _____ Code: _____

Direction: The following are statements determine the COMPOSURE behaviours of advanced beginner nurses. Please put a check (√) mark on the boxes that correspond to your answer to the following:

5 = Always

4 = Often

3 = Sometimes

2 = Rarely

1 = Never

COMPOSURE Behaviors					
COMPETENCE	5	4	3	2	1
1. Examines patient by obtaining a thorough history, systems review, and administering selected test and applying appropriate nursing measures					
2. Assesses the patient as to level of understanding and level of consciousness					
3. Provides skin care such as sponging of the affected extremity					
4. Changes the patient's bed linen					
5. Provides bedpan as needed and serves bedpan on the unaffected side, provides pillow at the back and provides privacy.					
6. Provides perineal care					
7. Provides ROM exercises with the use of trapeze					
8. Assists the patient doing deep breathing exercises, static quadriceps exercises, and toes pedal exercises					
9. Prepares equipment for balance skeletal traction application, hardware, and gadgets					
10. Performs application of balance skeletal traction efficiently and competently					
11. Manifests good interpersonal and communication skills					

in dealing with patients and able to extract significant information to aid in planning and delivery of effective nursing care					
12. Develops health education plan based on the assessed and anticipated needs of the patients					
13. Knowledgeable in different usage of various hardware and gadgets and establishes mechanism to ensure proper functioning of equipment					
14. Maintains accurate and updated documentation of client care and observes legal imperatives in record keeping					
15. Establishes collaborative relationship with colleagues and other members of the health care team to improve patient care					
16. Identifies nursing problems of the patient and gathers data in order to render quality nursing intervention					
17. Generates good clinical care to maximize patient outcome					
18. Explains the scientific principles behind patients' condition, nursing management, and principles of traction, hardware, and gadgets application					
19. Knowledgeable on the curative and harmful effects of drugs and other therapeutics and exhibits satisfactory aptitude in stating nursing responsibilities					
20. Evaluates nursing intervention based on the extent to which goals are achieved and formulate alternative nursing intervention needed					
21. Reports to duty on time in appropriate uniform and paraphernalia					
22. Shows enthusiasm, diligence, initiative and tactfulness in dealing with others and able to respond to patients' needs promptly and appropriately					
23. Shows adherence to institution's guidelines and policies					
PRAYER	5	4	3	2	1
24. Encourages the patient to pray.					
25. Touches the patient and demonstrate sensitivity and sincerity.					
26. Allows some moment of silence.					
27. Prays with the patient.					
PRESENCE	5	4	3	2	1

28. Establishes the purpose of the interaction.					
29. Displays interest to the patient.					
30. Encourages expression of feelings.					
31. Focuses completely on the interaction by suppressing prejudice, bias, assumptions, preoccupying personal concerns, and other distractions.					
32. Displays an awareness of and sensitivity to emotions.					
33. Spends time with patient even in silence.					
34. Demonstrates awareness of physical stance conveying nonverbal messages.					
35. Listens for the unexpressed message and feelings as well as content of the conversation.					
36. Demonstrates sensitivity and awareness of which words are avoided, as well as nonverbal messages that accompany the expressed words.					
37. Observes appropriate tone, tempo, volume, pitch, and inflection of the voice.					
38. Determines the meaning of the message by reflecting on attitudes, past experiences, and the current situation.					
39. Avoids barriers to active listening (e.g., minimizing feelings, offering easy solutions, interrupting, talking about self, and premature closure).					
OPEN-MINDEDNESS	5	4	3	2	1
40. Creates an environment of trust and rapport.					
41. Encourages openness to patient's feelings.					
42. Listens attentively to patient.					
43. Allows the patient to have some degree of control over himself/herself.					
44. Respect the rights and opinion of patient and others.					
STIMULATION	5	4	3	2	1
45. Shows genuine interest through gentle touch and smile					
46. Provides guidance and encouragement in doing activities of daily living.					
47. Tells patient what he can do, what he is suppose to do, and how to do it.					
48. Provides praise and complimentary words.					
49. Encourages goal setting by asking patient to decide on the type of change needed.					
50. Encourages decisions by asking the patient to make a choice among options.					

51. Encourages patient to evaluate his action.					
UNDERSTANDING	5	4	3	2	1
52. Encourages the patient to feel comfortable in the relationship.					
53. Takes time to a response so that it reflects understanding of the received message.					
54. Clarifies the message through the use of question and feedback.					
RESPECT	5	4	3	2	1
55. Calls the patient by his/her preferred name.					
56. Provide privacy whenever certain part of the body has to be examined.					
57. Provides respect for whatever decisions made regarding patient's own preferences.					
58. Provides options before making decisions.					
59. Utilizes "po" and "opo" when being asked.					
RELAXATION (PROGRESSIVE)	5	4	3	2	1
60. Asks the patient to empty his/her bladder before the start of the intervention.					
61. Assists the patient in finding a comfortable position.					
62. Describes progressive relaxation, its rationale, and benefits.					
63. Considers the patient's willingness to participate, preferences, past experiences, contraindications, and fears before starting with the procedure.					
64. Asks the patient to close his/her eyes.					
65. Instructs the patient to do deep breathing and relax					
66. Sets goals with the patient. For example, reduction of pain, tension, and anxiety.					
67. Have patient quantify level of parameters to be changed. For example, "my pain level sensation is at this moment."					
68. Takes note of facial expression and unnecessary body movements.					
69. Guides through progressive relaxation technique.					
70. Provides undisturbed time because patient may fall asleep.					
71. Regularly evaluates reports of the individual's feedback about relaxation achieved.					
72. Periodically monitors vital signs and muscle tension.					

73. Plans to provide regular reinforcement for the use of relaxation.					
74. Praises patient's effort and acknowledge possible outcomes.					
75. Evaluates and document the patient's response to the intervention.					
76. Observes his breathing. Ask if he is feeling relaxed.					
77. Asks the patient to describe the technique and assess whether your patient is able to understand the technique well.					
78. Asks whether the technique was helpful for reducing the tension and pain sensation.					
79. If the technique increases your patient's comfort level, explores whether the benefits was significant to him.					
EMPATHY	5	4	3	2	1
80. Encourages expression of feelings; focus on verbal and nonverbal behaviour.					
81. Lean forward with head and body turned toward the patient.					
82. Displays an awareness of and sensitivity to emotions.					
83. Provides verbal responses to the patient's previous comments.					
84. Provides verbal responses that focus on patient's strengths and limitations.					
85. Maintain a good tone of voice consistent with facial and verbal response. The tone should be similar with that of the patient.					
86. Formulates responses of empathy in a language and manner that are most easily understood by the patient.					
87. Provides continuous feedback.					
88. Explores feelings toward termination of relationship.					
89. Encourages sharing of feelings and emotions.					

“COMPOSURE Behaviors” Nursing Measure Protocol

Competence

Description:

This refers to in-depth knowledge and clinical expertise demonstrated by the novice nurse. This also stands for consistency and congruency of words and deeds of the nurse.

Nurse Patient Interaction	Activities
<p>A. Briefing</p> <p>Begin by introducing self to patient and establishing rapport.</p> <p>“Good morning. I am _____ and I will be in charge with you for the next eight hours.”</p> <p>“How do you want to be called?”</p>	<p>Introduces self to patient.</p> <p>Establishes rapport.</p> <p>Conveys interest and maintain eye contact.</p>
<p>B. Actual Nursing Measure</p> <p>“I would like to examine you from your head down to your toes. Then I will check on your pulse rate and blood pressure.”</p> <p>“What is it really that bothers you?”</p> <p>“Is there anything you would like to ask or be cleared about your condition?”</p>	<p>Assesses patient’s needs and concerns.</p> <p>Put patient in a comfortable position.</p> <p>Allows time for patient to verbalize his problems and concerns.</p> <p>Pays attention to manner of doing activities of daily living, position, and tolerance to activities done.</p> <p>Provides nursing care and comfort measures to meet the needs of patient.</p> <p>Assist patient in carrying out activities of daily living.</p> <p>Show knowledge of the rules and regulation of the hospital</p>

	Explain the procedure, drugs, and treatment within the level of patient's understanding
C. Debriefing Get feedback	Asks about thoughts, feelings, and concerns.

“COMPOSURE Behaviors” Nursing Measure Protocol

Presence

Description:

This is a form of nursing measure which means being with another person during times of need. This includes use of therapeutic communication, active listening and touch.

Nurse-Patient Interaction	Activities
<p>A. Briefing</p> <p>Explain the purpose of the intervention.</p>	<p>Establishes the purpose of the interaction.</p>
<p>B. Actual Nursing Measure</p> <p>Use of therapeutic communication, active listening and touch.</p>	<p>Displays interest to the patient.</p> <p>Encourages expression of feelings.</p> <p>Focuses completely on the interaction by suppressing prejudice, bias, assumptions, preoccupying personal concerns, and other distractions.</p> <p>Displays an awareness of and sensitivity to emotions.</p> <p>Spends time with patient even in silence.</p> <p>Demonstrates awareness of physical stance conveying nonverbal messages.</p> <p>Listens for the unexpressed message and feelings as well as content of the conversation.</p>

	<p>Demonstrates sensitivity and awareness of which words are avoided, as well as nonverbal messages that accompany the expressed words.</p> <p>Observes appropriate tone, tempo, volume, pitch, and inflection of the voice.</p> <p>Identifies the predominant themes.</p> <p>Determines the meaning of the message by reflecting on attitudes, past experiences, and the current situation.</p> <p>Avoids barriers to active listening (e.g., minimizing feelings, offering easy solutions, interrupting, talking about self, and premature closure).</p>
<p>C. Debriefing</p> <p>Get feedback.</p>	

“COMPOSURE Behaviors” Nursing Measure Protocol

Open-mindedness

Description:

This is a form of nursing measure which means being receptive to new ideas or to reason. It conveys openness and consideration to patient’s preferences and opinions.

Nurse-Patient Interaction	Activities
<p>A. Briefing</p> <p>Begin by introducing yourself to the patient and establishing rapport.</p> <p>“Good morning. I am _____ and I will be your nurse for the next 8 hours.”</p>	<p>Introduces self to patient.</p> <p>Creates an environment of trust and rapport.</p> <p>Faces the patient and maintains eye contact.</p> <p>Conveys interest and concern in facial expression.</p>
<p>B. Actual nursing measure</p> <p>“Tell me about your feelings.”</p> <p>“What is it really that bothers you?”</p> <p>“I am listening. I hear what you are saying.”</p> <p>“Which do you think is good for you?”</p>	<p>Encourages openness to patient’s feelings.</p> <p>Listens attentively to patient.</p> <p>Allows the patient to have some degree of control over himself/herself.</p> <p>Respect the rights and opinion of patient and others.</p>
<p>C. Debriefing</p> <p>Get feedback.</p>	<p>asks about feelings, thoughts, and comments.</p>

“COMPOSURE Behaviors” Nursing Measure Protocol

Stimulation

Description:

This is a form of nursing measure that includes encouragement, guidance, use of complimentary words and a smile.

Nurse-Patient Interaction	Activities
<p>A. Briefing</p> <p>Begin by introducing yourself to the patient and establishing rapport.</p>	<p>Introduces self to patient.</p> <p>Creates an environment of trust and rapport.</p> <p>Faces the patient and maintain eye contact.</p> <p>Conveys interest and concern in facial expression.</p>
<p>B. Actual Nursing Measure</p> <p>“I know a lot of people who recovered from fracture after following the strict therapeutic regimen.”</p> <p>“I know it isn’t easy to do this but I believe you can do it.”</p> <p>“What do you think needs to change?”</p> <p>“What do you think is the best alternative for you?”</p> <p>“What would work best?”</p> <p>“What else do you need to do?”</p>	<p>Provides encouragement to patient who is losing hope.</p> <p>Show genuine interest through gentle touch and smile</p> <p>Encourages goal setting by asking patient to decide on the type of change needed.</p> <p>Encourages decisions by asking the patient to make a choice among options.</p> <p>Encourage patient to evaluate his action.</p>

<p>“How well did it work when you tried?”</p> <p>“We will limit your activity from moving slowly out of bed and then walk around the bedside.”</p> <p>“This is how we will do it.”</p> <p>“Sit up and erect in bed, do it slowly and then rest.”</p> <p>“Move your feet to your side, slowly again and then rest for a while.”</p> <p>“Now stand up at the bedside.”</p> <p>“Start to move around, slowly, and then, rest for a while.”</p> <p>“Okay, that is good.”</p> <p>“You are doing well.”</p> <p>“You are learning a lot.”</p>	<p>Provides guidance and encouragement in doing activities of daily living.</p> <p>Tells patient what he can do, what he is suppose to do, and how to do it.</p> <p>Provides praise and complimentary words.</p>
<p>C. Debriefing</p> <p>Get feedback.</p>	<p>Asks about feelings, thoughts, and comments.</p>

COMPOSURE Behaviors Nursing Measure Protocol

Understanding

Description:

This is a form of nursing measure which conveys interest and acceptance not only of patient's condition but also his entire being and his wholeness as a person.

Nurse-Patient Interaction	Activities
<p>A. Briefing</p> <p>Begin by introducing yourself to the patient and establishing rapport.</p>	<p>Introduces self to patient.</p> <p>Creates an environment of trust and rapport.</p> <p>Faces the patient and maintain eye contact.</p> <p>Conveys interest and concern in facial expression.</p>
<p>B. Actual Nursing Measure</p> <p>Use of therapeutic self, active listening, consistent eye contact.</p> <p>“I want to help you figure out what has been happening to you lately.”</p> <p>“I want to get to know you what has been bothering you.”</p> <p>“What are you feeling right now? You may say it.”</p>	<p>Encourages the patient to feel comfortable in the relationship. Be honest about intention and be consistent with words.</p> <p>Listens and allow patient to express himself.</p> <p>Takes time to a response so that it reflects understanding of the received message.</p> <p>Clarifies the message through the use of question and feedback.</p>
<p>C. Debriefing</p> <p>Get feedback.</p>	<p>Ask about feelings, thoughts, and comments.</p>

COMPOSURE Behaviors Nursing Measure Protocol

Respect

Description:

This means acknowledging the patient’s presence, use of preferred name and use of your own name, recognizing individually and respecting individual need.

Nurse-Patient Interaction	Activities
<p>A. Briefing</p> <p>Begin by introducing yourself to patient and establishing rapport.</p> <p>“Good morning. I am _____ and I will be your nurse today.”</p> <p>You may just call me _____.”</p> <p>And how do you want me to call you, Mrs/Mr _____.”</p>	<p>Introduces self to patient.</p> <p>Establishes rapport.</p> <p>Displays interest and maintains eye contact as you talk to the patient.</p> <p>Calls the patient by his/her preferred name.</p>
<p>B. Actual Nursing Measure</p> <p>“What would you like to do first? “Would you like to eat your breakfast or take a bath first?”</p> <p>“Which of these two would you like to wear?”</p> <p>“This looks good for you but if that is what you want, it’s alright with me.”</p>	<p>Provide privacy whenever certain part of the body has to be examined.</p> <p>Provides respect for whatever decisions made regarding patient’s own preferences.</p> <p>Provides options before making decisions.</p> <p>Utilizes “po” and “opo” when being asked.</p>
<p>C. Debriefing</p> <p>Get feedback.</p>	<p>Ask about feelings, thoughts, and comments.</p>

COMPOSURE Behaviors Nursing Measure Protocol

Empathy

Description:

Empathy is a process where in an individual can sense accurately other person’s inner experience. The empathic nurse accurately perceives the patient’s thoughts and feelings and understands the communication by putting himself in the patient’s place. This involves the establishment of a therapeutic nurse-patient relationship.

Nurse-Patient Relationship	Activities
<p>A. Briefing</p> <p>Explain the purpose of the intervention.</p> <p>Begin by introducing yourself to the patient and establishing rapport.</p>	<p>Introduces yourself to patient.</p> <p>Creates an environment of trust and rapport.</p> <p>Displays interest to patient.</p> <p>Encourages expression of feelings; focus on verbal and nonverbal behaviour.</p>
<p>B. Actual nursing measure</p> <p>The use of therapeutic self, active listening, touch, and consistent eye contact.</p>	<p>Lean forward with head and body turned toward the patient.</p> <p>Displays an awareness of and sensitivity to emotions.</p> <p>Provides verbal responses to the patient’s previous comments.</p> <p>Provides verbal responses that focus on patient’s strengths and limitations.</p> <p>Maintains good eye contact and respond to patient’s nonverbal cues</p>

	<p>such as facial expression, tone of voice, and restlessness.</p> <p>Conveys interest, concern and warmth by your own facial expression.</p> <p>Maintain a good tone of voice consistent with facial and verbal response. The tone should be similar with that of the patient.</p> <p>Formulates responses of empathy in a language and manner that are most easily understood by the patient.</p> <p>Provides continuous feedback.</p> <p>Explores feelings toward termination of relationship.</p> <p>Encourages sharing of feelings and emotions.</p>
<p>C. Debriefing</p> <p>Get feedback.</p>	<p>Ask about feelings, thoughts, and comments.</p>

COMPOSURE Behaviors Nursing Measure Protocol

Progressive Relaxation

Description:

Progressive relaxation is a method of deep muscle relaxation that is based on the premise that the body responds to anxiety-provoking thoughts and events with muscle tension. Here, each muscle group is tensed for 5 -7 seconds and then relaxed for 20 – 30 seconds. The use of this technique relieves muscle tension, anxiety, fatigue, muscle spasm, neck and back pains and high blood pressure.

Nurse-Patient Interaction	Activities
<p>A. Briefing – Preliminary instructions to the subject</p> <p>“I will be assisting you in doing progressive relaxation. This involves deep muscle relaxation. The technique is very simple. Here, each muscle group is tensed for 5-7 seconds and then relaxed for 20-30 seconds. This intervention will help you achieve a relaxation response that your body needs to relieve yourself of muscle tension, anxiety, fatigue, muscle spasm, neck, and back pains. I know that you can do it alone later and anytime you feel any tension or anxieties okay?”</p>	<p>Before the session:</p> <p>Arranges medical and nursing care to allow for 20 minutes of uninterrupted time.</p> <p>Places a note in the door indicating a need for privacy until a designated time.</p> <p>Asks the patient to empty his/her bladder before the start of the intervention.</p> <p>Assists the patient in finding a comfortable position.</p> <p>Describes progressive relaxation, its rationale, and benefits.</p> <p>Considers the individual’s willingness to participate, preferences, past experiences, contraindications, and fears before starting with the procedure.</p> <p>Creates a quiet, non-disrupting</p>

<p>“There are four things that should be noted to elicit a relaxation response.”</p> <ol style="list-style-type: none"> 1. A comfortable position 2. A quiet environment 3. A passive attitude 4. An object to focus on <p>“Sit down comfortably in a chair with hands in lap and feet flat on the floor. You may choose to have slow background music to facilitate relaxation or think of scenery that is relaxing.”</p> <p>“Now, close your eyes slowly but not tightly.”</p> <p>“Begin by taking three deep, slow breaths, inhaling through the nose and releasing the air slowly through the mouth.”</p> <p>“Now starting with your feet, pull the toes forward toward the knees, stiffen your calves and hold for a count of 5. Then release the hold. Let go of the tension. Feel the sensation of relaxation and warmth as the tension flows out the muscle. Observe yourself as your muscle relaxes. You will do this to all your muscle groups like the thighs and</p>	<p>environment with dim lights and comfortable temperature, when possible.</p> <p>Suggests that he/she imagine himself/herself in a very calming and relaxing place.</p> <p>Instructs the individual to assume a comfortable position, with unrestricted clothing.</p> <p>Asks him to close his eyes.</p> <p>Elicits behaviour that are considered to produce relaxation such as deep breathing.</p> <p>Instructs patient to relax and let the sensation happen. Do this slowly with a soothing voice.</p> <p>Demonstrates and practices the relaxation technique with the patient.</p> <p>Encourages return demonstration, if possible.</p> <p>Provides honest feedback.</p>
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<p>buttocks, abdominal muscles, muscle in the back and neck, muscle of the hands, biceps, forearms, shoulders, and then of the face.</p> <p>“Try to recognize a light, warm feeling flowing into your muscles. Feel the relaxation as tenseness leave your entire being. Feel completely relaxed.”</p> <p>“Now, let us start.”</p>	<p>Provides reassurance and tell that you will guide him/her in doing progressive relaxation techniques to experience inward relaxation and be aware of body and mind connection.</p> <p>Makes sure that patient understands that you are merely a guide and that any result obtained will depend on the patient’s involvement, interest and practice.</p> <p>Sets goals with the patient. For example, reduction of pain, tension, and anxiety.</p> <p>Have patient quantify level of parameters to be changed. For example, “my pain level sensation is _____ at this moment.”</p>
<p>B. Actual Progressive relaxation technique</p> <p>“Do you feel comfortable now?”</p> <p>“Put your hands on your lap and feet flat on the floor.”</p> <p>“Listen to the music or think of a scenery that provides relaxation.”</p> <p>“Now slowly close your eyes and focus.”</p> <p>“Take a deep breath. Slowly breathe as I</p>	<p>Records vital signs.</p> <p>You may also take note of facial expression and unnecessary body movements.</p> <p>Guides through progressive relaxation technique.</p> <p>Provides undisturbed time because patient may fall asleep.</p>

<p>count 1,2,3,4,5.”</p> <p>Breathe through your nose then release through your mouth. You may repeat this 3x.”</p> <p>“Okay, you are doing well.”</p> <p>“Let’s move to your feet. Pull the toes forward toward the knees, stiffen your calves as I count 1,2,3,4,5. Now, release the hold and let go of the tension. Slowly, feel the sensation of relaxation and warmth as the tension flows out of the muscle.”</p> <p>Next, tense the muscle of your thighs and buttocks and hold as I count 1,2,3,4,5. Now, release the hold and feel the tension drain away.</p> <p>“Concentrate on this feeling for a few seconds.”</p> <p>“Next, tense your abdominal muscles. Hold for a count of 5. Release the hold and concentrate on the feeling of relaxation for 20-30 seconds. You are now feeling good. Continue doing this.”</p> <p>“Now, tense your muscles in the back. Feel the tension and hold as I count 1,2,3,4,5. Release the hold and feel the tension as it moves out from your body.</p>	<p>Regularly evaluates reports of the individual’s feedback about relaxation achieved.</p> <p>Periodically monitors vital signs and muscle tension.</p> <p>Plans to provide regular reinforcement for the use of relaxation.</p> <p>Praises patient’s effort and acknowledge possible outcomes.</p> <p>Evaluates and document the patient’s response to the intervention.</p> <p>Always speaks in a relaxed manner and provide honest feedback.</p> <p>Paces instructions.</p> <p>Makes a careful observation. Notice whether there is a grimace or frown on his face.</p> <p>Observes his breathing. Ask if he is feeling relaxed.</p> <p>Encourages return demonstration.</p> <p>Asks the patient to describe the technique and assess whether your patient is able to understand the technique well.</p>
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<p>Feel relaxed.</p> <p>“Now, tense the muscles of your hands, biceps, and forearms, clench your hands into a tight fist and hold as I count 1,2,3,4,5. Release the hold slowly and feel relaxed.</p> <p>“Next, let us move to your shoulders. Tense the muscle of your shoulders and neck as I count 1,2,3,4,5. Release the hold and feel the tension as it leaves the muscle and experience the feeling of relaxation.”</p> <p>“Now, tense the muscles of your face. Wrinkle your forehead. Frown, squint your eyes and purse the lips. Hold as I count 1,2,3,4,5. Now, release the hold.</p> <p>“Recognize a light, warm feeling flowing into the muscles and feel the relaxation in your whole body.”</p> <p>“You did well. Feel completely relaxed. Open your eyes and enjoy renewed energy.”</p>	<p>Asks whether the technique was helpful for reducing the tension and pain sensation.</p> <p>If the technique increases your patient’s comfort level, explores whether the benefits was significant to him.</p>
<p>C. Debriefing – Processing of Experience</p> <p>“How do you feel now?”</p> <p>“Do you think you can do it on your won?”</p> <p>At the start, you may not feel the relaxation response but as you become accustomed to this technique and as you let your mind and body connect, you</p>	

will feel much more relaxed. You can share this with your family. This is a healthy way of getting the tension out of your body.”

Inform patient about the next activity.

Say goodbye to your patient.

COMPOSURE Behaviors Nursing Measure Protocol

Prayer

Description:

This is a nursing measure that involves prayer to be recited by the nurse together with the patient.

Nurse-Patient Interaction	Activitiess
<p>A. Briefing</p> <p>Begin by introducing self to the patient and establishing rapport.</p> <p>“Good morning. I am _____ and I will be in charge with you for the next 8 hours.”</p> <p>“How are you feeling today?”</p>	<p>Introduces self to patient.</p> <p>Establishes rapport.</p>
<p>B. Actual Nursing Measure</p> <p>“Would you like to pray?”</p> <p>“I can spend some time with you in prayer. Maybe we can pray together.”</p> <p>“There is a prayer that I know which I can share with you.”</p> <p>Teach the patient to pray using “Touch Me Lord.”</p>	<p>Conveys interest and maintain eye contact.</p> <p>Encourages the patient to pray.</p> <p>Touches the patient and demonstrate sensitivity and sincerity.</p> <p>Allows some moment of silence.</p>

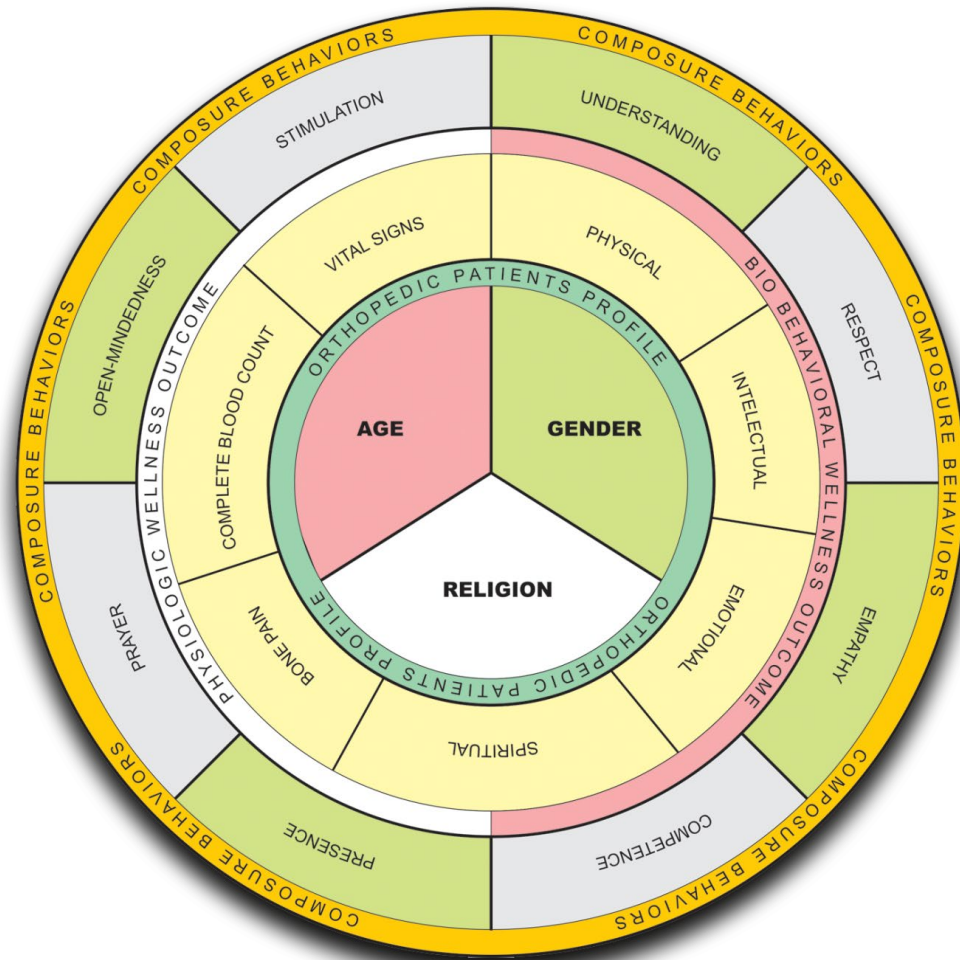
	Prays with the patient.
C. Debriefing Get feedback.	Asks about thoughts, feelings, and concerns.

Teaching Program for COMPOSURE Behaviors for Nurses

Objectives	Content	Activities	Resources	Evaluation
<p>Describe COMPOSURE behaviour as a model for patient care.</p> <p>Discuss the significance of COMPOSURE behaviour as component of care in nurses</p> <p>Demonstrate the steps in the development of COMPOSURE behaviours:</p> <p>COMpetence</p> <p>Presence & prayer</p> <p>Openmindedness</p> <p>Stimulation</p> <p>Understanding</p>	<p>I. Introduction</p> <p>COMPOSURE behaviour as a model for patient care.</p> <p>II. Significance of COMPOSURE behaviour</p> <p>Quality of nursing care</p> <p>Quality of patient wellness outcome</p> <p>III. Steps involved in the development of COMPOSURE behaviours</p>	<p>Lecture-discussion</p> <p>Demonstration</p> <p>Role playing</p>	<p>Reading materials</p> <p>Books, journals, and research studies</p>	<p>Question and answer</p> <p>Performance appraisal for the COMPOSURE behaviours</p>

<p>Respect & relaxation</p> <p>Empathy</p> <p>Integrate the COMPOSURE behaviours as part of their nursing measure in clinical practice</p>	<ol style="list-style-type: none"> 1. Competence in orthopaedic nursing: assessment, planning, implementation, & evaluation 2. Presence & prayer 3. Open-mindedness 4. Sensitivity 5. Understanding 6. Respect and relaxation 7. Empathy 			<p>Return demonstration</p>
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An Enhanced Model of COMPOSURE Behaviours of Advanced Beginner Nurses and its Effect on the Wellness Outcome Among Selected Orthopaedic Patients



This enhanced model of COMPOSURE behaviours has three components: (1) orthopaedic patients' profile, (2) patient wellness outcome divided into physiologic and bibehavioral wellness outcome, and (3) COMPOSURE behaviours.

The orthopaedic patients' profile mentioned here is age, gender, and religion. These particular demographic profiles have tremendous effect in the bone structures of human beings. Age has known to be a significant factor in bone growth, formation, recovery, and rehabilitation. As the patient's age increases, the probability of having a fracture goes up with it. Likewise, gender plays a recognized role in terms of formation and utilization of calcium and phosphorous in our body. In addition, religion plays a big function in terms of beliefs and practices that a person has, whether it be in health promotion, disease prevention, and treatment.

In connection with this, an orthopaedic patient has two patient wellness outcomes which have been categorized as biobehavioral and physiologic. This dichotomous patient wellness outcome is apparent in all kinds of patients. In this manner, it cannot be separated to the core of the patient. These patient wellness outcomes reflect their needs as their illness turn to recovery and rehabilitation. These needs must be met through high quality nursing care, none other than through COMPOSURE behaviors.

COMPOSURE behaviours have been inspired to the principle of holistic care wherein a patient wellness outcome can be achieved through series of quality attributes of nurses, which caters to every aspect of patient wellness, may it be biobehavioral or physiologic wellness outcome.

Table 42
Summary of Values on the Consolidated Table for
COMPOSURE Behaviours of Advanced Beginner Nurses

COMPOSURE Behaviors	Results	
	Highest Mean	Lowest Mean
Competence	They always manifest good interpersonal and communication skills in dealing with patients and able to extract significant information to aid in planning and delivery of effective nursing care. Mean = 4.50 (Always)	They rarely develops health education plan based on the assessed and anticipated needs of the patients. Mean = 2.27 (Rarely)
Prayer	They allows some moment of silence. Mean = 4.50 (Always)	They rarely pray with the patients. Mean = 1.83 (Rarely)
Presence	They establish the purpose of the interaction and display interest to the patient. Mean = 3.83 (Often)	They spend time with patient even in silence. Mean = 3.08 (Sometimes)
Open-mindedness	They create an environment of trust and rapport. Mean = 4.00 (Often)	They listen attentively to patient. Mean = 3.33 (Sometimes)
Stimulation	They tell the patient what he can do, what he is suppose to do, and how to do it. Mean = 4.33 (Always)	They encourage patient to evaluate his action. Mean = 3.67 (Often)
Understanding	They encourage the patient to feel comfortable in the nurse-patient relationship. Mean = 4.08 (Often)	They clarify the message through the use of question and feedback. Mean = 3.75 (Often)
Respect	They call the patient by his/her preferred name and utilize “po” and	They provide options before making decisions. Mean = 3.83 (Often)

	“opo” when being asked. Mean = 4.67 (Always)	
Relaxation	They evaluate and document the patient’s response to the intervention, observe his/her breathing, and ask if he/she is feeling relaxed. Mean = 4.25 (Always)	They take note of facial expression and unnecessary body movements. Mean = 3.08 (Sometimes)
Empathy	They encourage expression of feelings; focus on verbal and nonverbal behaviour. Mean = 4.33 (Always)	They often provide continuous feedback. Mean = 3.50 (Often)

Table 43
Summary of Values on the Consolidated Table for Biobehavioral Wellness
Outcome of Selected Orthopaedic Patients Before and After the
COMPOSURE Behaviours of Advanced Beginner Nurses

Problem	Results			
	Before		After	
Biobehavioral wellness outcome	Highest Mean	Lowest Mean	Highest Mean	Lowest Mean
Physical	The patient feels bone pain on the affected area when she/he perform physical activities. Mean = 3.76 (Agree)	The patient can walk without difficulty. Mean = 2.20 (Disagree)	The patient exercise every day and they feel rested when they wake up in the morning. Mean = 3.88 (Agree)	The patient can walk without difficulty. Mean = 2.43 (Disagree)
Intellectual	The patients know that fruits and vegetables should always be part of their daily diet. Mean = 4.65 (Strongly Agree)	They are alert and aware of what is happening around them. Mean = 3.92 (Agree)	The patients know exercise is good for their bones. Mean = 4.51 (Strongly Agree)	They are alert and aware of what is happening around them. Mean = 4.08 (Agree)
Emotional	They know how to relax at the end of the day. Mean = 4.37 (Strongly Agree)	They get angry easily. Mean = 3.08 (Neutral)	They love and take care of their selves, they do not care about others especially if it do not affect them and their values guide their daily life.	They get angry easily. Mean = 3.10 (Neutral)

			Mean = 4.41 (Strongly Agree)	
Spiritual	They leave to God what they cannot take or change. Mean = 4.60 (Strongly Agree)	They reflect on their personal life and how they affect others. Mean = 4.13 (Agree)	They leave to God what they cannot take or change. Mean = 4.65 (Strongly Agree)	They reflect on their personal life and how they affect others and they are all connected with people and surroundings. Mean = 4.37 (Strongly Agree)

Table 44
ACTION PLAN
FALL PREVENTION PROGRAM
OUTPATIENT

GOAL: To reduce incidences of fall in household settings

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To establish baseline data about the patients' condition	Make an appointment with your doctor <ul style="list-style-type: none"> • Medications taking • History of fall if there is any • Medical history • Present illness 	Anytime possible	Patient, Companion of the patient, Doctor, and Nurse	Clinic, Prescription	Payment for professional fees
To improve strength, balance, coordination and flexibility	Physical activity (with doctor's approval) <ul style="list-style-type: none"> • Walking • Water workouts • Tai chi 	Most days of the week or 5-6 times per week for at least 30 minutes	Patient, Companion of the patient, and/or gym instructor physical therapist	Exercise program, venue for exercise, schedule of physical activity	Comfortable outfit suitable for work outs
To prevent	Wear sensible shoes	All the	Patient, and	Shoe stores	Appropriate

slipping and stumbling that may result to fall	<ul style="list-style-type: none"> • Have feet measurement each time when buying shoes, since foot size can change. • Buy properly fitting, sturdy shoes with nonskid soles. • Avoid shoes with extra-thick soles. • Choose lace-up shoes instead of slip-ons, and keep the laces tied. If there is trouble in tying laces, select footwear with fabric fasteners. • For a woman who can't find wide enough shoes, try men's shoes. 	time	Companion of the patient		shoes and size
To provide safer ground for the whole households	<p>Remove home hazards</p> <ul style="list-style-type: none"> • Remove boxes, newspapers, electrical cords and phone cords from walkways. • Move coffee tables, magazine racks and plant stands from high-traffic areas. • Secure loose rugs with double-faced tape, tacks or a 	All the time	Patient, and the whole family	Cleaning materials, organizing cabinets	Non-skid floorwax, non-slip mats, renovation funds

	<p>slip-resistant backing — or remove loose rugs from your home.</p> <ul style="list-style-type: none"> • Repair loose, wooden floorboards and carpeting right away. • Store clothing, dishes, food and other necessities within easy reach. • Immediately clean spilled liquids, grease or food. • Use nonskid floor wax. • Use nonslip mats in your bathtub or shower. 				
To avoid tripping on objects that are hard to see	<p>Light up your living space</p> <ul style="list-style-type: none"> • Place night lights in your bedroom, bathroom and hallways. • Place a lamp within reach of your bed for middle-of-the-night needs. • Make clear paths to light switches that aren't near room entrances. Consider trading traditional switches for glow-in-the-dark or illuminated 	As necessary especially at night	Patient, and the whole family	Lights, electric plugs	More lights along the corridors, stairs, and rooms

	<p>switches.</p> <ul style="list-style-type: none"> • Turn on the lights before going up or down stairs. • Store flashlights in easy-to-find place in case of power outtages. 				
<p>To maintain steady gait and support when walking</p>	<p>Use assistive devices</p> <ul style="list-style-type: none"> • Hand rails for both sides of stairways • Nonslip treads for bare-wood steps • A raised toilet seat or one with armrests • Grab bars for the shower or tub • A sturdy plastic seat for the shower or tub — plus a hand-held shower nozzle for bathing while sitting down 	<p>At all times</p>	<p>Patient, and Companion of the patient</p>	<p>Stairways, toilets, bathrooms and corridors</p>	<p>Renovation funds</p>

Table 45
ACTION PLAN
FALL PREVENTION PROGRAM
INPATIENT

GOAL: To reduce incidences of fall in hospital settings

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To determine the patients' condition and risk factors to fall	Utilize fall risk assessment tool (Morse Scale) to identify the risk factors of the patient has such as: <ul style="list-style-type: none"> • Age • Fall history • Mobility • Elimination • Mental status changes • Medications • Patient care equipment 	Every patient's admission in the hospital	Nurses, Doctors, and Pharmacists	Nurses, Doctors, Pharmacists, and Nursing aids	Fall prevention program training for all health care professionals including nursing aids
To provide safety	Clinical Interventions	At all times as	Charge nurses	Manpower	Fall

<p>precautions for patient most likely to fall</p>	<ul style="list-style-type: none"> • Place the “Please Call, Don’t Fall” sign in the patient’s room • If patient unable to call, increase observation • Maintain close supervision, checking at least every two hours and as needed 	<p>necessary</p>	<p>and Bedside Nurses</p>		<p>prevention protocol</p>
<p>To provide patient-friendly environment</p>	<p>Environmental Interventions</p> <ul style="list-style-type: none"> • Keep the bed in a low position • Keep at least one side rail down • Keep the brakes locked on the bed at all times • Keep a dim light on in the evening and at night • Check the patient’s elimination needs every two hours with scheduled and 	<p>At all times as necessary</p>	<p>Charge nurses and Bedside Nurses</p>	<p>Manpower</p>	<p>Mechanical beds with side rails, and brakes, dim light at bedside, call bells, bedside commodes,</p>

	<p>supervised elimination</p> <ul style="list-style-type: none">• Keep the call bell and personal items within the patient's reach at all times• Arrange furniture and objects in the room so that they do not create obstacles• Assist the patient out of bed and remain with the patient while transferring or ambulating• Ensure that patients wear shoes/slippers with non-skid surfaces• Provide a bedside commode for patients with frequent elimination needs• Do not leave patient unattended				
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	<p>while on bedside commode or in the bathroom</p> <ul style="list-style-type: none">• Consider physical therapy consult to assess the need for assist devices for ambulation• When patients have orthostatic hypotension, instruct them to wear elastic stockings, arise slowly, and dangle before standing• Place confused patients in area where they can be observed easily• Implement the protocol for Confused/Agitated Patient as appropriate• Consider the use of a private duty nurse and/or				
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	<p>patient sitter when appropriate and discuss with physician/licensed practitioner</p> <ul style="list-style-type: none"> • Use physical restraints ONLY when other measures to prevent falls have proven ineffective— follow the restraint policy and procedure 				
To guide the patient and his/her family how to prevent fall	<p>Patient Interventions</p> <ul style="list-style-type: none"> • Inform the patient/family when the patient is at high risk for falls and why • Instruct patient/family in fall prevent strategies they can implement • Educate the patient/family in 	Upon patient’s admission to the hospital and when necessary	Patient/family, Charge nurses, Bedside Nurses, attending physician	Manpower	Instructional materials for patient/family

	<p>fall prevention strategies that the staff will implement</p> <ul style="list-style-type: none">• Encourage the patient to ask for assistance when moving• Discuss with the patient/family which current/discharge medications may increase the risk for falls/injury				
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Table 46

ACTION PLAN
NUTRITION SUPPORT PROGRAM

GOAL: To accelerate fracture healing through giving of well-balanced meals

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To provide the body with adequate energy and preventing protein/muscle breakdown	Increase caloric intake through eating the following food: Fruits, vegetables, legumes (beans), breads, cereals, rice, pasta, and grains	Everyday divided into 3 meals and 2 snacks	Charge nurse, bedside nurses, nutritionist, attending physician, and patient for his/her preference	Local foods and drinks	Clinical nutritionist that will formulate the food serving according to patients' needs
To accelerate tissue repair and re-growth	Check the patient's protein intake: increase protein intake of 10 – 20 grams: meat, poultry, fish, eggs, milk,	Everyday divided into 3 meals	Charge nurse, bedside nurses, nutritionist, attending	Local foods and drinks	Clinical nutritionist that will formulate

	cheese, legumes (dried beans, ie, kidney beans, lentils, chick peas), soy products, nuts, and seeds	and 2 snacks	physician, and patient for his/her preference		the food serving according to patients' needs
To build connective tissue and reduce pain	Increase anti-inflammatory nutrients such as vitamins C and E, lycopene, and alpha-lipoic acid, bioflavonoids and flavonols and omega-3 fatty acids such as: citrus fruits, strawberries, tomatoes, peppers, greens, raw cabbage, melon, vegetable oils (e.g. corn or sunflower), beef liver, milk, eggs, butter, green leafy vegetables, and fortified cereals	Everyday divided into 3 meals and 2 snacks Do <u>NOT</u> take vitamin E supplements 7-10 days before surgery.	Charge nurse, bedside nurses, nutritionist, attending physician, and patient for his/her preference	Local foods and drinks	Clinical nutritionist that will formulate the food serving according to patients' needs
To enhance haemoglobin and hematocrit production that helps to produce oxygen in the blood	Increase food consumption rich in iron such as: liver, lean red meat, poultry, fish, iron - fortified cereals, legumes, dark leafy greens, and dried fruits. These foods are best when eaten w/ vitamin C rich foods	Everyday divided into 3 meals and 2 snacks	Charge nurse, bedside nurses, nutritionist, attending physician, and patient for his/her preference	Local foods and drinks	Clinical nutritionist that will formulate the food serving according to patients'

					needs
To help in component of enzymes, building/maintaining bones and muscle contraction	Boost mineral intake such as zinc, copper, calcium and phosphorus, and silicon through eating foods such as: meat, liver, eggs, oysters and other seafood, milk, cheese, yogurt, soy products, turnip and mustard greens, collards, kale, broccoli, and almonds	Everyday divided into 3 meals and 2 snacks	Charge nurse, bedside nurses, nutritionist, attending physician, and patient for his/her preference	Local foods and drinks	Clinical nutritionist that will formulate the food serving according to patients' needs
To aid in bone healing and calcium Absorption and blood clotting	Enhance vitamin intake such as vitamin D, vitamin K, and vitamin B complex through food consumption such as: fortified milk, butter, margarine, fortified cereals, liver, fatty fish (salmon), egg yolk, green leafy vegetables, fatty fish, liver, and vegetable oils	Everyday divided into 3 meals and 2 snacks	Charge nurse, bedside nurses, nutritionist, attending physician, and patient for his/her preference	Local foods and drinks	Clinical nutritionist that will formulate the food serving according to patients' needs

Table 47

**ACTION PLAN
HEALTH EDUCATION PROGRAM**

GOAL: To provide quality orthopaedic nursing care to patients from pre-operative to rehabilitation

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To orient the patient on what to do before surgery	Preoperative Nursing Care <ul style="list-style-type: none"> • Pain management • Proper positioning • Exercises: Deep breathing, coughing exercises and calf pumping 	On or before 24 hours after fracture	Attending physician, orthopaedic surgeon, nurses, pharmacists, and nutritionist	Emergency room, hospital room and manpower	Monetary fund, and emotional support
To guide the patient on what to bring during hospital stay to have comfort	During the hospital stay, bring the following: <ul style="list-style-type: none"> • Medications • Proper clothing • Walking aids 	1 – 7 days	Attending physician, orthopaedic surgeon, nurses, pharmacists, physical therapists, and nutritionist	Hospital room, operating room, and manpower	Monetary fund, medication, proper clothing, walking aids
To provide comprehensive postoperative nursing	Postoperative Nursing Care <ul style="list-style-type: none"> • Pain management 	After surgery up to 4 weeks	Attending physician, orthopaedic	Hospital room, and manpower	Monetary fund, electrical

care that will assist the patient to achieve calmness after surgery	<ul style="list-style-type: none"> • Assessment of change in behaviour or mood • Anticoagulant protocol • Assessment of bowel movement • Exercises • Proper positioning 		surgeon, nurses, pharmacists, physical therapists, and nutritionist		bed, emotional support
To facilitate fast recovery	<p>During rehabilitation</p> <ul style="list-style-type: none"> • Home exercise program • Positioning in bed • Getting in and out of bed • Sitting • Toileting • Bathing • Dressing • Going up and down the stairs • Activities around the house • Sexual activity • Returning to work • Sports/leisure 	1 – 6 months	Attending physician, orthopaedic surgeon, nurses, pharmacists, physical therapists, occupational therapist, and nutritionist	Family, friends, emotional support	House renovation, monetary fund, additional lights, and fixtures

Table 48
ACTION PLAN
PRAYER INTERVENTION PROGRAM

GOAL: To provide appropriate prayer according to patients' needs for achievement of comfort and renewal

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To determine the patient's preference	Ask the patient if he/she wants to pray with the nurse	As necessary	Patient, bedside nurse, attending physician	Patient's room, chapel	Prayer room, privacy
To facilitate focused communication with God	Ritual <ul style="list-style-type: none"> Memorized prayers that can be repeated such as praying the rosary, or salat (for Muslims), or prayer books 	As needed & preferred by the patient	Bedside nurse, chaplain's office	Chapel	Ritual prayer materials according to patient's religious affiliations, Chaplain's services, and prayer protocol for manpower's guidance
To assist patient in asking for personal healing from God by expressing pain,	Petitionary <ul style="list-style-type: none"> Intercessory prayers when one is requesting something of the 	As needed & preferred by the patient	Bedside nurse, chaplain's office	Chapel	Ritual prayer materials according to patient's religious

grief, anger, isolation, and need	divine; e.g., “God, cure me!”; it is usually for personal healing				affiliations, Chaplain’s services, and prayer protocol for manpower’s guidance
To communicate with God in an informal and honest way	Colloquial <ul style="list-style-type: none"> • Conversational prayers • Scripture readings 	As needed & preferred by the patient	Bedside nurse, chaplain’s office	Chapel	Ritual prayer materials according to patient’s religious affiliations, Chaplain’s services, and prayer protocol for manpower’s guidance
To provide calmness and balance of energies	Meditational <ul style="list-style-type: none"> • Moments of silence focused on nothing • A meaningful phrase • A certain aspect of the divine 	As needed & preferred by the patient	Bedside nurse, chaplain’s office	Chapel	Ritual prayer materials according to patient’s religious affiliations, Chaplain’s services, and prayer protocol for manpower’s guidance

Table 49

ACTION PLAN

ACTIVE LISTENING & FOCUSING INTERVENTION

GOAL: To provide holistic nursing care through active listening and focusing as therapeutic communication skills

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To pay attention to the whole person and provide him/her with empathic understanding	Active listening <ul style="list-style-type: none"> • Face the patient and maintain eye contact. • Be attentive, but relaxed. • Keep an open mind. • Don't interrupt and don't impose "solutions. • Wait for the patient to pause to ask clarifying questions. • Ask questions only to ensure understanding. 	Every conversation with patient and/or family	All healthcare professionals	Conference rooms, papers, pencils, ballpens, & manpower	Active listening and focusing training program

	<ul style="list-style-type: none"> • Give the patient regular feedback. 				
To gain a deeper and more meaningful understanding of patients' feeling	<p>Focusing</p> <ul style="list-style-type: none"> • Listen to the words and try to picture what the patient is saying. • Try to feel what the patient is feeling. • Pay attention to nonverbal cues. 	Every conversation with patient and/or family	All healthcare professionals	Conference rooms, papers, pencils, ballpens, & manpower	Active listening and focusing training program

Table 50

**ACTION PLAN
EMOTIONAL SUPPORT PROGRAM**

GOAL: To improve the patient's mental status

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To seek professional help about his/her mental status	Talk to the attending physician about getting counselling for the patient.	As soon as the patient shows sign of depression	Nurses, attending physician, patient, family members, psychiatrists, psychologists	Manpower	Assessment protocol for mental status, referral process
To provide support system to the patient other than health care professionals	Talk with someone the patient trusts.	Every visiting hours or as needed by the patient	Nurses, attending physician, patient, family members	Manpower, family, relatives, friends	Patient's lounge or a room where they can talk in private
To allow the patient to examine his/her present situation	Let the patient write down his/her feelings such as: things that are bothering him/her. Decide which things he/she can change,	Once in every shift or as patient requested	Nurses, attending physician, patient, family members	Manpower	Writing materials for the patient

	and how he/she can change them.				
To release the anger, tension, boredom, and helplessness	Exercise, draw, paint, or listen to music	Once in every shift or as patient requested	Nurses, and attending physician	Manpower	Materials for painting, drawing, and music
To ease emotional turmoil	Relax by using techniques such as meditation, or guided imagery	Once in every shift or as patient requested	Nurses, attending physician, physical therapists	Manpower	Patient's lounge or a room where they can meditate

Table 51

ACTION PLAN

PAIN ASSESSMENT INTERVENTION

GOAL: To provide quality care to decrease pain through collaborative health care team

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To have a baseline data about patient's level of pain	Assess the nature, intensity, site of pain, causes and precipitating factors of pain by talking to the patient and observing them	Every 4 hours as routine; every 2 hours if postoperative	Patient, nurses, attending physician, pain management team	Nurses, doctors, patient, hospital, & pharmacy	Pain intervention protocol, pain management team
To inform and provide intervention accordingly with the healthcare team	Plan and refer to the attending physician for medication	Immediately upon onset of pain	Charge nurse, bedside nurse	Nurses, doctors, patient, hospital, & pharmacy	Pain intervention protocol, pain management team
To document the occurrence and	Record the frequency and level of pain	At all times	Bedside nurse	Charts, pens, manpower	Specific space in the

intensity of pain					chart where to document pain level
To establish the pattern of the patient's pain	Monitor the pain level regularly at the request of the patient, in response to the severity of pain, when pain is anticipated or expected	Every 4 hours as routine; every 2 hours if postoperative	Bedside nurse	Nurses, doctors, patient, hospital, & pharmacy	Pain intervention protocol, pain management team
To decrease the patient's level of pain	Implement nursing care (non-pharmacologic measures) and collaborative care such as pain medications and monitor side effects and progress	Immediately at all times	Charge nurse, bedside nurse, attending physician, pain management team	Nurses, doctors, patient, hospital, & pharmacy	Pain intervention protocol, pain management team
To establish effectiveness of the given care and change the treatment given if needed	Evaluate the pain level of the patient	30 minutes after the given treatment	Patient, nurses, attending physician, pain management team	Nurses, doctors, patient, hospital, & pharmacy	Pain intervention protocol, pain management team

Table 52

**ACTION PLAN
SPIRITUAL NURSING CARE PROGRAM**

GOAL: To provide holistic nursing care to patient through facilitating spiritual care

OBJECTIVES	ACTIVITIES	TIME TABLE	PERSON RESPONSIBLE	RESOURCES	
				Available	Needed
To establish the spiritual needs of the patient	Assess the spiritual needs of the patient such as: needs related to the self, needs related to others, needs related to the Ultimate Other, & needs among and within groups	Upon patient's admission and as necessary during hospital stay	Nurses, patient, attending physician, chaplain	Manpower, chapel	Protocol in giving of spiritual nursing care to patient and family members
To support the patient's request	Follow the patient's expressed wishes regarding spiritual care	As necessary during hospital stay	Nurses, patient, attending physician, chaplain	Manpower, chapel	Protocol in giving of spiritual nursing care to patient and family members
To respect the patient's preference	Do not prescribe or urge clients to adopt certain	At all times	Nurses, patient, attending	Manpower, chapel	Protocol in giving of

when it comes to spirituality	spiritual beliefs or practices, and do not pressure them to relinquish such beliefs or practices		physician, chaplain		spiritual nursing care to patient and family members
To enhance the nurses' capacity to give care in accordance to spiritual wellness	Strive to understand personal spirituality and how it influences caregiving	At all times	Nurses, patient, attending physician, chaplain	Manpower, chapel	Annual spiritual retreat specifically for all healthcare professionals
To facilitate comfort to patient as well as harmony to self and people	Provide spiritual nursing care in a way that is consistent with personal beliefs	At all times	Nurses, patient, attending physician, chaplain	Manpower, chapel	Protocol in giving of spiritual nursing care to patient and family members

Table 53			
SPIRITUAL NEEDS OF PATIENTS			
Needs related to self	Needs related to others	Needs related to the Ultimate Other	Needs related among and within groups
<ul style="list-style-type: none"> • Need for meaning and purpose • Need to express creativity • Need for hope • Need to transcend life challenges • Need for personal dignity • Need for gratitude • Need for vision • Need to prepare for and accept death 	<ul style="list-style-type: none"> • Need to forgive others • Need to cope with loss of loved ones 	<ul style="list-style-type: none"> • Need to be certain there is a God or Ultimate Power in the universe • Need to believe that God is loving, and personally present • Need to worship 	<ul style="list-style-type: none"> • Need to contribute or improve one's community • Need to be respected and valued • Need to know what and when to give and take

CURRICULUM VITAE

Name: BEA-GRACIA M. CRUZ, RN, MAN

Address: [REDACTED],

[REDACTED]

Contact Nos.

Cell Phone: [REDACTED]

Email Address: [REDACTED]@yahoo.com



I. EDUCATION

(Graduate) Degree: Doctor of Nursing Management Yr. Graduated: Dec 2013

School: Trinity University of Asia

(Graduate) Degree: Master of Arts in Nursing

School: Trinity University of Asia

Yr. Graduated: August 2008

(Bachelor) Degree: Bachelor of Arts in Nursing

School: Trinity University of Asia -

Yr. Graduated: March 2002

St. Luke's College of Nursing

II. EMPLOYMENT AND ADMINISTRATIVE POSITION

Position: **NURSE AREA MANAGER – General Units**

Employer: **Our Lady of Lourdes Hospital**

Date of Employment: **June 2, 2014 up to present**

Position: **Associate Professor 3**

Faculty/Lecturer/Clinical Instructor Date of Employment: June 2004 – May 2014

Integrated Management of Childhood Illness (IMCI) Coordinator : June 2007 - May 2014

Batch Adviser, Class of 2009 : 2007-2009

Thesis Adviser/Panel : 2007 – present

IMCI Reviewer : 2007 - present

Clinical Instructor in the following areas: : 2004 - present

- **St. Luke’s Medical Center**
 - OPD/Minor OR
 - Cardiovascular Units
 - Geriatric unit
 - Intensive Care Unit
 - Telemetry
 - Coronary Care Unit
 - Institute of Neuroscience
 - Maternity Unit
 - Surgical-oncology Unit
 - Pediatric Unit
 - Medical Unit
- **Philippine Orthopedic Center**
 - Orthopedic areas (adult & pedia)
 - Spinal ward
 - Hardware and gadgets
 - OPD (cast application & removal)
- **Community Health/Public Health**
 - Integrated Management of Childhood Illness (IMCI)

Lecturer of: Community Health Nursing
 Integrated Management of Childhood Illness
 Orthopedic Nursing Care
 Neurologic Nursing Care

Nutrition

Employer: Trinity University of Asia- St. Luke's College of Nursing

Position: **Company Nurse** Date of Employment: Feb 2004 -June 2004

Employer: Legacy Consolidated Plans, Inc.

Position: **Staff Nurse** Date of Employment: Feb 2003-Jan 2004

Assigned in: Bone Marrow Transplant Unit

Floated in: Intensive Care Unit

Coronary Care Unit

Pediatric ICU

Neuro ICU

Telemetry

Cardiovascular Units

Acute Stroke Unit

General wards

Employer: St. Luke's Medical Center

III. SEMINARS/WORKSHOPS ATTENDED:

Role: Lecturer/Resource Speaker

Title of Seminar: Endorsement Process

Venue: Our Lady of Lourdes Hospital

Date: August 8, 2014

Role: Lecturer/Resource Speaker

Title of Seminar: Organizing: Structure & Resources

Venue: Our Lady of Lourdes Hospital

Date: June 25, 2014

Role: **Presenter**

Title of Seminar: 17th EAFONS (East Asian Forum of Nursing Scholars)

Venue: Century Park Hotel, Manila, Philippines

Date: February 20 – 21, 2014

Role: **Participant**

Title of Seminar: Graduate School Research Forum

Venue: Trinity University of Asia

E. Rodriguez Sr. Ave., QC

Date: February 8, 2014

Role: **Participant**

Title of Seminar: Essential Newborn Intrapartum Care

Venue: Trinity University of Asia

E. Rodriguez Sr. Ave., QC

Date: July 19, 2013

Role: **Participant**

Title of Seminar: Neonatal Care

Venue: National Children Hospital

E. Rodriguez Sr. Ave., QC

Date: January 20, 2012

Venue: Trinity University of Asia –
St. Luke's College of Nursing

Date: November 5 – 9, 2007

Role: **IMCI Facilitator**

Title of Seminar: IMCI 5-day Course

Venue: University of the Philippines –
College of Nursing

Date: October 15 – 19, 2007

Role: **Facilitator**

Title of Seminar: Documentation in Nursing

Venue: St. Luke's Medical Center

Date: October 2005

Role: **Participant**

Title of Seminar: Essential Intrapartum Newborn Care

Venue: AVR Health Science Building, TUA – SLCN

E. Rodriguez Sr. Ave., QC

Date: July 19, 2013

Role: **Participant**

Title of Seminar: Neonatal Care

Venue: National Children Hospital

E. Rodriguez Sr. Ave., QC

Date: January 20, 2012

Role: **Participant**

Title of Seminar: Nursing Informatics: From Fragments to Meaningful Use

Venue: St. Luke's Medical Center – QC Date: January 12, 2012

Role: **Participant**

Title of Seminar: Workshop on Critiquing Research Papers

Venue: Trinity University of Asia –

St. Luke's College of Nursing

Date: January 11, 2012

Role: **Participant**

Title of Seminar: Medication Safety Practices Towards Quality Healthcare Year 7

Venue: Angelo King Auditorium,

St. Luke's College of Medicine, QC

Date: November 23, 2012

Role: **Participant**

Title of Seminar: The 1st Neurocritical Care Nursing Symposium:

The Essentials in the Excellent Care of Acute Brain Injuries

Venue: Angelo King Auditorium, College of Medicine,

St Luke's Medical Center – QC

Date: November 11, 2011

Role: **Participant**

Title of Seminar: IVT Update: Ethico-Legal Issues in IV Therapy

Venue: Meycauyan Doctor's Hospital Function Hall

Date: October 6, 2011

Role: **Participant**

Title of Seminar: Qualitative Data Analysis: Let Your Data Bloom

Venue: Trinity University of Asia – Graduate School Date: September 25, 2011

Role: **Participant**

Title of Seminar: Practical Urologic Nursing Care

Venue: St. Luke's Medical Center – Quezon City Date: September 2, 2011

Role: **Participant**

Title of Seminar: Taking Care of Lolo and Lola

Venue: Trinity University of Asia – SLCN Date: June 6 – 7, 2011

Role: **Participant**

Title of Seminar: Critical Care Nursing: Synergizing Nursing Practice in a Highly Technical World

Venue: Diamond Hotel, Philippines Date: October 5 – 6, 2010

Role: **Participant**

Title of Seminar: Regular I.V. Training Program

Venue: Meycauayan Doctor's Hospital Date: November 13 – 15, 2009

Role: **Participant**

Title of Seminar: Conducting True Experimental Research

Venue: Trinity University of Asia Date November 4, 2009

Role: **Participant**

Title of Seminar: ICATT Training

Venue: Contemporary Hotel, Quezon City Date: September 21 – 25, 2009

Role: Participant

Title of Seminar: Orthopedic Nursing: Preceptorship Training

Venue: Philippine Orthopedic Center, Banawe, Quezon City Date: May 25 – 29, 2009

Role: Participant

Title of Seminar: IMCI Convention

Venue: Island Cove Resort, Cavite Date: January 6 – 9, 2009

Role: Participant

Title of Seminar: Emergency Nursing Faculty Development Seminar: 2008 AHA Updates in BLS & ACLS

Venue: Trinity University of Asia –
St. Luke's College of Nursing Date: November 3 – 4, 2008

Role: Participant

Title of Seminar: The Current Nursing Shortage/Opportunities for Filipino Nurses for Lifelong Learning and Workforce Development

Venue: Mandell Hall, Trinity University of Asia QC
Date: January 17, 2007

Role: Participant

Title of Seminar: Basic 11 Days Training on IMCI

Venue: Hotel Fortuna, Cebu City
Date: April 23 – May 4, 2007

Role: Participant

Title of Seminar: IMCI Facilitators Course for Academe

Venue: Meridian Hotel, Tagbilaran City, Bohol

Date: August 13 – 17, 2007

Role: Participant

Title of Seminar: Crucial Discussions and Evidence-based Nursing: TUA – SLCN's Roadmap to Research and Excellence

Venue: Shangri-La Hotel, Makati, Philippines

Date: October 6, 2007

Role: Participant

Title of Seminar: The Current Nursing Shortage/Opportunities for Filipino Nurses

Venue: Trinity University of Asia –
St. Luke's College of Nursing

Date: January 17, 2007

Role: Participant

Title of Seminar: Harnessing Competencies on Research: Evaluation of Community-Related Program

Venue: Trinity University of Asia

Date: September 19, 2006

Role: Participant

Title of Seminar: The Art and Science of Diabetes Education: From Womb to Tomb

Venue: Century Park Hotel, Manila

Date: June 30 – July 1, 2006

Role: Participant

Title of Seminar: Research Forum

Venue: Trinity University of Asia

Date: February 18, 2006

Role: Participant

Title of Seminar: Basic I.V. Training Program

Venue: Trinity University of Asia

Date: October 10 – 12, 2005

Role: Participant

Title of Seminar: Faculty Development Program: Our Job, Our Mission, and Our Commitment

Venue: Trinity University of Asia

Date: November 17, 2004

Role: Participant

Title of Seminar: Customer First!

Venue: St. Luke's Medical Center

Date: August 2003

Role: Participant

Title of Seminar: Charting for Nurses

Venue: St. Luke's Medical Center

Date: September 4, 2003

Role: Participant

Title of Seminar: Induction to St. Luke's Family

Venue: St. Luke's Medical Center

Date: December 27, 2002

Role: **Participant**

Title of Seminar: Nursing Staff Effectiveness Training Program

Venue: St. Luke's Medical Center

Date: Nov 10 – December 17, 2002

IV. MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS:

Position: **Member**

Organization: Philippine Nurses Association (2002- present)

Position: **Member**

Organization: St. Luke's College of Nursing Alumni Association (2002- present)

Position: **Member**

Organization: Philippine Association of Diabetes Educators (2006 – present)

Position: **Member**

Organization: Ang NARS

V. AWARDS/FELLOWSHIPS

Bishop Paul M. Matthews Award

Date: February 5, 2010

5 Years of Service Awardee

Champagne Hall Gazebo Royale

Facilitator/Trainer

Date: June 24 – 26, 2008

3 days Basic Training on IMCI (didactic only)

Venue: Letran University – Calamba Campus

Facilitator/Trainer, Coordinator

Date: November 5-9, 2007

5 days Basic Training on IMCI

Venue: Trinity University of Asia

Facilitator/Trainer

Date: October 2007

5 days Basic Training on IMCI

Venue: university of the Philippines – Manila

Scholarship Award

Date: August 2004

Xavier University

Cincinnati, Ohio, USA

Valedictorian

Date: March 1998

Panaon Institute

San Francisco, Southern Leyte

Valedictorian

Date: March 1994

San Francisco Central Elementary School

San Francisco, Southern Leyte

VI. RESEARCHES/PUBLICATIONS:

Title: GENDER AND SOCIOECONOMIC STATUS OF NURSING STUDENTS AS CORRELATES OF THEIR COMPETENCY LEVEL ON CASE MANAGEMENT PROCESS IN INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS STRATEGY TOWARDS AN ENHANCED IMPLEMENTATION (Master's Thesis)

Trinity University of Asia – Graduate School

Title: Lived Experiences of Mothers of Children with Autism Spectrum Disorder: Basis for Enhanced Nursing Care

Poster Presented in the 17th EAFONS (East Asian Forum of Nursing Scholars) that will be held on February 20 – 21, 2014 at the Century Park Hotel, Manila, Philippines.

VII. HOSPITAL & SCHOOL INVOLVEMENT/PARTICIPATION:

Activity: **Patient Experience Project (Our Lady of Lourdes Hospital)**

Role: **Special Project Manager**

Date: June 2014 up to present

Activity: **RQUAT Accreditation**

Date: September 2012

Role: **Committee Member, Library**

Activity: **PAASCU Accreditation**

Date: November 2011

Role: **Committee Member, Library**

Activity: **Christian Emphasis Week**

Date: School Year 2007-08

Role: Coordinator for Nursing

Activity: LINK: The Official Newsletter of the Employees of Trinity University of Asia

Role: Contributing Writer

Date: June - August 2007

Activity: 45th Founding Anniversary

Date: September 2007

Role: Committee Member, Thanksgiving Service Committee

Activity: PAASCU Accreditation

Date: September 2007

Role: Committee Member, Community

VIII. CREATIVE PRODUCTIONS

1. Literary Works

Title: SLCN HOLDS COPAR TRAINING

Date Published: Vol. 6 No. 15 (June - August 2007)

Where: TUA – LINK

Title: Professor's Note: The Lifeguard on Duty

Date Published: March 2012

Where: SNA Gazette

IX. SCHOLARLY ACCOMPLISHMENTS

1. Government Examinations

Nursing Licensure Examination June 2002

Rating: 78.80%

2. Non Degree Training

Title of Training: IMCI Facilitator's Course

Venue: Bohol

Date: July 2007

Title of Training: 11 Days Basic Course on IMCI

Venue: Cebu

Date: April 23– May 4, 2007

Title of Training: Regular IV Therapy Training Program

Venue: Our Lady of Lourdes Hospital

Date: October 10-12, 2005

Title of Training: Nursing Staff Effectiveness Training

Venue: St. Luke's Medical Center

Date: Nov 10 – Dec 17, 2003

X. COMMUNITY SERVICE

Role: Volunteer

Place: Villaverde, Nueva Vizcaya, Philippines

Date: December 19, 2009

XI. EXTENSION SERVICE (Participation outside the College)

Role: Volunteer

Place: Villaverde, Nueva Vizcaya, Phils

Date: December 19, 2009

XII. References

1. Dr. Eufemia F. Octaviano
Professor

Trinity University of Asia – Graduate School



2. Dr. Lydia A. Cabigao
Professor/ Thesis Adviser

Department Head

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