Saludamay

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Aquinas University of Legazpi
COLLEGE OF NURSING AND HEALTH SCIENCES
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Saludamay is a term coined from the words "salud," which means health and "damay," meaning comforting help.

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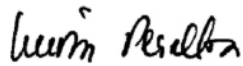
FOREWORD

The Board of Nursing through the Technical Committee on Nursing Education crafted the Enhanced BSN curriculum of 2009 (CMO 14, s. 2009). This new BSN curriculum, implemented this school year 2009-2010, emphasized the 11 Key Areas of Responsibility of a practicing nurse with specific core competencies in each key area.

Three of these key areas; e.g.. Safe and Quality Nursing Care, Management of Resources and Environment, Ethico-Moral Responsibility, are reinforced by the research outputs of our faculty. A research on Quality Improvement, another key area, is also represented by two (2) researches on Nursing Education, specifically, on the Related Learning Experiences of nursing students from the University.

From these researches, we wish to improve the practice of infection control in hospitals and communities, trouble shoot the missing link in nursing education, and imbibe Catholic ideals in nursing practice.

The college appreciates the efforts of our faculty for taking time to put together the selected researches of our Level IV students. With this collaboration, we hope to create a research culture among our students and faculty, truly worthy for our institution to be called a University.



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02/17/2010

A PHILOSOPHY OF THE HUMAN PERSON TOWARDS AN ETHIC OF HEALTH CARE

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Abstract

The paper aims to provide a philosophy of the human person towards an ethic of health care through a re-interpretation of the human person as care as the fundamental human condition of being human as I and Other and health care as basic right and social good. It primarily argues that we need to recognize and embrace the conception of the human person as care himself as manifested both in his nature and condition thereby facilitating concepts and principles for health care taken as already a basic right and a social good at the same time. Hence, all human persons and democratic constitutional societies shall view and respect all human persons as providers and beneficiaries of care and health care.

Keywords: Health Care, Philosophical Anthropology, Ethics, Care

Care as the Fundamental Human Condition of Being Human as I and Other

What makes a human being *being* human?

Essentialists would tell us that there are truths in reality that are completely *universal*, absolutely *objective*, and generally *necessary* that serve as foundation of everything that is in the objective world. They make the

material world definite, concrete, and pluralist. For example, the concept of man is defined as rational animal. What makes man *man* is man*ness*. This man*ness* speaks of the human essence. This human essence is rational animal, that is, man is generally classified as animal and what makes him different from all other animals is that he is rational. Hence, man is a rational animal. And since man then is defined as rational animal, man is confined to his rationality. Hence, his nature is reduced as a thinking subject. Man, now as the *cogito* (Descartes, 1951), discovers reality and contemplates the essences of things around him.

Existentialists **contend** the claim that there are essences, rather, they believe that *human condition speaks of human reality*. Human condition constitutes human experience establishing the relationship of the world as the human world and man making himself a being-in-the-world. For instance, human experience of his body, his work, his love, his death, and his belief in God as the themes of his existence are the cornerstones of his way and experience of life. These conditions are experienced because man is seen as an embodied subject (Dy, 2005). Hence, his condition defines his being. Man, then, is what he makes of himself (Sartre, 1992). He has to find and make meanings out of his experiences in the world.

Thomas Aquinas synthesizes the claims of the essentialists and existentialists. He believes that *essence* and *existence* are substantially united in man, that is, essence and existence as metaphysical duality in man, are actually simultaneous (Coplestone, 1993). One is not prior to the other. The two elements must be viewed as one. This is because essence and existence cannot speak of truth if they are not actual and real for each other at the same time.

The paper argues that human nature and human condition can be seen in a synthesis through the concept of **care re-interpreted as the fundamental human condition** of being human as I and Other (Negado, 2009), that is, *human nature* is defined as care which is the fundamental *human condition* at the same time. In order to substantiate such synthesis, the following claims are asserted:

1. That the human person is d**asein**;
2. That the human person is a **relational subject**;

3. That there is consistency and conformity to the **moral** and **social identities** of the human person;
4. That **face-to-face encounter leads the human person to autonomy** that form part human capacities;
5. That the human person as a meaning-making rational agent finds and justifies his existence through **sense of moral obligation and social responsibility**; and
6. That the human person is **CARE** as seen through **empathy and compassion**.

The Human Person is *Dasein*

According to Martin Heidegger (1962), a contemporary German philosopher, the being of man, as an embodied spirit, is a being-in-the-world. He is primordially directed towards the world. We can say that he is somehow *thrown into the world*. It is **not** a *question of self-determination*, but the facticity of his existence remains, and that is, that he is existing into that world, and hence, he is indeed truly present in that world. Such presence declares that he is a historical being. His fact of existence connotes his being present in a given time and space, making himself a historical being. And as man realizes not only his environment but more significantly his own life world that he recognizes (and appreciates) his being as social. As he continuously relates with all others existing and present in the world, he comes to establish and build up his own sense of being. He then truly realizes that he is *dasein*, *a there-being*. There-being is the There of Being among beings (Richardson, 1963). He is now rooted in his own life world based on concern and solicitude; *concern* because he is now reflexive of all things present, both objective and non-objective, and *solicitude* because he is now a being-with others. As *dasein*, man is now so involved in all realities found in his world, that which is experience-based and context-laden. And as historical and at the same time social, he has the power-to-be. He has all the potentialities as *dasein* to constantly actualize those potentialities both of his existence and presence in the world. As long as man exists and remains present in the world, his potentiality for his being *being* cannot and can never be exhausted. Man as *dasein* is always incomplete; there is something to be settled yet in man, and he has never reached his

wholeness in this sense. He intends to have a complete sense of wholeness but by virtue of the facticity of his existence as *dasein*, he will never realize such sense of wholeness. The fact of completion happens only in man as *dasein* only during his death. He is an unfinished character so-called. Hence, the human person is *dasein* himself.

The Human Person as *Dasein* is a *Relational* **Subject**

And since man is now established and conceived as *dasein*, it is a consequent fact that he is a *relational* subject. He is a relational subject because man, through a sense both of concern and solicitude, now interacts with his own life world, defined categorically and metaphorically by the presence of all others such as by the significant others (family, loved ones, friends, co-workers), the world of things (physical objects), time (past, present, future), and the Absolute i.e. God.

The human person is a subjectivity, a unique core or center, source, depth, well spring of initiative and meaning (Dy, 1986). As such, he gives and supplies meanings not only to himself but more so all persons and things found outside himself. His world connotes dialectics of meanings and structures articulating meanings based on such subjectivity. Hence, the human person cannot but to establish relationships and connections with all others, and this time, *out of his self-determination*. His life world is a world of fellowman, conceived with meanings attributed to his very own subjectivity. We can say, therefore, that human nature is defined by his own condition of **relatedness**.

The Human Person as Both *Dasein* and *Relational Subject* Finds Conformity and Consistency Both in His **Moral** and **Social** *Identities*

The human person, as *dasein* and *relational subject*, should recognize and appreciate the formation of identities within himself, as he continuously establishes different forms of relationships with all those existing and present in his life world. These identities are natural to us as *having been*

thrown into the world. We can speak of social or *practical identity* and *moral identity*.

Practical identity refers to *a set of descriptions under which one values himself and finds his life to be worth living and his actions worth undertaking*. It regards all social roles that one has which is fundamentally the source of his reasons and obligations. This set of identities determines how one thinks of himself. His duties and responsibilities are attached to this social/practical identity. One's social identity is relative to his status, religion, profession, organization, class type, etc. These conceptions of us are very important because it gives rise to certain obligations. To go against them is to deny one's integrity and therefore identity. And in case there is conflict, some parts of it are shed. This shedding is intended to stabilize in order for one to continuously think of himself under a set of descriptions in which he values himself. Since the reflective structure of human identity requires identification of oneself to some law or principle to govern his choices, the autonomous self is the source of normativity and obligation. In this sense, a certain identity should rise up from social or practical identity. It is better to think of oneself, to value himself, to be governed by value he places to himself such as by being human simply, and as a member of the human race. To value oneself as a human being is to have moral identity. Valuing oneself as a human being posits valuing others (and with it are moral obligations). It is necessary for one to have some conceptions of his practical identity (particular ties and commitments) he has in certain community, for without this social identity he cannot have reasons to act. He endorses or rejects his impulses by determining whether they are consistent with the ways he identifies himself. It is a reason he has only if he treats humanity as practical, normative form of identity. He must value himself if he is to value anything at all. And if he has to have practical identity, he must recognize himself to have moral identity. To treat his human identity as normative which is a source of reasons and obligations is to have moral identity. Among the many things that he is, he is a Citizen of the Kingdom of Ends (Kant, 1993).

Practical identity is horizontal; moral identity is vertical. Practical identity is the overall social contingent roles and identity one has and therefore includes duties and obligations as son-daughter, father-mother, Christian-

Muslim, professional-non-professional, teacher-student, politician-religious, etcetera. Every status indicates a set of duties and obligations one has to perform in the honor of those identities. Who one is can be answered in the light of his social positions. In this sense, we can say that one is defined by his particular ties and commitments. Practical identity is an ocean of social labels. No one can escape these names since his very identity as a person is characterized by such labels. **Practical identity is a social psychology**.

Moral identity is a universal identity since it is an identity that underlies all aspects of social identity. Since all social roles reside in a person, the very fundamental identity then is the identity as being a person; being a human person capable of reflection looking for universal principles for the Kingdom of Ends as its participants and citizens. In other words, being human as such or being a humanity in and for itself. Moral identity serves as the repository for all other social identity. Lexical ordering is a must here. A certain kind of prioritization should be set. Since moral identity grounds all practical identity, in case of conflict, moral identity is and should be in the first-order arrangement. Social roles and identity must harmonize with the moral identity. In this case, to identify a set of moral principles to guide moral identity is a first-level point also for the social identity. But moral identity should be regarded as independent to (all) social identity. But moral identity has special relationship with the rest of practical identity.

Practical identity is contingent; moral identity is necessary. Since practical identity is simply a conglomeration of social identity which are dependent on the social rules and norms, such identity is simply accidental and random. It could change. Moral identity is necessary because it covers and strikes all kinds of identity and that the various social labels inhere in the fundamental identity of the self, of the human identity, which is the moral identity itself. **Moral identity is a rational psychology**.

Moral identity is tenable for some reasons. First, *moral identity treats the subject as the fundamental aspect of all sorts as human*. It makes us humans. It recognizes and asserts that all human endeavors should always be seen as an effort to affirm oneself in his very basic aspect, human nature for instance. Second, *moral identity appeals to humanity as such and pos-*

its a universal application. It identifies the self as fundamentally a citizen of the Kingdom of Ends where men as humans agree to follow and abide and bind themselves to the laws all willed to be laws. It sets the stage for the acknowledgment of self as Citizen in such Kingdom of Ends. Third, *moral identity emerges from deep-seated particular ties and commitments*. It is identified as the meta-entity to practical and social identity. Fourth, *moral identity is the universal ethical self*. Moral identity serves as the identity of all social identity. It is the seat of human nature. Man is basically human. With it flows the basic duty and obligation of man to himself as human. Fifth, *moral identity resolves conflicts of identities and re-source the nature of such identities*. Moral identity serves as the groundwork and the final judge in the activities of various social identities.

Both the moral and social identities must form **consistency and conformity** with each other. *Consistency* here means that what is desired and exercised by social identity must be at the same willed by the moral identity. Recognizing the premise that moral identity has the lexical priority over the social identity, the latter should be in cognizance or parallel with the former. *Conformity* here means there is a squaring up or adequation between the two identities. This means that social identity and moral identity must be taken as one and the same thing. The difference between the two descriptions is that there is ordering and following in consistency whereas in conformity there is congruence. When consistency and conformity define the relationship between the two identities, the human person, now holistic and no longer dualistic, grounds himself more to his experience in his life world as dasein and relational subject. This is because his approach in his experience is not fragmented, divided, and partial; rather there is an attempt for becoming wholeness.

Human Autonomy and **Face-To-Face Encounter**
are Human Capacities of the Human Person
as *Dasein* and *Relational Subject*

Based on the flow of our discussion, we now have seen that the human person, as *dasein* and *relational subject*, has social and moral identities. And these two identities need to establish conformity and consistency with

each other; otherwise, human existence shall become inauthentic, making him *dasman* (Heidegger, 1962) and **not** *dasein*. And by virtue of such conformity and consistency, moral identity is the basis of social identity. But such framework needs human capacities in order for the human will to will social identity in the light of moral identity, leading him to realize himself as *dasein* given his being a *relational subject*. Such will needs to be **autonomous**.

The autonomous will, having certain maxims, suggests that every human person has the capacity to arrive at certain objective and valid principles separate from his subjectivity. This is so because man has self-determination and self-objectification as well as ability to self-correction. He has self-determination because he has rational freedom to choose what is best and which is better for him. He has self-objectification because he has the power to separate himself from the issue at hand and therefore would have a bird's eye view and treat it therefore more objectively and more distant. He has self-corrective ability because he has the power to correct himself, recognize mistakes, and improve from the errors he has made. Self-distantiation is another quality man has corollary to his self-objectification. We need distance to see things as they truly are and view them more impartially. Corollary also to self-determination is self-origination. Man has the capacity to originate from himself objective values and objective principles.

Man as being autonomous means and implies his rational capacity and power to form principles and derive rules from his self based on his reflection. This further suggests that the authority gained in his reflection is stronger than authority seen in institutions, which sometimes excessively controls and manipulates human will and freedom. It also implies that he is able to assess his ideas and evaluate them based not only on the imposed social criteria but also on his own set of criteria. This resolves the problem of the interaction of man and his society as they operate with each other. The autonomous human being is called to critique his self and at the same time his society to arrive at more objective principles and standards.

But human autonomy needs to be balanced, that is, by a **face-to-face encounter**. Human autonomy cannot be the sole and absolute basis for being

dasein and being a *relational subject*. A human person needs to transcend himself through the Other begetting from him obligation and responsibility towards the Other to arrive not only at objective values and necessary principles but at a genuinely meaning-full existence as a human person as *dasein* and *relational subject*. This means that, the human person, now as 'face,' needs to encounter and interact with the 'other face,' to realize his full potential as *dasein*.

The 'face,' according to Emmanuel Levinas, a contemporary French philosopher, as having endowed with a specific role, does not only refer to the expressive front and feature of man; not the plasticity of the visual form, rather it is the theatrical 'production' of the appearance of the person, of man himself. (Smith, 2003) It is through the face that man is able to present in reality the internal conflicts and resolutions happening within him, and realizes it as he then relates to the world. Levinas further stresses the ultimate responsibility of the I for the face. The face is also the Other, the 'not-me', and requires and demands this responsibility precisely because the Other is transcendent. By transcendent, Levinas means the internal struggle of man for 'escape.' 'Escape' he writes "*is the need to get out of oneself, that is, to break what is the most radical and unalterably binding of chains, the fact that the I is oneself*."

The I constructs a world, his own world within his own self, and that this constructed world, is his reality, which has boundaries, limits, and horizons. But when the 'face' of the other intrudes, as in an 'encounter,' it becomes a 'Face-to-Face Encounter.' The constructed horizons and boundaries that he has created, the "our same," the Other, inevitably becomes part of our construction, and becomes part of human reality, an aspect of his existence. (Carriere, 2007) But because the construction of the Other is not as similar with that of the I, it can never be one with 'our same,' with the I. It continuously transcends human attempts to know it. The Other, in a sense, exists outside, despite man's attempt to contain it, to know it, to understand it. It still remains outside of the frame of 'our same,' of our understanding. The Other rises up above the boundaries that he has created, his constructed knowledge, and thus transcends him, transcends the I. The Other becomes *'the one for whom I am responsible. . . the one to whom I have to respond.'* (Carriere, 2007) For as the I encounters the Other, he

realizes the Other's totality as compared on his constructed knowledge of I. If it is done, a form of human relationship is established. This then formulates the *me just here for you* ('me voici'), understanding himself as the *ethical self* towards the responsibility for the Other. (Smith, 2003) Hence, we can say that when the face *encounters* the face, the 'face' cannot but to recognize and embrace the social responsibility he has towards the 'other face'. Given the dynamism of the *face-to-face encounter*, the human person is inclined to exercise his autonomy for beneficence. Through the face-to-face encounter, the human person exercises more and arrives at more meanings with his autonomy.

The Human Person as a *Meaning Making Rational Agent* has **Moral Obligation** and **Social Responsibility**

We have asserted that the human person is *dasein* and at the same time a *relational subject*, leading to the *unity of his moral and practical identities*, through the exercise of his *autonomy* and *face-to-face encounter*. Realizing the level of participation his being demands and entails towards all others as present in his life world, the human person identifies his own sense of moral obligation and social responsibility not only to himself initially but fundamentally to them. The human person now finds meaning in his sense of being as he exists in his life world, assuming the role of a meaning making rational agent, fulfilling therefore the call of his being *being* in terms of moral obligation and social responsibility. He comes to acknowledge that he has to take charge and take care of the *Other*, the *other face*, the one(s) in being-with given the mark of concern and solicitude. The human person now realizes his fundamental human condition.

The Human Person is C**ARE** through Empathy and Compassion

The social life world is generally characterized by the relationship between the *intrasubjective* inner world and the *intersubjective* outer world. Such relationship is an interaction between the *external constraints on ourselves* such as law and culture and *intense self-awareness that reaches out to others* such as moral obligation and social responsibility. This inter-

action operates on the principles of equality and freedom. The I who realizes himself as morally attached and socially connected to the Other treats the Other as co-equal and realizes more his freedom as the I continuously relates with the Other. Such interaction demands new forms of subjectivity and at the same time a reconstruction of law. It invites *new forms of subjectivity* because there is already a difficulty in clearly delineating which is that of the I and the Other in terms of identity and teleology. It suggests reconstruction of law because the I relating to the Other creates a dynamism that promotes empathy and compassion. The two conditions transcend the limitations posed by the relationship. These conditions can be best achieved through ethical proximity (which is the most original form of relation, whereby the Other is truly Other and the I becomes me here for you!), praxis (the teleology of the relational framework is parallel to the greater life plan of the I), solicitude (which is living the good life with and for others), and generalizable desires (where the subjective desires are elevated into collective consensual desires). These four expressions of the two conditions taken together form the fundamental responsibility, which is the basic human condition that forms reasonable basis for rights and rational direction of power. Such *fundamental responsibility* leads to **CARE based on empathy and compassion** as the foundation of equality and freedom and at the same time the locus of power and rights. And this is where an ethic of solidarity i.e. fraternity (made explicitly in i.e. health care) grounds itself. (Sario, 2008) **Hence, the human person is CARE himself taken as the fundamental human condition of being human as I and Other**. Empathy and compassion define the human person as care. Both are essential human qualities that allow one to feel, understand, and respond to the suffering of others. They enable individuals to enter into and maintain relationships of caring. Empathy is the recognition and understanding of one's suffering; it is the feeling of solidarity with and for others. It requires an openness to receiving and holding the other's experience without reservation or judgment. It is the feeling of being one with others. It establishes a deep connection of mutual vulnerability and intimacy. Compassion encompasses empathy. It involves an active concern for and effort to alleviate that suffering. Mother Theresa calls it *love in action*. Without empathy, there can be no compassion. The two strong feelings are explicit forms of care as the fundamental human condition in human reality. Without empathy and compassion, the human person is not

care, both for himself and for others. The human person, not as care, is not dasein; he becomes *dasman*.

Health Care as a Basic Right and as a Social Good

Embracing the idea *that care is the fundamental human condition of being human as I and Other* suggests that we need to contextualize it in many forms, and for our purposes, in health care. Health care is taken as a field and discipline which involves all the essential elements and characteristics of care in order to render the appropriate person preventive, remedial and therapeutic services as he tries to maintain his subjective sense of health and well-being. As such, we need to *view health care as a basic right and as a social good*. (Negrete, *et. al.*, 2009) To do this, the following premises are presented:

1. That health care enables persons to pursue their conceptions of the good and to develop and exercise their moral powers;
2. That health care is inherent, fundamental, imprescriptible, indivisible, universal, and interdependent;
3. That health care is both a moral obligation and social responsibility; and
4. That health care provision is the concrete realization of care taken as the fundamental human condition of being human as I and Other.

Health Care, Moral Powers, and the *Good Life*

Human freedom, better known as self-determination, is said to be the qualifying nature of the human person. Freedom is a liberal value. It is out of freedom that man is able to follow the rules and principles he has formulated to himself in order to attain his personal goals. It becomes a moral obligation on his part to observe these rules as they lead him to the attainment of his end. This is self-determination. The person has the moral duty to make and unmake moral principles that would lead him to good life. And at the same time, this suggests *self-distantiation*. He is able to distance himself from the society as he reflects and discerns

on what principles and maxims are best that would bring him to good life. Human persons, now taken as citizens as free are able to pursue their conceptions of the good given their moral powers. *"Their freedom consists in their possession of the two moral powers, which define their sense of autonomy, but at the same time are conditions for open and communal principles. These moral powers are a capacity for a sense of justice and for a conception of the good."* (Rawls, 1993) Insofar as they have these to the degree necessary to be fully cooperating members of society, they are equal. *"A conception of the good includes a conception of what is valuable in human life. Normally it consists of a more or less determinate scheme of final ends, that is, ends [goals] that we want to realize for their own sake, as well as attachments to other persons and loyalties to various groups and associations."* (Rawls, 1993) Rawls says, *"We also connect such a conception with a view of our relation to the world...by reference to which the value and significance of our ends and attachments are understood."* (Rawls, 1993) The rules that are formulated and followed, though personal in nature, could not be that totally far, separate, and different from the social values. Man, though autonomous (since he is as free is able to make laws for himself), is social in a sense that he is always in a given social milieu. This gives the idea that the rules he has formulated could parallel or cohere to the communal principles. It is because man and society are interconnected and interrelated. The two moral powers bring man to his society. It is they that bridge the gap between the personal rules and social principles. They make the autonomous self as a cooperating member of his society. **They define his autonomy and at the same time his public life.** The autonomous individuals in the society cooperate for the reason of mutual advantage. Each sees the significance of cooperation in realizing and promoting his sense of the good. This suggests that every moral person is able and willing to conform his pursuit of the good to public principles. This leads him to participate in the social deliberations for public principles of justice. He adjusts his aims and aspirations in the light of what he can reasonably expect to provide for. He also restricts his claims in matters of justice to the kinds of things the principles of justice allow. His sense of justice as *"...the capacity to understand, to apply, and to act from the public conception of justice…expresses a willingness...to act in relation to others on terms that they also can publicly endorse."* (Rawls,

1993) His conceptions of the good then must be rational in order to relate those conceptions to the concerns of the social sphere. Rational conception of the good translates itself to become objective and logical. Such rational conception of the good categorically makes connection with the way he stipulates and articulates his sense of justice. It becomes now his desire to conform his pursuit of the good his moral expectations from others to the public social principles of justice. In this way, his sense of justice and conception of the good correlate. This brings in (again) the capacity to cooperate for mutual benefits.

Given such two moral powers and realizing them towards the attainment of the good life, one cannot deny but to accept the fact that as beings-in-the-world in a human world, there is a need to establish and promote health care, which is a basic need taken as a public good given as a basic right.

Human Rights and Health Care

Human rights are basic rights to humane dignified treatment and things one should have access simply because of the fact of being a human person. Hence, human rights, as basic rights, belong to everyone. We all have these rights simply because we are humans regardless of who we are, where we live, and what we do. They represent all the things that are important to us as human beings such as being able to choose how to live our life and being treated with dignity and respect. Human rights are based on a number of core values such as fairness, respect, equality, dignity, and autonomy.

Human rights are taken into account when we speak of health care especially when delivering services to ensure quality care. We can say that human rights and health care are interrelated. Rights are an inherent part of care. Putting human rights at the heart of the way health care services are designed and delivered can make for better services for everyone, with health care professionals exhibiting and practicing the identified core values.

Health care is a human right. It is unlawful for everyone to act in a way that is incompatible or contrary to the establishment and promotion of

health care taken as a universal right. All health care and health care related professionals are called to be fully aware of the impact to human rights of their actions. They should be aware that health care as a human right flows even from a set of rights such as the following:

1. The right not to be tortured or treated in an inhuman or degrading way (absolute right);
2. The right to respect for private and family life, home, and correspondence (qualified right);
3. The right to liberty (limited right);
4. The right to life (fundamental right);
5. The right to a fair trial (absolute right); and
6. The right not to be discriminated against (qualified right).

Health care as a human right is *inherent, fundamental, imprescriptible, indivisible, universal,* and *interdependent*. (Aruego, 1981) Taking the human person as care himself makes it inherent to the human being. It is simultaneous with the very moment of conception. The human person as a being-in-the-world in a human world posits that health care is a primary concern of his existence. As an inherent right, it is fundamental. The human person as dasein necessitates that health care be so basic and as one primary component of human existence. Every moment from conception to birth and from birth to death requires primary and fundamental health care. As both inherent and fundamental, it becomes imprescriptible; it is (to be) taken as a given. It is indivisible, universal, and interdependent by virtue of its being inalienable and absolutely applied to all regardless of one's backgrounds. With all these essential qualities, we need to assert and accept that indeed health care is a basic human right (a qualified right).

Health Care, **Moral Obligation**, and Social Responsibility

Health care, now taken as a fundamental human right, benefiting every human being, becoming a seat of equality for the entire humanity, posits moral obligation from each person and demands social responsibility to each person. It becomes a moral obligation because everyone is bound to uphold and promote health care as a human right. As such, all human

persons are duty bound to respect and assert such right to health care. And since everyone is entitled to such right, everyone also assumes it as a social responsibility. As said, in every moral obligation there is a corresponding social responsibility. Each human person has both the social benefit and social burden in the entire field of health care.

Health Care and the **Fundamental Human Condition** of Being Human as I and Other

Taking health care as a basic human right, enabling persons to pursue their conceptions of the good developing and exercising their moral powers, making it both a moral obligation and social responsibility, leads to the conception that indeed health care as the concrete realization of care, is *the implication of the fundamental human condition of being human as I and Other*.

An Ethic of Health Care

Care, taken as the fundamental human condition of being human as I and Other, presents itself to us as the synthesis of our human nature and human condition. Our nature poses that man is *dasein* and that it is his *historicality* that shapes his understanding of his very own life world. Health care, as the concrete manifestation of care as the fundamental human condition, posits itself as a basic human right regarding itself as a primary social good.

Some concepts and principles serving as strategic principles and substantial mechanisms for an ethic of health care are the following propositions:

1. That the human person is rational and at the same time reasonable;
2. That the 'Four Principles' is the basis for an ethic of health care;
3. That Reflective Equilibrium is the methodology for public reason i.e. health care; and
4. That health care is a political conception of justice as fairness

These principles/mechanisms constitute an ethic of health care that could serve as baselines or framework to approach health care (1) as a concrete manifestation of care as the fundamental human condition of human being as being human, and (2) as a basic human right.

That the **human person** is **rational** and at the same time **reasonable**

In order for us to conceive of an ethic of health care, the idea of the human person must be clear first. We said that the human person must be perceived as holistic, an embodied subjectivity for that matter, not to be taken as fragmented and dualist. The human person must be taken as a synthesis or balance of the rational mind and emotional heart. And to demonstrate such synthesis or balance, the human person must be **re-asserted as rational** but at the same time **asserted as reasonable**. Such demonstration recognizes the embodied subjectivity.

The human person can be seen as rational and at the same time reasonable. The rational is a distant idea from the reasonable and applies to a single, unified agent with the powers of judgment and deliberation in seeking ends and interests particularly its own. (Rawls, 1993) The human person as rational represents pure practical reason, adopts the most effective means to ends, and selects more probable alternatives. Persons are reasonable in the basic aspect when, among equals say, they are ready to propose principles and standards as fair terms of cooperation, and to abide by them willingly, given the assurance that others will likewise do so. (Rawls, 1993) Reasonable persons are not moved by the general good as such that derive for its own sake a social world in which they, as free and equal, can cooperate with others on terms all can accept. (Rawls, 1993) Knowing that people are rational we do not know the ends they will pursue, only that they will pursue them intelligently. Knowing that people are reasonable where others are concerned, we know that they are willing to govern their conduct by a principle from which they and others can reason in common; and reasonable people take into account the consequences of their actions on others' well being. It is by reasonable that citizens enter as equals the public world of others and stand ready to propose, or to accept fair terms of cooperation with them. (Rawls, 1993) They are complementary ideas.

Each is an element in the idea of social cooperation and each connects with the two moral powers.

Hence, the human person, as both rational and reasonable, is to be taken as the nature/condition for ethic of health care. All other principles emanate from such.

That the '**Four Principles'** are the **basis for an ethic of health care**

The Four Principles in Biomedical Ethics are upheld as the basis for an ethic of health care. They are considered to be basis because they provide us a certain framework on how to approach health care given the various situations and contexts facing health care professionals especially when cases have ethical and legal implications. These Four principles are Autonomy, Beneficence, Nonmaleficence, and Justice.

Autonomy, commonly referred to as self-determination and self-governance, has four qualifications (de Gracias & Mappes, 2005), and these are:

1. It must be intentional;
2. It must be based on sufficient understanding;
3. It must be sufficiently free from external constraints; and
4. It must be sufficiently free from internal constraints.

The four qualifications categorically stress the importance of the human free will to will something as categorical expression of autonomy strengthening the full exercise of the human person his liberal value to soar even beyond limits to realize his own conception of the good, and therefore fulfilling his sense of good life.

Beneficence, which is doing good to others, encompasses any act that benefits others. (Edge & Groves, 2006). It is an act of goodness giving emphasis to charity and mercy benefiting others in the process. It tries to relate the exercise of autonomy to the welfare of others, thereby extending the will of autonomy to the will of others.

Nonmaleficence, beneficence negatively stated, stresses that one ought not to inflict evil or harm. Everyone is bound by the general positive law (do good, avoid evil). Each one is forbidden to do something that would cause injury and harm to anyone. As such, nonmaleficence is further strengthened by autonomy when doing good and avoiding evil is already the will of autonomy fostering beneficence.

Justice, which is generally giving one his due, is the main principle that would establish and stabilize the first three principles putting them in harmony and balance as basic principles in health care.

The 'Four Principles' serve as the foundation of all issues in health care. All moral and legal challenges and concerns are based on these principles. Each health care case is studied based on the viewpoint of the four principles. Various ethical principles are followed if they follow and obey the rules as loyal to the four principles.

That **Reflective Equilibrium** is the **methodology for public reason** i.e. health care

Reflective Equilibrium is a coherence account of justification. It is in reflective equilibrium that the main points and areas of certainty for health care are identified. Reflective Equilibrium is the basis of health care; a methodology of public reason.

Reflective Equilibrium is the end-point of a deliberative process in which we reflect on and revise our beliefs about moral or non-moral claims. It consists in working back and forth among our considered judgments or intuitions. It comprises particular instances or cases and principles or rules that we believe govern these intuitions or judgments. It contains theoretical considerations that we believe bear on accepting these considered judgments, principles, or rules. But it also includes the possibility and capacity of revising any of these elements if necessary to achieve adequate coherence among them. It allows possible revisions to set up health care as a right.

Reflective Equilibrium promotes reasoning and inquiry, concept formation, and meaning making. Rational and reasonable judgments serve as bases for a reflective equilibrium. Hence, health care is one main object/subject in the reflective equilibrium. The right to die, assisted suicide, Do Not Resuscitate Orders (DNRs), the right to privacy, the right to informed consent/choice, generic drugs, and therapeutic abortion are some cases/examples needing some public reason in order to arrive at better judgments, better reasons, and therefore better decisions through reflective equilibrium. Through such methodology, reasoned criteria are articulated for better judgments for both legal and moral situations and cases. Reflective Equilibrium is the venue for all stakeholders in health care to discuss, argue, debate, on issues and concerns affecting health care.

Correct judgments are the causes of good management and human wisdom. Errors in judgment result into difficulties, problems, and tragedies of individual activities and social organizations. The kind of judgment we have and do affect human events. It even holds the fate of things of importance. Attitudes presuppose judgments. To understand human actions is to know the attitudes that are formed behind them, which explain to us the nature of judgments and reason for the actualization of these judgments.

To make good judgments we must possess the ability, the inclination, and the sensitivity to learn from what we experience. We register what we have learned by formulating and using criteria. Sound judgments are those which are based on good criteria. The cultivation of good judgment requires each person to examine our own attitudes, values, and behavior. Such examination, in turn, involves reflecting and deliberating on experience and altering one's thinking when necessary. Judgments involve thinking rationally and logically. But we also need to question our own judgments, and hence our criteria. We should recognize and accept (and appreciate) that there are other judgments and criteria. To arrive at better judgments, we should look for better criteria. *Better criteria sometimes, if not most of the times, are found in others' judgments and criteria.* A person should be reasonable in this respect. It is in his being reasonable that he is able to compare, contrast, test, and evaluate his own judgments. It is only after some judicious examination (which involves of being sensitive to other ideas) that we can have

better judgments. Better judgments posit better criteria. The criteria that would define, determine, and describe better judgments should be reasoned criteria. By reasoned criteria we mean the criteria that are more objective and are mutually acceptable among a reasonable group of persons. In this sense, reasoned criteria are crucial for better judgments. Reasoned criteria transcend bases for good decisions; they assume universality. Hence, people cannot but to submit to them. Through Reflective Equilibrium, such reasoned criteria are articulated.

That **health care is a political conception of justice as fairness**

A liberal political conception of justice as fairness must consider in broad sense not only in positing and securing rights and measures but also the significance of forming and raising (moral) obligations in the whole sphere of justice. We may be very active promoting our secured rights but forgetting the responsibility and obligation these rights and measures entail on the individual and social spheres of justice. Health care can be formulated and strategized based on the knowledge of citizens of their obligation to do their part in optimizing and maximizing their roles as free and equal, reasonable and rational.

In order to establish health care in the atmosphere of liberal political conception of justice as fairness, some substantive principles must be placed first to make the environment conducive to the construction of a philosophy of the human person towards an ethic of health care. The substantive principles are: (1) prioritizing basic rights and liberties (such as the right to health care and the rights enumerated above); (2) encouraging cooperative political virtues (promoting a public political culture conducive to health care as a basic human right); (3) promoting social cooperation (to recognize, appreciate, and embrace the principle that care, i.e. health care, is a fundamental human condition of being human); (4) enhancing reflective equilibrium (to arrive at reasoned and better criteria eliciting better judgment on health care issues and concerns having moral and legal implications); and (5) facilitating public reason (widening the collective consciousness of everyone in matters of right, justice, and good).

Conclusion

The paper has argued that human nature and human condition can be seen in a synthesis through the concept of care re-interpreted as the fundamental human condition of being human as I and Other, that is, *human nature* is defined as care which is the fundamental *human condition* at the same time. Such argument was substantiated by asserting the following claims: (1) That the human person is dasein; (2) That the human person is a relational subject; (3) That there is consistency and conformity to the moral and social identities of the human person; (4) That face-to-face encounter leads the human person to autonomy that form part human capacities; (5) That the human person as a meaning-making rational agent finds and justifies his existence through sense of moral obligation and social responsibility; and (6) That the human person is CARE as seen through empathy and compassion.

Embracing the idea *that care is the fundamental human condition of being human as I and Other* suggests that we need to contextualize it in many forms, and for our purposes, in health care. As such, we viewed health care as a basic right and as a social good. We explicated on the following premises to establish such view: (1) That health care enables persons to pursue their conceptions of the good and to develop and exercise their moral powers; (2) That health care is inherent, fundamental, imprescriptible, indivisible, universal, and interdependent; (3) That health care is both a moral obligation and social responsibility; and (4) That health care provision is the concrete realization of care taken as the fundamental human condition of being human as I and Other.

Care, taken as the fundamental human condition of being human as I and Other, presents itself to us as the synthesis of our human nature and human condition. Our nature poses that man is *dasein* and that it is his *historicality* that shapes his understanding of his very own life world. Health care, as the concrete manifestation of care as the fundamental human condition, posits itself as a basic human right regarding itself as a primary social good. Some concepts and principles serving as strategic principles and substantial mechanisms for an ethic of health care are the following propositions: (1) That the human person is rational and at the same time

reasonable; (2) That the 'Four Principles' is the basis for an ethic of health care; (3) That Reflective Equilibrium is the methodology for public reason i.e. health care; and (4) That health care is a political conception of justice as fairness. These principles/mechanisms constitute an ethic of health care that could serve as baselines or framework to approach health care (1) as a concrete manifestation of care as the fundamental human condition of human being as being human, and (2) as a basic human right.

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AN ASSESSMENT OF THE SOLID WASTE MANAGEMENT PRACTICES OF SELECTED BARANGAYS IN DARAGA, ALBAY

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Abstract

The Ecological Solid Waste Management Act of 2000 (RA 9003) provides the framework for the adoption of a systematic, comprehensive, and ecological solid waste management program of the local government units. This paper is a presentation of the salient features of the solid waste management practices of Barangays Alcala, Kidaco, Kilicao, Kiwalo, Lacag, Penafrancia and Sagpon of the Municipality of Daraga, Province of Albay. Using the descriptive method of research and utilizing the survey questionnaire as an instrument, with 558 respondents, the following were determined: 1) Situation of selected communities in terms of educational attainment, family income, family size and house structure; 2) Extent of solid waste management practices by the households in terms of hazardous and non-hazardous wastes; 3) Issues and concerns encountered in the practice of solid waste management; and 4) Nursing measures that can be afforded to improve existing SWM practices and address the problems on solid waste management practices. Findings identify the lack of knowledge in handling household hazardous wastes and the continuous practice of burning of dried leaves, scrap of woods and other biodegradable materials despite being prohibited. Good practices such as recycling plastic materials, bottles and containers, composting and segregating non-biodegradable and biodegradable wastes are often or sometimes applied by households. At the

core of the issues and concerns in the solid waste management is the poor attitude of the people towards proper solid waste handling coupled by the ineffectiveness of the government itself in the implementation of solid waste management programs. These issues and concerns can be addressed through intensive advocacy on the observance of the existing government programs on environmental sanitation e.g. Campaign on Clean and Green, Tangod ko, Linig ko and a strong IEC campaign on solid waste management. In promoting solid waste management, nursing plays a key role specifically in educating people on the importance of maintaining a clean environment.

Keywords: solid waste management practices, nursing measures, assessment

Introduction

An Assessment of Solid Waste Management (SWM) practices of Barangays Alcala, Kidaco, Kilicao, Kiwalo, Lacag, Peñafrancia and Sagpon of the Municipality of Daraga, Province of Albay was done respectively by different groups of Level 4 Block 4 Nursing Students of Aquinas University College of Nursing and Health Sciences (CNHS).

The assessment anchors primarily on Florence Nightingale's Environment Theory (Kozier, *et.al.*), that focuses on changing and manipulating the environment in order to put every individual in the best possible conditions for nature to act. Nightingale advocates that a healthy environment should not only exist in hospitals alone but also in communities and at home.

The bottom line of the assessment was to determine the role of nursing to maintaining health and proper sanitation within communities and homes as an effective strategy to promoting health and preventing illness.

This was done in conjunction with the critical responsibility local government units (LGUs) have assumed under Republic Act 9003, otherwise known as Ecological Solid Waste Management Act of 2000. The Act re-

tains with the LGUs the primary enforcement and responsibility of solid waste management as mandated under the 1991 Local Government Code of the Philippines within the spirit of public-private sector cooperation.

Within this backdrop, the assessment aimed to understand the following:

1. Situation of selected communities in terms of educational attainment, family income, family size and house structure;
2. Extent of SWM practices by the households in terms of hazardous and non-hazardous wastes;
3. Issues and concerns encountered in the practice of SWM; and
4. Nursing measures that can improve existing SWM practices and address the problems on SWM practices.

SWM Situation of Target Communities

Among the 54 barangays in Daraga, Alcala, Kidaco, Kilicao, Kiwalo, Lacag, Peñafrancia and Sagpon were selected for the assessment based on their relative experience and reputation in managing their solid wastes.

In terms of classification, Barangays Kilicao and Sagpon are considered urban and the rests rural. This situation of the barangays provides a picture of the challenges these communities confront in managing their solid wastes specifically in terms of the extent of solid wastes they produced and disposed and the availability of or access to services related to sanitation and garbage collection afforded by the municipal government.

As the research groups observed, urban barangays such as Sagpon, the most densely populated barangay in Daraga, experienced more problem in terms of SWM. Although Sagpon is more accessible to government services related to SWM than rural barangays, its burgeoning population due to the influx of transients results in unabated waste accumulation which if poorly managed, could have negative impact to the health of its residents.

The rural barangays have different experiences in SWM. Among these barangays, Alcala seems to have households which began proper solid

wastes disposal. The research group assigned to assess this barangay reported that residents "*separate biodegradable from non-biodegradable, and wastes that can be sold to junkshops such as metals, glassware and products made of plastics which can still be recycled*."

However, the other rural barangays, due to irregular or absence of garbage collection services because of their distance from the town center, retain the traditional mode of disposing wastes. Wastes are not segregated instead they are burned together. The research groups also observed the poor sanitary condition of these barangays due to absence of public toilets and lavatories at home.

Of the barangays assessed, the condition of Barangay Peñafrancia poses a grim situation in terms of SWM. Purok 2 of this barangay hosts an active solid waste open landfill for several years now. The landfill is on a five-hectare private land rented by the Daraga LGU. Reports show that the residents near the landfill suffer in terms of health, environmental and sanitary condition.

Methodology

The assessments used the descriptive survey method with a survey questionnaire as tool. The survey questionnaire was designed to have four parts, namely: 1) profile of the respondent; 2) SWM practices of the respondent; 3) issues and concerns encountered in the practice of SWM; and 4) nursing measures that can improve existing SWM practices and address the problems on SWM practices

The instrument was pre-tested by research groups and reviewed by research advisers prior to actual data gathering. Stratified random sampling was applied to get the household samples. Using Slovin formula with 10 percent margin of error, a total of 558 household respondents from all target barangays were identified. The respondent per household was either the head of the family or a household member capable of answering the questionnaire.

After the field work, the data were analyzed and interpreted. Statistical treatment of the data includes frequency, mean, percentage, and ranking.

Results and Discussion

I. *Situation of selected communities in terms of educational attainment, family income, family size and house structure*

Table 1 summarizes the profile of the respondents in terms of educational attainment, family income, family size and house structure.

Table 1. **Profile of Respondents**

Indicators/ Barangay	Alcala	Kidaco	Kilicao	Kiwalo	Lacag	Peñafrancia	Sagpon	Total	%
	f	*f*	*f*	*f*	*f*	*f*	*f*		
Educational Attainment									
Elementary	29	19	6	11	11	7	4	87	16%
Elementary Undergraduate	8	4	2	4	0	5	0	23	4%
High school	22	11	12	28	15	20	6	114	20%
High school Undergraduate	4	20	18	13	4	3	4	66	12%
College	8	9	26	9	25	21	45	143	26%
College Undergraduate	10	8	14	6	10	20	22	90	16%
Vocational	0	1	12	0	0	7	11	31	6%
Others	0	0	0	0	2	1	1	4	1%
Total	*81*	*72*	*90*	*71*	*67*	*84*	*93*	*558*	*100%*
Family Income									
below 1,000	26	19	12	22	8	8	11	106	19%
1,001-5,000	40	42	52	39	32	41	38	284	51%
5,000-10,000	11	8	22	9	22	21	36	129	23%
above 10,000	4	3	4	1	5	14	8	39	7%
Total	*81*	*72*	*90*	*71*	*67*	*84*	*93*	*558*	*100%*
Family size									
1 to 3	23	22	22	14	12	15	16	124	22%
4 to 6	30	34	54	36	34	48	60	296	53%
7 to 10	26	16	13	18	15	21	16	125	22%
above 10	2	0	1	3	6	0	1	13	2%
Total	*81*	*72*	*90*	*71*	*67*	*84*	*93*	*558*	*99%*

Indicators/ Barangay	Alcala	Kidaco	Kilicao	Kiwalo	Lacag	Peñafrancia	Sagpon	Total	%
	f	*f*	*f*	*f*	*f*	*f*	*f*		
House Structure									
Concrete	19	11	14	4	34	25	63	170	31%
Semi concrete	44	36	50	35	21	44	28	258	46%
Makeshift	18	25	26	31	12	15	2	129	23%
Total	*81*	*72*	*90*	*70*	*67*	*84*	*93*	*557*	*100%*

Educational Attainment

Of the 558 respondents from the 7 barangays, 143 or 26% are college graduates, 114 or 20% are high school graduates, 90 or 16% are college undergraduates, 31 or 6% have taken up vocational courses, 66 or 12% are high school undergraduates, 87 or 15% are elementary graduates, 23 or 4% are elementary undergraduates and 3 or 1% belong to *others*.

The data show that the majority of the households selected for the assessments have family members who finished tertiary or secondary education. Generally, all households have family members who have gone to school.

The assessments point out that there is no straightforward relationship between SWM practices and educational attainment.

Family Income

The income data show that, despite higher educational attainment, the majority of the respondents have income below the poverty threshold. There are 284 respondents or 51% who have a monthly income of PhP1,001 to 5,000, 129 repondents or 23% have PhP5,000 – 10,000 monthly income and 106 or 19% with a monthly income below PhP1,000. Only 39 or 7% have a monthly income of more than PhP10,000.00 just enough for their families to survive.

Bhattarai (2002) in a paper on Household Behavior on Solid Waste Management: A Case of Kathmandu Metropolitan City, establishes that waste is a function of consumption. Increase in income is expected to increase the demand for convenience factors and services embodied in commodities. This implies that families with high income may generate more wastes.

Low-income families, as represented by the majority of respondents, have the tendency to reuse and recycle their wastes to lessen their expenditure and optimize their meager income for basic needs. Rather than buying new materials, they reuse old ones. This is supported by the data in Table 2, that households often practice recycling bottles, plastic bags and containers. Likewise, low-income families take advantage of the benefits that wastes can offer to augment their income.

However, low income families and communities have limited resources in affording themselves the material and technological requirements of SWM which requires government support.

Family Size

While most of the respondents have low income, the majority of the respondents belong to a household with 4 members and more. More than half of the respondents (i.e., 296 or 53%) belong to a household of 4-6 members, 125 or 23% belong to a household of 7-10 members while 13 or 2% belong to a household with more than 10 members. Only 124 or 22% belong to a household of 1-3 members.

A study on "Factors Which Influence Household Waste Generation" by Jones, *et.al.*, identifies that waste generating potential of households is dependent on several factors. The most important among these factors is household size, i.e. the number of persons present in a household.

This factor influences the rate of generation of several categories of waste, including packaging wastes, kitchen wastes, miscellaneous plastic wastes and miscellaneous combustible wastes. The study demonstrates that the effect of this factor was the same in each case, i.e., as the number of persons in the household increases, the amount of wastes produced by the household also increases.

This implies that larger households contribute significantly to the total amount of waste the communities produced. Thus, with more wastes disposed, the greater is the challenge for communities to manage their

wastes. As the population of the country grows, the amount of solid wastes also increases which become an environmental hazard. It is sad to note that as much as 50% of these wastes are finding their way into the ocean. Improper waste disposal endanger the livelihood and source of protein of most communities in the world (De Sagun, *et.al.,* 2010).

On the positive side, larger households may also mean more human resources to help in waste management of their homes and communities.

House Structure

House structures of the respondents vary from concrete to makeshift. The majority of the respondents have semi-concrete (i.e., 258 or 46%) and concrete dwellings (i.e., 170 or 31%) which can protect them from typhoons regularly visiting the region. Only 129 or 23% of respondents live in makeshift houses.

II. Extent of SWM practices by the households in terms of hazardous and non-hazardous wastes

Tables 2 and 3 below present the extent of SWM practices by the households in terms of hazardous and non-hazardous wastes.

The practices were rated based on mean interpretation using the rating scale below:

Scale	*Rating*	*Interpretation*
3.55 - 4.00	Often	*Practiced at all times (5 times out of 5)*
2.55 - 3.44	Always	*Practiced from time to time (4 times out 5)*
1.55 - 2.54	Sometimes	*Practiced rarely (3 times out of 5)*
0.55 - 1.54	Seldom	*Practiced if necessary (2 times out of 5)*
0 - 0.54	Never	*Never practiced*

For hazardous wastes, practices that are sometimes or practiced rarely include the following: 1. Discharged batteries are placed in a trashcan for disposal to

landfill (2.26), 2. Burning of plastics on the ground (2.22), 3. Broken fluorescents are picked up by hard cardboard and placed on a sealed plastic (2.06), 4. Burying of broken glasses and plastics on the ground (1.91), 5. Throwing chemical containers on an open dump pit (1.82), 6. Dumping broken glasses and plastics on the ground (1.78), and 7. Discharged batteries and broken fluorescent are buried on the ground (1.68).

Table 2. **Solid Waste Management Practices of the Respondents *(Hazardous Wastes)***

Indicators	Mean	Interpretation
1. Discharged batteries are placed in a trash-can for disposal to landfill	2.26	sometimes or practiced rarely
2. Burning of plastics on the ground	2.22	sometimes or practiced rarely
3. Broken fluorescents are picked up by hard cardboard and placed on a sealed plastic	2.06	sometimes or practiced rarely
4. Burying of broken glasses, and plastics on the ground	1.91	sometimes or practiced rarely
5. Throwing chemicals containers on an open dump pit	1.82	sometimes or practiced rarely
6. Dumping broken glasses, and plastics on the ground	1.78	sometimes or practiced rarely
7. Discharged batteries and broken fluorescent are buried on the ground	1.68	sometimes or practiced rarely
8. Broken fluorescent are picked up by bare hand cautiously and thrown to the trashcan	1.33	seldom or practiced if necessary
9. Empty pesticide containers are tripled rinse before they are thrown and wrapped in a newspaper and discarded with household trash	1.31	seldom or practiced if necessary
10. Thinners and used oil are used to ignite fire	1.15	seldom or practiced if necessary
11. Paints, thinners and used oil and other chemicals are poured on the ground or thrown into the river	0.86	seldom or practiced if necessary
12. Paints, thinners and used oil and other hazardous chemicals are flushed on the toilet	0.73	seldom or practiced if necessary

As shown in Table 2, while families often practice recycling bottles, plastic bags and containers, their "old habits" which are prohibited under the law such as burning of dried leaves, scrap of woods and other biodegradable materials are also oftentimes practiced, in spite of the high educational attainment of the respondents.

Although there is likelihood that, those who have gone through lengthier schooling, may have more exposure to SWM-related knowledge and/or activities. This situation would help them to be more responsible and responsive when it comes to applying proper SWM practices in their respective communities.

SWM is now integrated in the curriculum and co-curricular activities of formal schools in the Philippines. Recently, the Supreme Court directed government agencies including DepEd to "*integrate lessons on pollution prevention, waste management, environmental protection, and like subjects in the school curricula of all levels to inculcate in the minds and heart of the students, and through them, their parents and friends, the importance of their duty towards achieving and maintaining a healthy and balanced ecosystem*..." (at http://positivenewsmedia.ca, January 13, 2010)

In addition, there is also high possibility that educated individuals or households may have more literacy to understand and cooperate in SWM-related programs of their respective communities. The experience of Barangay Alcala, for one, promoting wastes segregation, is a good example of this community action.

Practices that are seldom employed or resorted if necessary include the following: 1) Broken fluorescent are picked up by bare hand cautiously and thrown to the trashcan (1.33), 2) Empty pesticide containers are tripled rinse before they are thrown and wrapped in a newspaper and discarded with household trash (1.31), 3) Thinners and used oil are used to ignite fire (1.15), 4. Paints, thinners and used oil and other hazardous chemicals are poured on the ground or thrown into the river (0.86), and 5. Paints, thinners and used oil and other hazardous chemicals are flushed on the toilet (0.73).

For ***Hazardous Wastes***, the residents of Barangays Kidaco, Kiwalo and Sagpon never practiced flushing of paints, thinners and used oil and other hazardous chemicals into the toilet. Barangays Kiwalo and Sagpon never practiced pouring on the ground and throwing paints, thinners, used oil and other hazardous chemicals into the river. Barangay Sagpon never practiced burying of broken glasses, and plastics on the ground as well as dumping broken materials on the ground. The people of these barangays do not practice improper disposal of hazardous wastes.

Another information to note, Barangay Kiwalo also never practiced throwing empty pesticide containers before wrapping them in newspaper and discarding them with household trash.

According to RA 9003, hazardous waste shall refer to solid waste or combination of solid waste which because of its quantity, concentration, or physical, chemical or infectious characteristics may:

1. cause, or significantly contribute to an increase in mortality or an increase in serious irreversible, or incapacitating reversible, illness; or
2. pose a substantial present or potential hazard to human health or the environment when improperly treated, stored, transported, or disposed of, or otherwise managed.

In the same law, household hazardous wastes refer to as special wastes which include paints, thinners, household batteries, lead-acid batteries, spray canisters and the like. These include wastes from residential and commercial sources comprised of bulky wastes, consumer electronics, white goods, yard wastes that are collected separately, batteries, oil, and tires. These wastes are usually handled separately from other residential and commercial wastes.

Sections 21 and 22 of RA 9003 provide for mandatory segregation of solid wastes and the requirements for the segregation and storage of solid wastes respectively. It stated that pending on-site collection, such special wastes shall be segregated from other wastes and placed on a solid waste container marked “special wastes.”

The findings show that there is lack of knowledge on the proper procedure of discarding such waste materials. Likewise, lack of compliance is also brought about by inefficiency or even the non-collection of garbage especially in far-flung barangays.

If this practice continues, these special wastes may pose a greater risk to the environment and human health than non-hazardous wastes. Improper disposal of hazardous items may pose health risks most especially to those people who live near or within waste disposal sites, as in the case of Brgy. Peñafrancia.

The case of Brgy. Kidaco mentions some detrimental effects of special wastes such as discharged batteries, thinners and paints which are thrown into trash cans or landfills. These wastes could harm the environment by seeping through the soil, and eventually affecting sources of water, which may harm plant, animal and even human life. Burning plastic materials causes air pollution and destroy the ozone layer.

Table 3. **Solid Waste Management Practices of the Respondents *(Non-Hazardous Wastes)***

Indicators	Mean	Interpretation
1. Burning of dry leaves, scrap of woods and other biodegradable materials	3.17	often or practiced at all times
2. Throwing non-hazardous wastes on the household thrash	2.76	often or practiced at all times
3. Recycling of bottles, plastics bags, containers etc.	2.63	often or practiced at all times
4. Composting by leaving the freshly mowed clippings on the lawn	2.38	sometimes or practiced rarely
5. Segregation of non-biodegradable and biodegradable materials	2.23	sometimes or practiced rarely
6. Burying kitchen scraps such as food vegetable leftover on the trench or hole	1.63	seldom or practiced if necessary
7. Throwing non-hazardous waste on the river	0.97	seldom or practiced if necessary

Given this situation, the need to conduct information dissemination on the laws of solid waste management, the proper ways of handling, storing, segregating and disposing of special wastes and the ill-effects of improper special wastes management, should really be addressed.

For ***Non-Hazardous Wastes***, the respondents indicate the following extent of practice. Practices that are often done or practiced at all times include: 1. Burning of dried leaves, scrap of woods and other biodegradable materials (3.17), 2. Throwing non-hazardous wastes on the household trash (2.76), and 3. Recycling of bottles, plastic bags, containers, etc. (2.63). Practices that are sometimes or practiced rarely include 1. Composting by leaving the freshly mowed clippings on the lawn (2.38), and 2. Segregation of non-biodegradable and biodegradable materials (2.23). Practices that are seldom or practiced if necessary include 1. Burying kitchen scraps such as food vegetable left-over on the trench or hole (1.63) and 2. Throwing non-hazardous waste on the river (0.97).

It is good to note that Barangays Kidaco, Kiwalo, Peñafrancia and Sagpon never practiced throwing non-hazardous wastes on the river.

The traditional practice of burning of dry leaves, scrap of woods and other biodegradable materials is still widely practiced across all the communities under study despite being prohibited.

Section 48 of RA 9003 prohibits the open burning of solid wastes. The Province of Albay has passed several resolutions in support of its agenda to mainstream climate change adaptation through local government action. Among the most significant resolution is an SP Ordinance strengthening Section 48, Item 3, Chapter 6 of RA 9003, which bans “open burning” and provides local mechanism for enforcement at the barangay or village level (Rangasa,2009). In spite of this law, the assessments indicate that people still could not do away with their “old habits”.

Good practices such as recycling plastic materials, bottles and containers, composting and segregating non-biodegradable and biodegradable wastes are often or sometimes applied by households.

Thus, this situation calls for a need to strengthen and sustain such good practices among communities/households.

III. Issues and concerns encountered in the practice of SWM

Table 4 presents the indicates issues and concerns encountered by the respondents in the practice of SWM, ranked accordingly.

Table 4. **Issues and Concerns Encountered in the Practice of SWM**

Indicators	*f*	*%*	*Rank*
1. Poor attitude of people towards proper solid waste handling	301	54%	**1**
2. Lack of law to punish sanitary offenders	281	50%	**2**
3. Presence of several vector-borne areas in the community	263	47%	**3**
4. Ignorance and negligence of local residents on solid waste management	260	46%	**4**
5. Irregular services rendered to producers of refuse by municipal councils compel them to find ways of disposing refuse improperly	247	44%	**5**
6. Lack of waste disposal culture as well as inadequacy of waste disposal facilities	228	41%	**6**
7. Indiscriminate dumping	226	40%	**7**
8. Inadequate involvement of local groups in solid waste management side by side with the operations of government agencies	218	39%	**8**
9. Resistance towards change on solid waste management due to cultural derivatives, beliefs, perceptions and attitudes	207	37%	**9**

As can be gleaned from the table, the most dominant concern is the poor behavior of people towards proper solid waste handling. Other related to behavioral concerns are: 1) Ignorance and negligence of local residents on solid waste management (no. 4); 2) Lack of waste disposal culture as well as inadequacy of waste disposal facilities (no. 6); 3) Indiscriminate

dumping (no. 7); 4) Inadequate involvement of local groups in solid waste management side by side with the operations of government agencies (no. 8); and 5) Resistance towards change on solid waste management due to cultural derivatives, beliefs, perceptions and attitudes (no. 9).

As mentioned earlier, the poor attitude of people towards proper solid waste handling is the major problem. If this scenario continues all government efforts on SWM will be futile. People who value health will not hesitate to participate in proactive efforts in managing wastes within their homes and communities. Educating people on the need to manage wastes as a means of promoting health and preventing illness is vital. All persons should understand their key role in maintaining a clean and healthy environment.

There was a concern pertaining to the presence of several vector-borne areas in the community, mainly due to unsanitary condition.

Laws related to SWM are already in place at the national and local levels. RA 9003 or the "Ecological Solid Waste Management Act of 2000" has outlined the necessary provisions for proper management of solid wastes. This law as well as other laws pertaining to SWM should be made known to people, and strictly enforced and implemented. It has to be recognized that SWM is a joint responsibility between the community and the government.

IV. Nursing measures to improve existing and other related problems on SWM practices

While there are issues and concerns confronted in managing SWM, there are also nursing measures that can be afforded to address these and enhance SWM practices in these communities as shown in Table 5. These nursing measures the respondents based on their priorities.

As indicated in Table 5, the recommended nursing measures boil down to advocacy activities and intensive information and education campaign (IEC). There is a need to push for a more rigorous promotion and implementation of environmental sanitation programs of the government, such as Clean and Green, Tangod ko, Linig ko, among others.

Table 5. **Nursing Measures to Improve SWM practices**

Indicators	*Mean*	*Rank*
1. Intensify advocacy on the observance of the existing government programs on environmental sanitation e.g. Campaign on Clean and Green, Tangod ko, Linig ko	2.07	**1**
2. Conduct health education/ seminars regarding Solid Waste Management (SWM)	2.67	**2**
3. Intensify education campaign regarding proper segregation of Biodegradable and Non-Biodegradable solid waste	2.81	**3**
4. Encourage 4 o'clock habit to avoid the occurrence of dengue	3.51	**4**
5. Eradicate vector-borne areas within their vicinity	3.89	**5**

Strengthening information and education campaign on SWM is also imperative. This way the limited knowledge of the communities on SWM identified could be addressed. This knowledge would then pave the way for a change in people's attitude toward waste and its management. A more supportive and participative community and a strongly willed government will ensure a successful SWM in communities.

Apparently, nursing plays a vital role in promoting SWM specifically in educating people on the importance of maintaining a clean environment to promote health and prevent illness, which can be part of government activities in relation to SWM.

Recommendations

From the findings of the assessment, the different research groups advanced the following recommendations to improve SWM practices in the target communities:

1. Conduct IEC activities in the barangay regarding SWM with emphasis on 3 R's (reuse, reduce and recycle), segregation of hazardous and non-hazardous wastes, proper handling of household hazardous wastes and the bad effects of open burning to their health and the environment,

2. Conduct a training for local government officials related to SWM,

3. Advocate activities that promote environmental sanitation such e.g. Campaign on Clean and Green, Tangod ko, Linig ko involving the barangay residents, NGO's and other local groups,

4. Strict enforcement of SWM laws,

5. Encourage local partners/stakeholders through the barangay officials to be take active part in SWM programs, and

6. Eradicate of vector-borne areas.

It is also advised that the different research groups return to their respective research sites to present the findings of the study and discuss ways to jointly advocate SWM among the residents of the barangay.

Other areas for further study are:

1. Assessment of SWM Program of the Barangay vis-à-vis Role of the DOH

2. Emerging benefits of SWM program to families/communities

3. Current strategies for health education on SWM

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INFECTION CONTROL PRACTICES OF MEDICAL WARD PERSONNEL OF SELECTED AFFILIATED HOSPITALS, AQUINAS UNIVERSITY

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Abstract

The paper assessed the Infection Control Practices of the Medical Ward Personnel of Selected Affiliated Hospitals of Aquinas University of Legazpi College of Nursing and Health Sciences. These hospitals include Ziga Memorial District Hospital (Ziga), Josefina Belmonte Duran Memorial District Hospital (Josefina Duran) and Dr. Fernando B. Duran Memorial Hospital (Fernando Duran). The results show that the Infection Control Practices in terms of standards concerning employees, in general, as perceived by the Medical Ward personnel of selected affiliated hospitals of Aquinas University of Legazpi College of Nursing and Health Sciences are "sometimes" practiced in Ziga (2.5) and Fernando Duran (2.9) but "often" practiced in Josefina Duran (3.5). These practices include those of the Infection Control Team and the Medical Ward Personnel. The Infection Control Team is "seldom" functional in Ziga (2.3) and Fernando Duran (2.2) however "often" functional in Josefina Duran (3.7). The results further

illustrate that the Infection Control Committee performs better than the Infection Control Team in Ziga and Fernando Duran, in which the standards for the ICC are "sometimes" practiced in Ziga (2.5) and Fernando Duran (2.6). However, the standards for the ICC and ICT in Josefina Duran are "often" practiced with a mean rate of 4.1 for the ICC standards. The study concludes that the status of the Infection Control Practices in terms of standards concerning employees is satisfactory in Ziga and Fernando Duran while very satisfactory in Josefina Duran. Infection Control Practices in terms of Medical Ward standards, collectively, are often practiced by the medical ward personnel of Josefina Duran (4.1) and Fernando Duran (3.5) while practiced sometimes in Ziga (3.0). A very satisfactory performance of infection control practices in Josefina Duran and Fernando Duran in terms of Medical Ward Standards is observed, while a "satisfactory" performance observed for Zìga. The study gives a clear picture of the problems encountered by the medical ward personnel in implementing infection control standards. Among these which appeared on top of the problems encountered in all three hospitals are: Understaffed Infection Control Team in the medical ward and insufficient availability of resources and equipment necessary to implement infection control; Lack of personnel trainings and seminars on infection control issues; Insufficient number of trained ICNs; and Inadequate support from the Infection Control Team.

Keywords: Infection Control, Nosocomial Infection, Healthcare-Associated Infection, Infection Control Practices

Infection Control in Hospitals: A Worldwide Problem

Nosocomial (hospital-acquired/healthcare-associated) infections are significant causes of morbidity and mortality in every health care system. Common nosocomial infections include pneumonia, decubitus ulcers, urinary tract infections, respiratory tract infections, surgical site infections and bloodstream infections. Outbreaks of these infections, in fact, have effects on both the clinical and economic perspective, particularly those healthcare facilities with limited resources. Outbreaks could affect numerous patients as well as staff,

thus unnecessarily consume further scarce resources. Furthermore, worldwide increases in the resistance of infectious organisms to common antimicrobials multiply the difficulties and expense of treating hospital infections. Overuse of antibiotics has increased the prevalence of Multi-Drug Resistant Organisms as emphasized by the Center for Disease Control (1996). Scott (2009) firmly believes that healthcare-associated infections (HAIs) in hospitals impose significant economic consequences on the nation's healthcare system.

Sound hospital infection control programs are essential in order to reduce the risk of serious, preventable, costly infections for patients and health care workers. Implementation of infection control programs in low- and middle-income countries is frequently hampered by financial constraints, limited laboratory capacity, and inadequate staff training in areas such as hand hygiene, sterilization procedures, isolation precautions, employee health programs, hospital epidemiology, and quality improvement. It is for this reason that the Infection Control Assessment Tool (ICAT) was formulated by the Rational Pharmaceutical Management Plus in 2006. The ICAT is a systematic approach to detect deficiencies in infection control practices. It also provides an approach that can be used by hospital staff to identify and solve problems economically and practically in low-resource health care facilities.

Problem Statement

The study aimed to assess the Infection Control Practices of the Medical Ward Personnel of Selected Affiliated Hospitals of Aquinas University of Legazpi College of Nursing and Health Sciences namely: Ziga Memorial District Hospital (Ziga), Josefina Belmonte Duran Memorial District Hospital (Josefina Belmonte) and Dr. Fernando B. Duran Memorial Hospital (Fernando Duran). It also sought answers to the following sub-problems: 1. What is the status of the infection control practices of the personnel at the medical ward of the selected affiliated hospitals of Aquinas University of Legazpi College of Nursing and Health Sciences in terms of: a. standards concerning employees and b. medical ward standards 2. What are the problems encountered in the implementation of infection control standards at the medical ward of selected affiliated hospitals of Aquinas University of Legazpi College of Nursing and Health Sciences?

The study utilized the descriptive method of research, a fact-finding endeavor which involves the description, recording, collection, presentation and interpretation of data. The descriptive method was used to determine the status of infection control practices of the personnel at the medical ward of the selected affiliated hospitals of Aquinas University of Legazpi College of Nursing and Health Sciences. Ninety six (96) respondents consisting of utility personnel, staff nurses, doctors, institutional workers and medical technologists were randomly selected and asked to accomplish the survey questionnaire. The questionnaire, the main instrument used in data gathering consisted of two parts: Part I dealt with the status of infection control practices along: (1) standards concerning employees and (2) medical ward standards; and Part II dealt with the problems encountered in the implementation of infection control standards at the medical ward of selected affiliated hospitals of Aquinas University of Legazpi College of Nursing and Health Sciences. The study utilized the statistical tools such as frequency count, percentage, and ranking, and the modified Likert scale as follows:

Scale	*Range*	*Interpretation*
5	4.5 – 5.0	*Always*
4	3.5 – 4.49	*Often*
3	2.5 – 3.49	*Sometimes*
2	1.5 – 2.49	*Seldom*
1	1.0 – 1.49	*Never*

The Status of Infection Control Practices of the Medical Ward Personnel

Part I of the questionnaire was based on the Standards on Infection Control for Healthcare Facilities prepared by the Technical Working Group on Development of Standards under Dr. Antonio Periquet, chairman of the Philippine Office of Hospital Facilities and Regulations of the Department of Health to establish Infection Control Committee on hospitals.

Table 1 illustrates the standard infection control practices of Medical Ward Personnel of Ziga Memorial District Hospital, Josefina Belmonte Duran Memorial District Hospital and Dr. Fernando B. Duran Memorial Hospital. The

research took into account the standard responsibilities of the Infection Control Committee of the Hospitals and the employees to determine whether a functional Infection Control Committee is existing and policies are being followed or practiced. The research also determined whether the the Infection Control Team, together with the employees possess the necessary information and abilities to control, minimize or eradicate infection.

The Infection Control Team consists of the infection control physician, infection control nurse and head of the microbiology unit. The study showed that the ICT is "seldom" functional in Ziga (2.3) and Fernando Duran (2.2) while "often" functional in Josefina Duran (3.7). This was based on the perception of the medical ward personnel. This further shows that in terms of the said standard, the performances of Ziga and Fernando Duran were almost the same. The performance of the Infection Control Team of a hospital is important since this group of individuals spearheads the Infection Control Committee. It will be easier for the rest of the hospital personnel to follow the Infection Control Policies set by the Infection Control Committee if the Infection Control Team is visible, functional and initiating.

There are 12 functions of the ICT cited under this standard. Results show that Josefina Duran "often" practiced 8 and "sometimes" practiced 3 of these functions. Josefina Duran "sometimes" practiced 3 and "seldom" practiced 9 functions. Fernando Duran "sometimes" practiced 2 and "seldom" practiced 10 functions. In terms of the participation of the ICT in the planning and design of medical ward critical to infection control, Josefina Duran obtained a high result of 4.6 which is interpreted as "always" practiced. It can be noted that this function is "seldom" practiced at Ziga (2.0) and Fernando Duran (1.7). A significant difference in the performances of the 3 hospitals can be noted in 5 functions of the ICT: *Conducts and documents surveillance activities; Investigates and initiates appropriate responses to incidents or outbreaks of infections; Responds to urgent problems through a 24-hour emergency referral system; Gives advice on the procurement of equipment and supplies; and Recommends to ICC actions which may have implications for infection control*. The said functions were "often" practiced by Josefina Duran and "seldom" practiced by Ziga and Fernando Duran.

Table 1. **Implementation of the Infection Control Standards as Perceived by Employees**

Infection Control Standards	Ziga		Josefina Duran		Fernando Duran	
	Mean	*Interpretation*	*Mean*	*Interpretation*	*Mean*	*Interpretation*
1. The Infection Control Team is functional as perceived by the Medical Ward Personnel	2.3	*Seldom*	3.7	*Often*	2.2	*Seldom*
1.1 The Infection Control Team ensures a day-to-day infection control activities at the Medical Ward.	2.6	*Sometimes*	3.9	*Often*	2.8	*Sometimes*
1.2 Conducts and documents surveillance activities.	2.3	*Seldom*	3.9	*Often*	2.1	*Seldom*
1.3 Coordinates with the Infectious Disease Section, Microbiology Laboratory and Administration as well as other departments about known or suspected cases of reportable infectious diseases, food poisoning and other significant infections such as Multi Drug Resistance Organism (MDRO).	2.5	*Sometimes*	3.6	*Often*	2.1	*Seldom*
1.4 Ensures adequate, accurate and timely reporting and feedback of information.	2.9	*Sometimes*	3.7	*Often*	2.3	*Seldom*
1.5 Investigates and initiates appropriate responses to incidents or outbreaks of infections, assess risks of infection and recommends allocation of resources for investigation, management and control.	2.3	*Seldom*	3.5	*Often*	2.4	*Seldom*
1.6 Responds to urgent problems of infection control through a 24-hour emergency referral system.	2.4	*Seldom*	3.5	*Often*	2.2	*Seldom*
1.7 Propose resource requirement for the program and any contingencies.	2.2	*Seldom*	3.2	*Sometimes*	2.5	*Sometimes*
1.8 Gives advice on the procurement of medical equipment, drugs/medicines and supplies.	2.2	*Seldom*	3.9	*Often*	2.0	*Seldom*
1.9 Participates in the planning and design of medical ward critical to infection control, i.e. renovations, repairs, relocation of critical care areas.	2.0	*Seldom*	4.6	*Always*	1.7	*Seldom*
1.10 Develops IC training modules, organizes the relevant education and training programs for all healthcare staff and encourages reflexive practice of infection control measures	1.9	*Seldom*	3.1	*Sometimes*	1.8	*Seldom*
1.11 Monitors compliance to infection control policies, guidelines and procedures.	2.3	*Seldom*	3.1	*Sometimes*	2.2	*Seldom*

Infection Control Standards	Ziga		Josefina Duran		Fernando Duran	
	Mean	*Interpretation*	*Mean*	*Interpretation*	*Mean*	*Interpretation*
2. The full-time trained Infection Control Nurses (ICNs) assigned at the Medical Ward is continually receiving training in infection control provided by accredited training organizations.	2.6	*Sometimes*	2.5	*Sometimes*	2.1	*Seldom*
3. The Medical Ward ICNs facilitates and ensures effective implementation of infection control program at the Medical Ward.	2.5	*Sometimes*	3.9	*Often*	2.4	*Seldom*
4. The Infection Control Committee (ICC) defines goals, objectives, strategies and priorities to achieve an effective infection control program for the Medical Ward.	2.5	*Sometimes*	4.1	*Often*	2.6	*Sometimes*
4.1. Formulates/updates infection control policies, guidelines and procedures.	2.3	*Seldom*	4.1	*Often*	3.4	*Sometimes*
4.2. Ensures implementation of infection control policies, guidelines and procedures.	2.8	*Sometimes*	4.0	*Often*	2.9	*Sometimes*
4.3. Ensures availability of resources and contingencies for infection control program.	2.3	*Seldom*	4.0	*Often*	2.5	*Sometimes*
4.4. Prepares, reviews and evaluates the progress and the effectiveness of the infection control.	2.5	*Sometimes*	3.8	*Often*	2.3	*Seldom*
4.5. Disseminates the necessary information and coordinate with medical, nursing, administration, and other hospital committees.	2.7	*Sometimes*	3.8	*Often*	2.4	*Seldom*
4.6. Oversees the performance of the employees assigned at the medical ward as part of the infection control team (ICT).	2.6	*Sometimes*	4.3	*Often*	2.1	*Seldom*
4.7. Approves infection control training modules.	2.3	*Seldom*	4.2	*Often*	2.5	*Sometimes*
4.8. Defines the goal, objectives and priorities for all surveillance activities and surveillance method to be used.	2.3	*Seldom*	4.2	*Often*	2.8	*Sometimes*

Infection Control Standards	Ziga		Josefina Duran		Fernando Duran	
	Mean	*Interpretation*	*Mean*	*Interpretation*	*Mean*	*Interpretation*
5.1 Hand hygiene	4.1	*Often*	4.9	*Always*	4.8	*Always*
5.2 Decontamination, Disinfection, Sterilization; Disinfectants for specific medical equipment/items and area	2.9	*Sometimes*	4.6	*Always*	3.9	*Often*
5.3 Environmental Care and Healthcare Waste Disposal and Management.	3.4	*Sometimes*	4.7	*Always*	4.3	*Often*
5.4 Protection of Healthcare workers	3.1	*Sometimes*	4.6	*Always*	3.8	*Often*
5.5 Prevention of Healthcare-associated Infections such as: Respiratory care, Urinary Catheter care, Wound Care	3.9	*Often*	4.9	*Always*	4.9	*Always*
5.6 Outbreak investigation guidelines	3.4	*Sometimes*	4.4	*Often*	3.9	*Often*
5.7 Purchasing of medical equipment, drugs/medicines and supplies guidelines.	3.4	*Sometimes*	2.5	*Sometimes*	4.0	*Often*
6. Education and Training of Medical Ward Healthcare Staff and Personnel	1.9	*Seldom*	1.7	*Seldom*	1.8	*Seldom*
6.1 Adequate resources for education, skills building and training.	2.0	*Seldom*	2.0	*Seldom*	1.8	*Seldom*
6.2 Available and accessible venues for teaching and training.	2.3	*Seldom*	2.5	*Sometimes*	2.8	*Sometimes*
6.3 Access to up-to-date tools like audio-visual materials and/or relevant books and journals in infection control and hospital epidemiology at the infection control office.	2.2	*Seldom*	1.6	*Seldom*	1.6	*Seldom*
6.4 Available budget to allow attendance of staff to infection control training, conferences, production of educational materials and related activities.	1.6	*Seldom*	1.2	*Never*	1.1	*Never*
6.5 Continuous education opportunities.	1.5	*Seldom*	1.2	*Never*	1.6	*Seldom*
7. The institutional materials are available for education and training for the Medical Ward Staff and Personnel.	2.5	*Sometimes*	3.9	*Often*	2.8	*Sometimes*
Total Weighted Mean	**2.5**	*Sometimes*	**3.5**	*Often*	**2.9**	*Sometimes*

It is important to note that the Infection Control Team of all three (3) hospitals showed varying performances in the observance of the standards. This implies that the ICT needs to exert more effort as leaders of the Infection Control Committee. On a positive note, this means that the ICT of the hospitals are able to perform well some of their functions.

It can also be deduced from the results that the Infection Control Team of Josefina Duran has a very satisfactory performance while those of Ziga and Fernando Duran are unsatisfactory.

As a member of the Infection Control Team, the Infection Control Nurse's primary responsibility is to coordinate and supervise all activities in hospital relevant to Infection Control. In order to efficiently perform its responsibility, the Infection Control Nurse (ICN) needs to continually receive training in Infection Control provided by accredited training organizations. However, the study showed that the Medical Ward ICNs in Ziga and Josefina Duran received training "sometimes" as indicated by the mean rates of 2.6 and 2.5, respectively and those in Fernando Duran "seldom" receives such trainings, with a mean rate of 2.1. The study further showed that the Medical Ward ICNs function of facilitating and ensuring effective implementation of infection control program at the Medical Ward is "seldom" performed in Fernando Duran (2.4) and "sometimes" performed in Ziga (2.5). It is surprising though that amidst the fact that the ICN receives training "sometimes", still they "often" perform the standard mentioned incurring a rate of 3.9. It is a fact that employees who are motivated can perform better than those who are not motivated. One motivation for an Infection Control Nurse is proper and continuous training. With this, the ICN can be expected to perform more effectively and be more confident with the position entrusted to her.

The Infection Control Committee (ICC) is composed of the Chief of Hospital, the Infection Control Team and the representatives of each department of the healthcare facility, from the Administration down to the auxiliary departments. The primary responsibility of the ICC is to *define goals, objectives, strategies and priorities to achieve an effective infection control program for the Medical Ward*. The ICC in Ziga and Fernando Duran "sometimes" practice the standard with a mean rating of

2.5 and 2.6, respectively. Josefina Duran obtained a rate of 4.1, statistically interpreted as "often" practiced.

The ICC in this study has eight (8) specific functions based on the standards. It can be noted that the ICC and ICT of Josefina Duran are consistent in performing their functions. Based on the results, the ICC of Josefina Duran "often" practice all of the eight (8) functions mentioned for the ICC standards, varying only with the mean rates. Fernando Duran "sometimes" practiced five (5) and "seldom" practiced three (3) functions. Ziga "sometimes" practiced four (4) and "seldom" practiced 4 of the eight (8) functions. The results further show that the three (3) hospitals showed varying performances in all the eight (8) functions.

A well-defined Infection Control Program is very important. Once established, proper implementation must be ensured. Based on the results, the written guidelines, policies, and procedures that address infection prevention, detection and control are "often" implemented at the Medical Ward in all the three (3) hospitals rated as follows: Josefina Duran, 4.4; Fernando Duran, 4.2; and Ziga, 3.5. This standard includes hand hygiene, which according to the results, is "always" practiced by the respondents of Josefina Duran (4.9) and Fernando Duran (4.8) and "often" practiced by the respondents of Ziga (4.1). High rates were noted in this area. The results herein support a very basic infection control practice i.e., hand washing as supported by the World Health Oganization (WHO), Center for Disease Control (CDC), Department of Health (DOH) in collaboration with Philippine Society of Microbiology and Infectious Diseases (PSMID), Philippine Hospital Infection Control Society (PHICS), and Philippine Hospital Infection Control Nurses Association (PHICNA). Dr. S. Gopalakrishnan M.D., D.P.H., in her Hospital Infection Control Program recommended the following: a) hand washing with plain soaps or detergents suspends microorganisms and allows them to be rinsed off b) for routine handwashing, a vigorous rubbing together of all surfaces of lathered hands for at least 10 seconds, followed by thorough rinsing under a stream of water, is recommended; and c) antimicrobial handwashing products should be used for handwashing before personnel care for newborns and when otherwise indicated during their care, between patients in high-risk units and before personnel

take care of severely immunocompromised patients. The hands are the primary source of infection thus it is expected of the respondents to "always" practice hand hygiene.

Decontamination, Disinfection, Sterilization and Disinfectants for specific medical equipment and area guidelines, Environmental Care and Healthcare Waste Disposal and Management. Guidelines and Protection of Healthcare Workers Guidelines are "always" practiced in Josefina Duran (4.6, 4.7, 4.6), and in Fernando Duran (3.9, 4.3, 3.8) however, "sometimes" practiced in Ziga (2.9, 3.4, 3.1). These guidelines should be equally implemented as that of hand hygiene particularly the guidelines on decontamination, disinfection and sterilization. In April 2009, the International Association of Healthcare Central Service Materiel Management (IAHCSMM) deeply expressed their concern over recent endoscope processing errors in the United States wherein nearly 10 000 patients were notified that they may have been exposed to hepatitis and HIV as a result. As of April 2009, 17 veterans were tested positive for infectious diseases, including 1 case of HIV, 5 of hepatitis B and 11 of hepatitis C. The IAHCSMM believed that sterile processing professionals in every facility must receive ongoing, formal training and become certified in order to perform their duties effectively. This is just one particular example of mishaps that may result in neglecting the abovementioned standards.

In terms of implementing the *Prevention of Healthcare-associated Infections such as: Respiratory care, Urinary Catheter care, Wound Care Guidelines*, Josefina Duran and Fernando Duran obtained the highest rate of 4.9 which is statistically interpreted as "always" practiced. The same area is "often" practiced in Ziga. According to studies, Nosocomial Pneumonia or Hospital-Acquired Pneumonia (HAP) is said to be the second most common nosocomial infection, but the infection is frequently associated with the most fatal outcome. This HAP can be prevented if the guidelines are properly executed.

Implementation of *Outbreak investigation guidelines* is "often" practiced both in Josefina Duran and Fernando Duran with mean rates of 4.4 and 3.9, respectively. The implementation is "sometimes" practiced in

Ziga. Although Kathy Dix (2006) in her article implied that Outbreak investigation is an Infection Control Practitioner's worst nightmare, it is a relief that the ICC in these hospitals are involved in such significant activity.

The four major elements to preventive practice are handwashing; protective barriers (gloves, masks, eyewear, gowns and plastic aprons); care of equipment which involves disposal of waste, contaminated laundry and sharps; and the cleaning, sterilization and disinfection of equipment, instruments and devices; and health practices of the personnel (College of Nurses of Ontario).

Implementation of Guidelines on *Purchasing of medical equipment, drugs/medicines and supplies* were "often" practiced in Fernando Duran with a rate of 4.0. It is "sometimes" implemented in Ziga (3.4) and Josefina Duran (2.5). It can be noted that in this standard, Josefina Duran obtained the lowest rank. This guideline may not be considered as important as the other mentioned guidelines since it deals with purchasing of supplies which is a responsibility of another department. However, the ICC is responsible for coordinating with the purchasing department its recommended equipment, supplies and drugs pertinent to infection control.

Training Personnel is also basic in Infection Control in order to properly implement the written guidelines and policies. The results showed that *Education and Training of Medical Ward Healthcare Staff and Personnel* are "seldom" practiced in all 3 hospitals. They obtained close rates of 1.9 (Ziga), 1.8 (Fernando Duran) and 1.7 (Josefina Duran). It is very important to note that the rates obtained in this standard and its indicators are significantly lower than the mean rates obtained in the abovementioned results. The majority of the standards are "seldom" practiced. There are also areas which are "never" practiced by the hospitals.

The standard on education and training of personnel encompasses the following: 1) *Adequate resources for education, skills building and training* is "seldom" practiced in all three (3) hospitals rated 2.0 for Ziga and Josefina Duran and 1.8 for Fernando Duran. 2) *Available and accessible ven-*

ues for teaching and training in Fernando Duran was rated 2.8(sometimes practiced), 2.5 for Josefina Duran (sometimes practiced) and 2.3 for Ziga (seldom practiced). 3) *Access to up-to-date tools like audio-visual materials and/or relevant books and journals in infection control and hospital epidemiology at the infection control office* is "seldom" practiced in all three (3) hospitals with mean rates of 1.6 for Josefina Duran and Fernando Duran and 2.2 for Ziga. It was observed that the hospitals seldom acquire materials like books and journals for the employees' use. The employee takes his initiative in the acquisition of materials. 4) *Available budget to allow attendance of staff to infection control training, conferences, production of educational materials and related activities*. This was rated 1.6 (seldom practiced) for Ziga. Significant values of 1.2 (never practiced) for Josefina Duran and 1.1 (never practiced) for Fernando Duran. Conferences and other infection control-related trainings are seldom, if not, conducted in the area. Thus, the employees still have to go to Manila and other cities to attend trainings which definitely require financial resources. 5) *Continuous education opportunities*. This was rated 1.6 for Fernando Duran and 1.5 for Ziga, both interpreted as "seldom" practiced. Josefina Duran obtained a 1.2 rate which is interpreted as "never practiced." In addition to the situation provided in the previous standard, continuing education is "seldom" offered by the institutions to their employees. The employees spend for their own graduate education.

The findings show that trainings and continuing education are not in the priority list for budget allocation of these hospitals. It is high time for the employers and administration to realize that strengthening and improving the knowledge and skills of the employees and staff is as important as improving the knowledge and skills of the top management.

Since the above results showed that the selected hospitals are incapable of sending the staff to trainings, an alternative should be available. The hospitals should provide learning materials for their own personnel. However, the results showed that the institutional materials are available "sometimes" in Fernando Duran (2.8) and Ziga (2.5) and they are "often" available in Josefina Duran (3.9). For education and training of the Medical Ward Staff and Personnel, the hospitals can produce learning materials for their own employees.

The overall Infection Control Practices in terms of standards concerning employees is "often" performed in Josefina Duran, rated as 3.5, "sometimes" practiced in Fernando Duran and Ziga with mean rates of 2.9 and 2.5, respectively. These results imply that the Infection Control Committees of Fernando Duran and Ziga should exert more effort in their campaign for Infection Control. Josefina Duran ICC must maintain, if not improve, its performance.

The Status of Infection Control Practices at the Medical Ward

Table 2 presents the Infection Control Practices of the Medical Ward Personnel in terms of Medical Ward Standards. As soon as the patient decided to be admitted, orientation must be done not only for the patient's welfare, but also for the visitors,' watchers' and hospital employees' benefit. Results showed that implementation of *thorough patient assessment before confinement in the Medical Ward* is "always" practiced at Josefina Duran and rated 4.9. The same standard is "often" performed at Fernando Duran (3.9) but "sometimes" practiced in Ziga. Thorough patient assessment is very critical since the necessary precautions can be implemented once the actual problem is identified.

The Medical Ward Personnel is responsible for providing health information to patients and members of their families about infection control precautions. In this standard, Josefina Duran obtained a 3.8 rating which is interpreted as "often" practiced. Fernando Duran "sometimes" practice this standard earning a 3.4 rate. Ziga was rated 2.2, interpreted as "seldom" practiced.

Results showed that the ICC/ICT is involved in the orientation and education of patients. However, this standard is only practiced "sometimes" at Josefina Duran (2.3), "seldom" practiced at Ziga and Fernando Duran obtaining mean rates of 1.9 and 1.8, respectively. This may be explained by the fact that the medical ward personnel are more in contact with the patients and the relatives, and that the ICC/ICT were able to delegate some of its functions to the medical ward personnel. However, this does

not excuse the ICC/ICT from not getting involved in such practices. It should be noted that the primary responsibility of the ICC/ICT is to ensure a day-to-day infection control activities and one activity that should be included is visiting patients and conducting information drive relevant to infection control.

Table 2. **Implementation of the Infection Control Standards at the Medical Ward**

Infection Control Standards	Ziga		Josefina Duran		Fernando Duran	
	Mean	*Interpretation*	*Mean*	*Interpretation*	*Mean*	*Interpretation*
1. Thorough patient assessment is implemented before confinement in the Medical Ward.	3.1	*Sometimes*	4.9	*Always*	3.9	*Often*
2. The Medical Ward Personnel provides health teaching to patients and members of their families about infection control precautions.	2.2	*Seldom*	3.8	*Often*	3.4	*Sometimes*
3. The ICC/ICT is involved in the orientation and education of patients.	1.9	*Seldom*	2.3	*Sometimes*	1.8	*Seldom*
4. The Medical Ward Personnel have the knowledge on infection control practices and procedures on when and how to isolate patients.	3.7	*Often*	4.5	*Always*	3.6	*Often*
5. The Medical Ward Personnel see to it that the patient and patient's visitors observes proper waste disposal.	3.3	*Sometimes*	4.6	*Always*	4.0	*Often*
6. The Medical Ward Personnel ensures the use of personal protective equipment for patients.	3.4	*Sometimes*	4.5	*Always*	4.1	*Often*
7. The Medical Ward Personnel limits patient exposure to infections from visitors, hospital staff, other patients, or equipment used in diagnosis or treatment.	3.5	*Often*	4.1	*Often*	4.0	*Often*
Total Weighted Mean	3.0	*Sometimes*	4.1	*Often*	3.5	*Often*

In terms of knowledge on infection control practices and procedures possessed by the medical ward personnel, Josefina Duran was believed to "always" practice the standard with a rate of 4.5. Meanwhile Fernando Duran and Ziga "often" practice the standard obtaining 3.6 and 3.7 respectively. The Center for Disease Control, United States Public Health Services classified seven types of isolation techniques as follows: 1) Strict Isolation (airborne transmission) 2) Respiratory Isolation (transmission through cough,

sneezing or breathing or in tissues and napkins) 3) Positive or Reverse Isolation (pathogenic organism) 4) Enteric Precaution Technique (prevents transmission through direct or indirect contact with infected excreta or feces) 5) Wound and Skin Precautions (prevents transmission by contact with wound) 6) Discharge Precautions (prevents transmission of organisms by contact with wounds, secretions, excretions, and heavily contaminated articles when there is possibility of cross-infection); and 7) Blood Precautions (prevents transmission of organisms by contact with blood or items that are contaminated with blood).

According to the Practical Guidelines for Infection Control in Health Care Facilities, Infection Control Practices can be grouped into 2 categories: 1) standard precautions, and 2) additional (transmission-based) precautions. The former must be applied to all patients at all times regardless of diagnosis or infectious status, the latter are specific to modes of transmission.

It is also the responsibility of the medical ward personnel to ensure that the patient and the family observes proper waste disposal. It is "always" practiced in Josefina Duran (4.6), "often" practiced in Fernando Duran (4.0) and "sometimes" practiced in Ziga (3.3). Instructions regarding proper waste segregation and disposal should be provided to the patient as well as the watchers and visitors. Posters or signs in corridors, lobbies and patient rooms are also helpful to increase awareness among patients and watchers.

The medical ward personnel must not only protect themselves with personal protective equipment, but also protect the patients with these PPEs (Personal Protective Equipment) if the case warrants. This is "always" practiced by the personnel at Josefina Duran, rated 4.1. A close rate (4.0) was obtained by Fernando Duran, interpreted as "often" practiced and Ziga got 3.5, also "often" practiced. PPE for patients includes masks, gown and bonnets or caps. PPEs may limit patient exposure to infections particularly for patients who are under isolation precautions.

Overall, in terms of Medical Ward Standards, Josefina Duran and Fernando Duran "often" practice them with mean rates of 4.1 and 3.5, respectively. On the other hand, Ziga "sometimes" observes these standards. This reflects

that the employees in this area may lack the various requirements for the effective and efficient implementation of infection control policies, but in an overall scenario, they are still capable of observing the policies with regards to the welfare of the patients in the medical ward.

Problems encountered during implementation of Infection Control Standards in the Medical Ward

Table 3 illustrates the Problems encountered by the personnel in the implementation of Infection Control Standards in the Medical Ward. There are nine (9) major problems identified. Ziga and Fernando Duran share two (2) problems on top of their list. First, on the issue of the *infection control team in the medical ward being understaffed* with a frequency of 28 and 37, respectively. This problem ranked 2nd for Josefina Duran. A healthcare facility shall have an Infection Control Team consisting of an Infection Control Physician, an Infection Control Nurse and the head of the Microbiology department. Based on the standards, there should be at least one (1) Infection control Nurse for every 250 beds. Considering the selected affiliated hospitals, one (1) Infection Control Nurse, one (1)Infection Control Physician and one (1)head of the Microbiology department is enough for each. If not possible for the smaller facilities, they shall link with the bigger facilities within the geographical area for infection control services.

Second, the problem on *insufficient number of trained Infection Control Nurses to facilitate and ensure effective implementation of infection control program*. In contrast this ranked 4th for Josefina Duran with a frequency of 26. Again, there is a need for a trained Infection Control Nurse for each of the facilities. In the Philippines, the Infection Control Nurses must receive training in infection control to facilitate implementation of the policies. This is being provided by accredited training organizations like the Philippine Society of Microbiology and Infectious Diseases (PSMID), Philippine Hospital Infection Control Society (PHICS), and Philippine Hospital Infection Control Nurses Association (PHICNA). These organizations frequently conduct seminars to provide updates for the healthcare workers regarding the infection control status.

Table 3. **Problems Encountered by Medical Ward Personnel**

Infection Control Standards	**Ziga**		**Josefina Duran**		**Fernando Duran**	
	F	*Rank*	*F*	*Rank*	*F*	*Rank*
1. The infection control team in the medical ward is understaffed.	28	**1**	30	**2**	37	**1**
2. The infection control team in the medical ward has insufficient availability of resources and equipment necessary to implement infection control.	27	**3**	31	**1**	37	**1**
3. The Medical Ward Staff and Personnel has limited knowledge and training to facilitate and ensure effective implementation of infection control program.	27	**3**	8	**7**	10	**6**
4. There is poor implementation of proper waste management system.	18	**5**	12	**6**	13	**5**
5. Budget and Procurement	27.75	**2**	28	**3**	35.25	**3**
5.1 Insufficient funds to conduct trainings, conferences, production of materials, and related activities to allow attendance of hospital personnel and ICC members.	28		29		35	
5.2 Insufficient funds to procure surveillance and monitoring systems.	28		29		37	
5.3 Insufficient funds to implement proper waste management system.	28		29		34	
5.4 Inadequate facilities and equipment to control infection.	27		25		35	
6. Insufficient number of trained Infection Control Nurses to facilitate and ensure effective implementation of infection control program.	28	**1**	26	**4**	37	**1**
7. Inadequate support from the Infection Control Team.	20	**4**	13	**5**	21	**4**
8. Failure of Medical Ward Personnel to read and observe policies regarding protocols and standard operating procedures on infection control.	10	**6**	2	**8**	6	**7**
9. The Medical Ward Personnel lack trainings and seminars on the latest trends and issues on nosocomial infection and infection control programs.	28	**1**	31	**1**	35	**3**

Similarly, it can be derived from the results that the *Medical Ward Personnel* of Ziga and Josefina Duran l*ack trainings and seminars on the latest trends and issues on nosocomial infection and infection control programs*. This ranked 1st for both hospitals, with frequencies of 28 and 31, respectively and 3rd for Fernando Duran in which 35 respondents agreed. Based on these results Fernando Duran seems to provide more training to the medical ward personnel than to the Infection Control Nurse. If the training cannot be equally provided, the ICN needs to possess a better training than the medical ward personnel since the ICN spearheads the Infection Control in the hospital thus can share what they gained and learned from the trainings.

The infection control team in the medical ward has insufficient availability of resources and equipment necessary to implement infection control. This problem ranked 1st for Fernando Duran (37) and Josefina Duran (31) and 3rd for Ziga. The selected hospitals are government hospitals. This means that their budget depends on the allocation from the government. Since the budget allocation for health in the Philippines is very low, the resources and equipment procurement is slow aside from the observation that Infection Control seems not to be a priority of the hospitals.

The issue on *budget and procurement* is 2nd in rank for Ziga (27.75) and 3rd for Josefina Duran (28) and Fernando Duran (35.25). The previous explanation on budgetary allocation also justifies these results. This problem involves specifically issues on *Insufficient funds to conduct trainings, conferences, production of materials, and related activities to allow attendance of hospital personnel and ICC member; Insufficient funds to procure surveillance and monitoring systems; Insufficient funds to implement proper waste management system; and Inadequate facilities and equipment to control infection*. It is necessary that all Healthcare facilities must allocate sufficient budget for Infection Control Services otherwise, even with the existence of an Infection Control Committee, infection control will fail.

Inadequate support from the Infection Control Team. The infection control team supervises all the healthcare workers. However, it was noted that there is a problem when it comes to the support from the Infection Control Team. This ranked 4th among the problems encountered in Ziga, with 20

respondents and Fernando Duran, with 21 respondents, while it ranked 5th for Josefina Duran in which 15 respondents agreed. This is contrary to the fact that the Infection Control Team shall be the supervising body when it comes to Infection Control issues.

There is poor implementation of proper waste management system. This is ranked 5th at Ziga (18) and Fernando Duran (13), while ranked 6th at Josefina Duran. Although one of the lowest ranking problems, there is still a number of the respondents who claimed that there is a poor implementation of proper waste management. The Infection Control Committee should give emphasis on this issue particularly the segregation of wastes and disposal of sharps, specimens and toxic wastes.

Failure of Medical Ward Personnel to read and observe policies regarding protocols and standard operating procedures on infection control. This problem is ranked 6th at Ziga, 7th at Fernando Duran and 8th at Josefina Duran, with frequencies of 10, 6 and 2, respectively. If the policies on infection control are already set and proper implementation is in effect, the next responsibility lies on the medical ward personnel to observe these policies. Operating Manuals must be readily available to the personnel. The personnel shall take the initiative of observing the written policies.

The Medical Ward Staff and Personnel has limited knowledge and training to facilitate and ensure effective implementation of infection control program. Although 3rd on the rank for Ziga, this problem ranked 6th for Fernando Duran and 7th for Josefina Duran, with respective frequencies of 27, 10 and 8. This is linked to the problem on budgetary allocation. There is an insufficient fund for infection control program thus limits the opportunities for trainings and continuing education for the medical ward personnel. However, once an effective and trained Infection Control Committee is present, this issue can be addressed by conducting in-house seminars and trainings.

Hospital-acquired infections can be controlled. To prevent and control infections among patients, watchers and visitors, as well as the staff, there shall be a careful and systematic attention on guidelines and procedures on Infection Control. After defining the goals, objectives, strategies and

priorities, initiative and cooperation among the personnel are needed in order to achieve an effective infection control program. Every employee is considered a member of the Infection Control Committee thus they must perform their respective functions with regard to infection control. Information dissemination to non-employees is as highly important since the patients and other persons are agents of infection transmission or control.

A sufficient budget for Infection Control Services must be allocated by the healthcare facilities. In some developing countries, about 50% of the budget on health is spent on Infection Control and its related services particularly to care for high risk patients such as the intensive care unit, newborn and surgical patients. A failure in Infection Control may further stress hospital budgets.

The issue on budget will address several concerns in infection control. With sufficient budget allocation, the healthcare facilities can send staff for trainings and continuing education on infection control, thus trained Infection Control Nurses will be able to facilitate and ensure the effective implementation of the Infection Control Program. The staff will have a clear picture of their responsibilities in infection control. Mandatory training should be done. A failure in training staff may increase the risk of cross infection due to poorly understood practices. The risk is high among the institution in terms of liability and poor image, among the professionals for being accountable and for not protecting themselves.

Procurement of surveillance and monitoring systems, facilities and equipment necessary for infection control is possible if a reasonable budget is provided. The staff cannot always put good knowledge into practice if facilities and equipment are lacking.

Conclusion

The following were drawn from the results of the study: 1) Infection Control Practices in terms of Standards concerning employees, in general, as perceived by the Medical Ward personnel of selected affiliated hospitals of Aquinas University of Legazpi College of Nursing and

Health Sciences, are "sometimes" practiced in Ziga and Fernando Duran but "often" practiced in Josefina Duran. These practices include those of the Infection Control Team and the Medical Ward Personnel. It was noted that the Infection Control Team is "seldom" functional in Ziga and Fernando Duran however "often" functional in Josefina Duran as perceived by the medical ward personnel. The Infection Control Committee however performs better than the Infection Control Team in Ziga and Fernando Duran, in which the standards for the ICC are "sometimes" practiced in Ziga and Fernando Duran. In addition, the standards for the ICC and ICT in Josefina Duran are both "often" practiced. It can be concluded that the status of the Infection Control Practices in terms of Standards concerning employees is satisfactory in Ziga and Fernando Duran while very satisfactory in Josefina Duran. 2) Infection Control Practices in terms of Medical Ward standards, collectively, are "often" performed by the medical ward personnel of Josefina Duran and Fernando Duran. It is "sometimes" practiced in Ziga. A very satisfactory performance of infection control practices in Josefina Duran and Fernando Duran in terms of Medical Ward Standards can be derived from these results, while a "satisfactory" performance for Ziga. 3) There were several problems encountered by the medical ward personnel in implementing infection control standards. These are the following with the corresponding rankings for the selected hospitals. Understaffed Infection Control Team in the medical ward and insufficient availability of resources and equipment necessary to implement infection control ranked first for Ziga and Fernando Duran while 2nd for Josefina Duran; Lack of personnel trainings and seminars on infection control issues which also ranked 1st in Ziga and Josefina Duran and 3rd in Fernando Duran; Insufficient number of trained ICNs ranked 1st in Ziga and Fernando Duran while 4th in Josefina Duran; Inadequate support from the Infection Control Team ranked 4th in Ziga and Fernando Duran and 5th in Josefina Duran; Limited knowledge of the personnel regarding effective implementation of infection control program ranked 3rd in Ziga , 6th in Fernando Duran and 7th in Josefina Duran; Poor implementation of proper waste management system ranked 5th in Ziga and Fernando Duran and 6th in Josefina Duran; and Failure of the medical ward personnel to read and observe policies on infection control which ranked 6th in Ziga, 7th in Fernando Duran and 8th in Josefina Duran.

Recommendations

Based on the findings and conclusions, the researchers offer the following recommendations:

1. A functional infection control committee/team with a well defined goals, objectives, strategies and priorities must be existing;

2. The Infection Control Team together with the personnel must be vigilant in ensuring a day-to-day infection control activities;

3. The Infection Control Nurses/Nurses must be trained by the accredited organizations and must be heedful in supervising infection control activities;

4. Sufficient budget should be allocated to facilitate procurement of surveillance systems and facilities for infection control, and to allow trainings and seminars for the personnel, to have access to up-to-date tools like audio-visual materials and/or relevant books and journals in infection control and hospital epidemiology at the infection control office, to conduct continuous education opportunities for ICC and ICT, to implement proper waste management system, and to allow sufficient staff to implement the infection control program;

5. The institutional materials must be available to educate and train the Medical Ward Personnel; and

6. Infection Control Policies must be regularly reviewed to ensure adherence to the existing standards.

For further studies, the researchers would recommend a correlation study on the status of infection control practices and the emergence or incidence of healthcare-associated infections to further find out the effectiveness of the infection control practices.

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MATERNAL PRACTICES ON THE PREVENTION OF NEONATAL INFECTION IN VICTORY VILLAGE AND ORO SITE, LEGAZPI CITY

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Abstract

This study determined maternal health practices that promote health and prevent infections among neonates aged 0-28 days old. Specifically, it described the women according to age, educational attainment, monthly family income, and work status; it identified indicators for health promotion and disease prevention; it specified the influences of the selected characteristics to the performance of maternal practices; it identified problems that hindered mothers in performing preventive actions; and, it recommended nursing interventions to enhance maternal health practices. The study gathered data from 112 women (i.e., 81 from Bgy. Victory Village and 31 from Bgy. Oro Site, Legazpi City) between June to August, 2009. It utilized the descriptive design with the self-answered questionnaire-checklist as the research tool. The respondents were young women, between 26-30 years old, at least high school graduate, who belong to families earning below P5,000 monthly, and may or may not be employed. There were eleven indicators specified as promoting health and ten indicators that prevent infection. The mothers *always* bathe their babies daily to promote health. They *always* submit them to scheduled immunizations to prevent illnesses. Because of the attributes of these women, indispensable maternal practices that involve minimal

expense are always performed. Financial constraints often impede women from performing preventive actions. It is recommended that maternal practices be intensified through improved decision-making skills, appropriate and effective health education strategies, continued participation to DOH programs, and providing families with small children with livelihood programs.

Keywords: maternal practices, neonatal infections, health promotion, disease prevention

Delicate Neonate

The World Health Organization Report (2006) showed that three out of five children below 5 years old who died were neonates. Neonates die due to severe infection (17%), neonatal tetanus (1%), and diarrheal diseases (1%). This phenomenon is reported as a global trend where the situation of infant mortality in the Philippines is of no exception Sato (2004). Indeed, the top three leading causes of morbidity in 2004 in the Bicol Region include respiratory infections and diarrhea (Cabrera, 2004). Aptly, the reduction of neonatal mortality has been specified as the fourth goal of the Millenium Development Goals.

The first month of life of a person is believed to determine one's predisposition to acquiring certain illnesses which may even become the reason for succumbing to death. Congenital problems and fatal vehicular accidents are exceptions to this. The immaturity of the body versus the virulence of various agents play significant role in child survival. Direct child care consisting of specific practices to promote health and prevent illnesses is imperative at this time to every neonate.

The research settings were chosen considering the occurrence of infections in children. In 2004, Legazpi City registered an infant mortality rate of 13.26 which is beyond the province's rate at 9.33. Cabrera (2004) further pointed out that the leading causes include respiratory infections and diarrheas. The selected barangays used in this study are accessible to the two groups of beginning researchers.

Problem Statement

This study aimed to determine the maternal health practices in preventing neonatal infections in barangays Victory Village and Oro Site, Legazpi City from June to August, 2009. Specifically, it sought answers to the following questions:

1. What are the characteristics of the respondents in terms of:
   a. age
   b. educational attainment
   c. monthly family income
   d. work status?

2. What are their maternal practices on preventing neonatal infections along:
   a. health promotion
   b. disease prevention?

3. What is the influence of the selected characteristics of the mothers on maternal practices?
4. What are the problems encountered by mothers in the prevention of neonatal infection?
5. What nursing interventions can be recommended to enhance the maternal practices in the prevention of neonatal infection?

Methodology

The study involved women who gave birth to infants 0-6 months of age at the time of the investigation. In Bgy. Victory Village, a sample of 81 mothers participated while all 31 mothers who fit the inclusion criteria participated in Bgy. Oro Site. The descriptive method guided this research and utilized a self-answered questionnaire-checklist to gather data. The tool was divided into three parts. Part I gathered the profile of the respondents which included: age, educational attainment, family income, and work status. Part II identified the frequency of performance of maternal practices. Part III dealt with the problems encountered on the prevention of neonatal infection.

Variables gathered from Part I of the tool were statistically treated using frequency count, percentage distribution and ranking. Variables in Parts II and III were determined by utilizing the Likert Scale with the following interpretation and description:

Scale	*Range*	*Interpretation*	*Description*
5	4.51 – 5.00	*Always*	Maternal practice in the prevention of neonatal infection is performed all the time (5 times out of 5)
4	3.51 – 4.50	*Often*	Maternal practice in the prevention of neonatal infection is performed frequently (4 times out of 5)
3	2.51 – 3.50	*Sometimes*	Maternal practice in the prevention of neonatal infection is performed at times (3 times out of 5)
2	1.51 – 2.50	*Seldom*	Maternal practice in the prevention of neonatal infection is performed rarely (2 times out of 5)
1	1.00 – 1.50	*Never*	Maternal practice in the prevention of neonatal infection is never performed (1 out of 5)

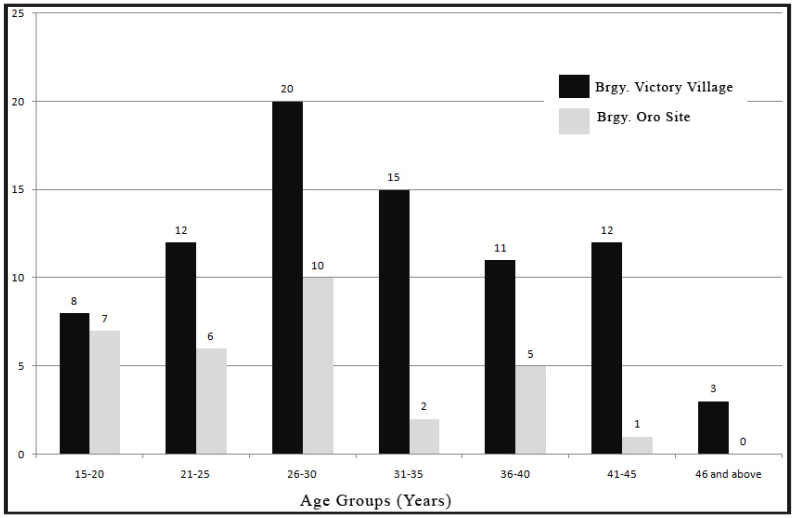
Mean rating was employed thereafter.

Study Findings

Profile

In both barangays Victory Village and Oro Site, most of the participants were between the age 26-30 years (24.7% and 32.3%, respectively). The youngest mother was 15 years old and the oldest was 46-year old.

Figure 1. **Distribution of Mothers with Neonates According to Age, Bgys. Victory Village and Oro Site, Legazpi City, 2009**



In terms of educational attainment, almost two out of five women were either high school graduates or have started a few years in college. It is worthy to note that all women who have neonates in Bgy. Oro Site pursued their studies beyond the elementary level.

The mothers in the two barangays reported similar monthly income. Most of the mothers were earning between P1,000 – P4,999. While a few families reported to gain more than P20,000, there are a number who earn less than P1,000 monthly as shown in figure 2.

In Bgy. Victory Village, mothers reported to have a source of income (43.0%) while those unemployed (51.6%) slightly overran the number of employed mothers (48.4%) in Bgy. Oro Site. The table below presents the variables describing the participants of this study.

In summary, mothers with neonates are young adults between 26-30 years old, are at least high school undergraduates, may or may not be employed, and belong to families which earn less than P5,000 a month.

Figure 2. **Distribution of Mothers with Neonates According to Monthly Family Income, Brgys. Victory Village and Oro Site, Legazpi City, 2009**

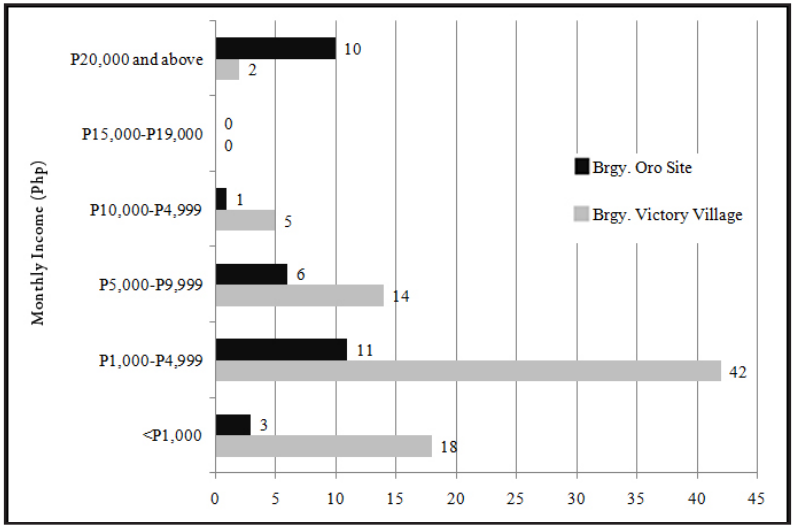


Table 1. **Profile of Mothers with Neonate Children in Brgys. Victory Village and Oro Site, Legazpi City, 2009**

Characteristics	Brgy. Victory Village			Brgy. Oro Site		
	f	%	Rank	*f*	%	Rank
Age Groups (years)						
15-20	8	9.9	6	7	22.6	2
21-25	12	14.8	3.5	6	19.4	3
26-30	20	24.7	1	10	32.3	1
31-35	15	18.5	2	2	6.5	5
36-40	11	13.6	5	5	16.1	4
41-45	12	14.8	3.5	1	3.2	6
46 and above	3	3.7	7	0	0	-
Total	*81*	*100.0*		*31*	*100.0*	

Characteristics	Brgy. Victory Village			Brgy. Oro Site		
	f	%	Rank	*f*	%	Rank
Educational Attainment						
Elementary Undergraduate	2	2.5	6	0	0.0	-
Elementary Graduate	7	8.6	4	0	0.0	-
High School Undergraduate	19	23.5	2	2	6.5	4
High School Graduate	32	39.5	1	7	22.6	3
College Undergraduate	17	20.9	3	12	38.7	1
College Graduate	4	5	5	10	32.3	2
Total	*81*	*100.0*		*31*	*100.0*	
Monthly Family Income						
< P1,000	18	22.2	2	3	9.7	4
P1,000 –P4,999	42	51.9	1	11	35.5	1
P5,000 – P9,999	14	17.2	3	6	19.4	3
P10,000 –14,999	5	6.2	4	1	3.2	5
P15,000 – P19,999	0	0.0	-	0	0.0	6
P20,000 and above	2	2.5	5	10	32.3	2
Total	81	100.0			100.0	
Work Status						
Employed	43	53.0	1	15	48.4	2
Unemployed	38	47.0	2	16	51.6	1
Total	*81*	*100.0*		*31*	*100.0*	

Maternal Practices on the Prevention of Neonatal Infection

The practices performed by mothers on preventing infections by the neonates were gathered. Their responses were categorized as health promotion and disease prevention.

Health Promoting Activities

Eleven indicators were used to identify maternal practices that promote health which include: They involve hygiene, rest and sleep, breastfeeding, living space, and receiving health education. In both barangays, daily bathing of the neonate is *always* practiced by mothers. This is supported by Pillitteri (2007) that bathing the baby everyday can minimize microorganisms and this in turn prevents neonatal infection. Mothers from Brgy.

Victory Village would *often* perform all other activities except for ironing baby's clothes which is done sometimes only. In Brgy. Oro Site, mothers perform the other activities often except for avoiding alcohol and cigarette-smoking. Table 2 presents the distribution of the mothers according to practices that promote their children's health.

Generally, mothers *often* perform activities that promote health often.

Table 2. **Distribution of Mothers with Neonates According to Health-Promoting Maternal Practices, Brgys. Victory Village and Oro Site, Legazpi City, 2009**

Characteristics	Brgy. Victory Village						Brgy. Oro Site					
	f					*Mean*	*f*					*Mean*
	5	**4**	**3**	**2**	**1**		**5**	**4**	**3**	**2**	**1**	
Hand washing before and after handling the baby	51	23	6	1	0	4.5	15	15	0	1	0	4.38
Adequate rest and sleep	33	29	14	5	0	4.1	10	13	4	4	0	3.93
Eating nutritious food	44	15	15	7	0	4.4	20	5	5	1	0	4.41
Proper handling of baby	50	23	7	1	0	4.5	23	8	0	0	20	4.74
Bathing of baby everyday	54	21	5	1	0	4.6	26	5	0	0	0	4.83
Maintaining good personal hygiene	45	26	6	4	0	4.3	19	12	0	0	0	4.61
Ironing baby's clothes	20	27	15	11	8	3.5	13	6	9	3	0	4.12
Avoiding alcohol and cigarette smoking	47	9	6	9	10	3.9	13	7	1	0	10	3.41
Adequate living space and maintaining clean environment	31	34	8	6	2	4.1	16	15	0	0	0	4.57
Attending health education on maternal and child health care	35	34	8	6	2	4.0	13	12	3	2	1	4.09
Compliance of breast feeding rather than bottle feeding	48	21	7	3	1	4.3	18	7	6	0	0	4.38
Overall Weighted Mean						**4.0**	**Overall Weighted Mean**					**4.31**

Disease Prevention

Nine (9) indicators were utilized to identify maternal practices that prevent diseases. They involved immunization, supplemental vitamins, herbal medicines, and environmental control. Mothers in Brgy. Victory Village *always* submit their neonates for immunization while those in Brgy. Oro Site always made sure that the child's soiled linens are frequently changed. They perform all other activities often except consulting herbolarios (from both settings) and providing babies with supplemental vitamins (Brgy. Oro Site). Table 3 presents statistically-treated data.

Generally, mothers *often* perform activities that prevent diseases.

Table 3. **Distribution of Mothers with Neonates According to Disease-Preventing Maternal Practices, Brgys. Victory Village and Oro Site, Legazpi City, 2009**

Characteristics	Brgy. Victory Village						Brgy. Oro Site					
	f					*Mean*	*f*					*Mean*
	5	**4**	**3**	**2**	**1**		**5**	**4**	**3**	**2**	**1**	
Submitting child for immunization	51	19	8	2	1	4.9	21	5	4	0	1	4.45
Washing breast before and after breastfeeding	40	25	9	4	3	4.2	13	9	3	1	0	3.61
Sterilization of feeding bottles	45	21	3	3	9	4.1	16	11	3	0	1	4.32
Use of supplemental vitamins	36	24	13	8	0	4.1	10	7	3	1	0	2.87
Regular follow-up check-up	18	22	25	16	0	3.5	13	8	10	1	0	4.16
Consulting herbolarios	13	24	16	25	3	3.2	8	8	6	0	9	3.19
Frequent changing of child's soiled linens	44	25	6	6	0	4.3	22	9	0	0	0	4.70
Minimizing exposure to environmental contamination	31	33	9	7	1	4.1	17	10	4	0	0	4.41
Use of herbal medicine	27	24	20	9	1	3.8	12	8	10	1	0	4.00
Overall Weighted Mean						**4.0**	**Overall Weighted Mean**					**3.96**

Problems Encountered

In preventing neonatal infections, mothers identified financial constraints as a problem they *often* encountered (in Brgy. Victory Village) or *some-*

times (in Brgy. Oro Site). In both settings, superstitious beliefs also hindered their actions *sometimes*.

In Brgy. Victory Village, they also found the following indicators *sometimes* hinder preventive actions: poor environmental sanitation, overcrowding, lack of knowledge, and lack of time for childcare. This is brought about by the unique set-up of this fishing village in downtown Legazpi. Houses made of light materials are set above the waters which are too many for the available space. This opportunity to earn is grabbed by all members of the family, including women who have small children to tend to. Their participation to vending may also be the reason for the lack of time to attend health education activities, thus, the low level of knowledge on maternal and child care and lack of awareness on immunizable diseases.

Generally, a mother's actions on preventing neonatal illness were sometimes impeded by one of the eleven indicators presented in the table below.

Table 4. **Distribution of Mothers with Neonates According to Problems Encountered in Preventing Neonatal Infection, Brgys. Victory Village and Oro Site, Legazpi City, 2009**

Characteristics	Brgy. Victory Village						Brgy. Oro Site					
	f					*Mean*	*f*					*Mean*
	5	**4**	**3**	**2**	**1**		**5**	**4**	**3**	**2**	**1**	
Financial shortfall	29	22	22	8	0	3.9	2	8	12	2	7	2.87
Lack of Knowledge on maternal and child care	15	21	37	1	7	3.4	0	5	11	9	6	2.48
Poor environment sanitation	21	17	25	13	5	3.4	1	3	11	9	7	2.41
Overcrowding	19	16	25	7	14	3.2	1	2	11	13	4	2.45
Superstitious beliefs	18	22	20	18	3	3.4	1	5	12	8	5	2.64
Distance of residence to health center	9	19	21	20	12	2.9	0	3	5	6	17	1.93
Poor transportation	10	17	18	15	21	2.8	1	1	7	5	18	1.87
Lack of time to take care of the baby due to work	12	20	20	21	8	3.0	0	0	7	9	15	1.74
Unhealthy lifestyles	10	14	19	31	7	2.9	0	2	3	13	13	1.80
Lack of knowledge concerning immunizable diseases	14	20	21	17	13	3.2	0	1	7	13	10	1.97
Lack of Knowledge on importance of proper nutrition	13	16	26	17	8	3.0	0	0	5	11	15	1.67
Overall Weighted Mean						**3.2**	**Overall Weighted Mean**					**2.17**

Analysis

Influence of Selected Characteristics on Maternal Practices

The general attributes of the mothers who participated in the study influence the performance of activities that promote health and prevent disease. These young adults, being high school graduates at least, have the ability to follow simple instructions and understand the consequences of doing (or not doing) something. They do put importance to bathing the baby daily and submitting them for immunizations to promote their baby's health by doing them always. They are also receptive to health education as it can be noted that they *often* attend such gatherings.

The mothers belong to families whose monthly earning is less than P5,000 and this could be the reason for their to providing only the basic needs of their children. Indeed, only few mothers iron baby's clothes or provide supplemental vitamins since these indicators involve a certain amount of additional expenses. Related to this, Espartinez, et. al. (2009) observed that mothers in Bgy. Oro Site always practice only those indicators that are indispensable and involve minimal expenses.

Nursing Interventions Recommended to Enhance Maternal Practices on the Prevention of Neonatal Infections

The role of nurses in public health is significant in empowering the community towards promoting and maintaining health and wellness among people in their home setting. In enhancing maternal practices on the prevention of neonatal infections, the best strategy is to provide health education. Focus shall be made on helping women identify priorities and improving time management in order to find balance between health of family members and other household matters. There is a need to emphasize that mothershave an opportunity to prevent diseases among their young children through the Newborn Screening, Expanded Program on Immunization (EPI), full breastfeeding through intake of affordable yet nutritious food, and maintaining personal hygiene when handling the baby. Six metabolic conditions which are identified (and referred for fur-

ther treatment) through the Newborn Screening include congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, phenylketonuria, homocystinuria, and glucose-6-phosphate dehydrogenase deficiency (Padilla, 2003). Diseases which are aimed to be eradicated through the EPI include polio, measles and neonatal tetanus.

Strategies employed may revolve on case-finding, small group discussions or tapping some of these mothers who can be trained to educate more mothers. Barangay health workers and other volunteers must be involved.

Recommendations

1. Public health workers, including physicians, nurses and midwives, could intensify maternal and child health programs focusing on helping mothers gain decision-making skills in prioritizing the health of their children and the rest of the members of the family. Thereafter, specific health education activities could be implemented which shall include promoting screening for diseases, availing of immunizations, personal hygiene, and environmental sanitation.

2. Existing programs like the Newborn Screening, Expanded Program on Immunization and the Integrated Management of Childhood Illnesses must be continued and intensified, assessing pockets of population with special needs as to availability of these services.

3. Research studies need to be initiated on viable alternatives for already existing maternal practices, taking as primary consideration the influences of the aforementioned characteristics of the respondents with considerations for attributes peculiar to specific communities and culture.

4. Livelihood projects may be offered to families with young children to support their needs. Even mothers can participate economically while at home. This can be facilitated further by drafting an Open University Program for mothers to enter or continue college education without having to leave their homes or workplaces with the aid of universities and educational agencies.

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ASSESSMENT OF THE INTENSIVE CLINICAL PRACTICE (ICP) OF AQUINAS UNIVERSITY COLLEGE OF NURSING AND HEALTH SCIENCES, SUMMER 2009

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Keywords: Intensive Clinical Practice, Assessment, Competencies, Aquinas University

Objectives

The study aimed to assess the Summer Affiliation Program of the Aquinas University College of Nursing in 2009. Specifically, it sought to answer the following questions: (a) What is the level of effectiveness of the Intensive Clinical Practice (ICP) of the nursing students in terms of skills and attitudes? (b) What affects the level of effectiveness of the ICP of nursing students along student and personal factors, teacher factor, clinical areas, and policies and guidelines? and (c) What are the measures that could be proposed to improve the Summer Affiliation of the nursing students in Aquinas University?

Methodology

A descriptive quantitative method was employed in this study. The gathering of data made use of survey questionnaires. The first part of the questionnaire determined the level of effectiveness of the ICP nursing students in terms of their skills and attitudes. Part II investigated the factors affecting the level of effectiveness of the ICP of the nursing students in rela-

tion to the conduct of its training in the different affiliate hospitals. The respondents were the Level III nursing students of Aquinas University of Legazpi, AY 2008–2009. The total population of the Level III Nursing students AY 2008-2009 is 428. To determine the sample size for the study, Slovin formula was used with 10% margin of error. The resulted sample size was 81. The total sample size was divided into three batches/strata with a resulting value of 27 students per batch/stratum. After the required sample size has been calculated, the respondents were selected applying the Systematic Sampling Method.

The survey instrument used in this study was adapted with permission from the study conducted in 2008 by Prof. Anecia Bailon entitled, "Intensive Clinical Practice Program of Aquinas University of Legazpi College of Nursing and Health Sciences: An Assessment."

To determine the quantity of data and interpret their quality generated from the questionnaires, frequency, mean, and ranking were used as the appropriate statistical treatments and techniques. Using the frequency distribution method, indicators used from the questionnaires were classified based on their occurrence or the number of times they appear. Weighted mean was employed to measure the extent to which the respondents rated and assess their skills and attitudes practiced during the summer affiliation program. To determine the highest value of priority or concern, ranking was used. This was only applied in the interpretation of data in Part II of the questionnaire concerned with the problems encountered by the students in the conduct of the Intensive Clinical Practice Program. The rating was based on Likert's five-point scale with corresponding description in conformity to the criteria under evaluation. In assessing the level of effectiveness of the ICP in terms of skills and attitudes, the following are the scale values for each statement with their corresponding interpretations:

Scale	*Range*	*Interpretation*
5	4.51 – 5.00	*At All Times Practiced*
4	3.51 – 4.50	*Often Practiced*
3	2.51 – 3.50	*Sometimes Practiced*
2	1.51 – 2.50	*Rarely Practiced*
1	1.00 – 1.50	*Never Practiced*

The descriptive interpretation applied to problems encountered by the students and clinical instructors are as follows:

Scale	*Range*	*Interpretation*
5	4.51 – 5.00	*Most Pressing Problem*
4	3.51 – 4.50	*More Pressing Problem*
3	2.51 – 3.50	*Moderately Pressing Problem*
2	1.51 – 2.50	*Less Pressing Problem*
1	1.00 – 1.50	*Not a Problem*

Review of Literature

The findings of Kozier (2004) showed that an active learning in the hospital setting is necessary to enhance the capability of the nursing students in their future careers as nurses. Also a stable and well-rounded clinical skill is essential in providing the best nursing care for their patients. According to Benner, the skills of a nurse undergo different levels of competencies which are necessary steps to being a clinical excellent nurse (Taylor, 2002). It determines the level of proficiency that nurses possess based on the characteristics of each level. In relation to Benner, Orem's Theory of Nursing System is a set of systems that a nurse should possess in dealing with different kinds of patients and dealing with a variety of cases in the hospital setting. It is generally patient-oriented and focuses mainly on the patient care (Taylor, 2002).

The study of Banua (2005) and Bartolata (2007) mainly focused on the problems encountered by the affiliating students. However, the studies of Andes, *et. al.*, (2007) and Chong, *et. al.,* (2007) focused on the benefits gained by the affiliating students during the conduct of the Manila Affiliation. On the other hand, Baronda and Baldo's Assessment of Manila Summer Affiliation Program (1999) revealed that the Colleges of Nursing in the Bicol Region has the same purposes of conducting such program.

These studies focused more on the problems encountered by the students on their related learning experiences such as clinical rotation resulting to overcrowding in the hospital, overloading of clinical instructors with other

responsibilities other than clinical teaching, and those related to the affiliate agency such as: lack of supplies and facilities, uncooperative hospital personnel, and lack of varied cases. The level of competencies in Related Learning Experience along three domains of learning (cognitive, affective, and psychomotor) was also studied. Some of the studies that were reviewed studied only the Manila Summer Affiliation Program and its benefits.

The research made a study of both the Manila and Local Affiliations of the Level III Nursing Students of Aquinas University. It also assessed the Program in terms of effectiveness in increasing the competencies of the students in the psychomotor and affective domains. The results of this study served as a tool to evaluate the programs of the nursing curricula in Aquinas University of Legazpi.

Conceptual Framework

The study is anchored on Patricia Benner's Model of Nursing Skills Acquisition and Dorothea Orem's Theory of Nursing System. The concept of Benner's Theory suggests that in the acquisition and development of a skill, a student passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Each level possesses certain characteristics that are classified accordingly. The model of Benner has been useful for clinical basis for differentiating clinical knowledge development and career progression in nursing. Thus, the purpose of Benner's Model is to categorize the level of proficiency of a nurse based on the characteristics that each level possessed. Also, it provides an assessment tool for the nurses on how competent they are in the clinical setting. It can also serve as a tool to evaluate the skills that a nurse possesses and leads to the identification of appropriate measures to improve one's skills, and to be able to attain the highest level of expertise. Guided by Benner's Model, the study can therefore utilize it to the competency level of the nursing students in the course of their experiences through the conduct of Intensive Clinical Practice Program. Hence, through the acquired experience, the Intensive Clinical Practice Program can be evaluated. On the other hand, Orem's Theory of Nursing System proposes that nursing is

composed of human actions and that nursing systems are action systems formed by nurses for individuals who cannot manage their self care. This theory has been used in variety of settings. Much of them are limited to other components of the theory as a way to explain practice. Specifically, this theory has been used in the formulation of curricular designs in the different schools of Nursing worldwide. The Theory of Nursing System is further divided into three categories which present the relationship between the patient action and nursing action. These subsystems are: a) wholly compensatory system; b) partially compensatory system; and c) supportive-educative system. This theory is patient-oriented; hence, it requires the ability of a nurse to care for the patient. Generally, Orem's Theory aims to inculcate to patient the autonomy in terms of self care. If self care cannot be met, this enables the patient to access on health care agency to manage self-care deficits. The role of the nurse is then recognized to compensate for the health-associated limitations of the individual. Hence, this theory states that the functioning of the nurse is required to regulate the individual's activity. Which allows the nurse to be critical thinker by developing an appropriate plan of care for the patient. Also, this assesses the ability of the nurse to initiate, implement, and elicit cooperation from the patient for a successful evaluation of the planned care. Moreover, the nurse should develop a knowledge-based method for providing health teachings for the discharge planning. Benner's Model was used to determine the skills and competency level of the nurse whereas Orem's Theory determines the skills and the ability of the nurse to care for the patient. Both theories should go hand in hand because their focus is needed for intensive clinical practice of the nurse, that is, the skills, competencies, and ability to care are needed to successfully fulfill the goal of patient care and the satisfaction of their needs.

Findings

This part discusses the assessment of the levels of skills and attitudes practiced in the different areas covered in Nursing during the 2009 summer affiliation program viewed from the perspective of the Level 3 Nursing students. The areas are: the Fundamentals of Nursing, Psychiatric, Orthopedic, Surgical, Medical, Maternal, and Pediatric Areas of Nursing.

1.1 Skills in Fundamentals of Nursing

Table 1. **Skills in Fundamentals of Nursing**

Indicators	Rating						Mean	Interpretation
	0	**1**	**2**	**3**	**4**	**5**		
Performs nursing procedures safely with proper body mechanics	0	1	0	16	39	19	4.00	*Often Practiced*
Utilizes nursing process accurately in the care of a sick client	0	0	1	17	35	22	4.04	*Often Practiced*
Provides comfort in performing procedures	0	0	1	11	27	36	4.31	*Often Practiced*
Promotes personal care and hygiene to client	0	1	6	17	26	25	3.91	*Often Practiced*
Observes universal precautions when caring for patient and performing procedures as indicated	0	0	1	6	29	39	4.41	*Often Practiced*
Performs NGT feeding with aspiration precaution	1	2	1	2	17	52	4.57	*At All Times Practiced*
Takes and monitors vital signs accurately	0	0	0	2	25	48	4.61	*At All Times Practiced*
Reassures patient's safety and comfort before during and after the process of drug administration	0	0	0	6	29	40	4.45	*Often Practiced*
Documents treatments andobservations accurately	0	0	1	5	29	40	4.44	*Often Practiced*
Mean							**4.30**	***Often Practiced***

Table 1 shows the frequency distribution and mean of the different indicators under the skills practiced in the Fundamentals of Nursing. It can be observed that 'taking and monitoring vital signs accurately', which got the highest mean of 4.61, and 'performs NGT Feeding with aspiration precaution' with a mean of 4.57, were practiced at all time.' 'Promoting personal care and hygiene to client', which got the lowest mean of 3.91, is still fairly high. This suggests that all indicators for skills in the Fundamentals of Nursing are attained and that all are 'oftenly practiced.' The Nursing students have all the basic skills for the Fundamentals of Nursing.

However, since these skills are necessary and fundamental in nursing, they should be carried out at all times.

1.2 Attitudes towards Fundamentals of Nursing

Table 2 shows the frequency distribution and mean of the different indicators under the attitudes towards Fundamentals of Nursing. 'Conferring due respect to medical personnel' was perceived to be "practiced at all times" hwith a mean value of 4.51.

Table 2. **Attitude Towards Fundamentals of Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Provides privacy in the care of the client	0	0	1	5	28	41	4.45	*Often Practiced*
Explains the procedure to the client	0	0	2	6	30	37	4.36	*Often Practiced*
Establishes rapport with the client	0	0	2	6	25	42	4.43	*Often Practiced*
Develops self-confidence in the care of client	0	1	2	11	38	23	4.07	*Often Practiced*
Participates on pre-/post-duty endorsement	1	1	5	26	27	15	3.68	*Often Practiced*
Utilizes proper communication in dealing with client	0	1	1	9	32	32	4.24	*Often Practiced*
Expresses concerns for clients in providing direct nursing care	0	0	1	12	35	27	4.17	*Often Practiced*
Confers due respect to the medical personnel	0	0	0	7	23	45	4.51	*At All Times Practiced*
Adheres to patient's rights	0	0	0	6	27	42	4.48	*Often Practiced*
Submits requirement on time	0	1	1	7	35	31	4.25	*Often Practiced*
Mean							**4.26**	***Often Practiced***

The least "practiced" which got a mean of 3.68 is the 'participation on the pre- and post- duty endorsement'. Students' oftenly experienced endorsement of shift due to problems in time management among themselves or

their clinical instructors who came late for the endorsement procedure. Sometimes only clinical instructors are allowed to receive endorsements from the staff. Lack of knowledge regarding the correct and proper endorsement procedure also poses a reason why students were not able to participate in pre- and post- duty endorsement. It appears that most of the indicators range from 3.68 to 4.51 which suggest that attitudes toward Fundamentals of Nursing are "oftenly practiced." Differences between patient's needs and demands posed a great challenge to the students since they are exposed to variety of patients who have varied necessities. Factors such as lack of interpersonal skills and self–confidence of the students and insufficient time exposure to patients contribute to such results. Though the average weighted mean is high, the students still have to improve themselves to effectively relate with their patients and to develop their attitudes towards their work.

2.1 Skills in Psychiatric Nursing

Table 3 presents the indicators skills in Psychiatric Nursing together with its frequency and mean. Establishing rapport with the client got the highest mean garnering 4.56 interpreted as "practiced at all times." Rapport building is the basic interpersonal skill that a student nurse should have to become well accustomed in dealing with the clients. Thus, nursing students were aware that establishing rapport is important to developing agreement and connection between them and their patients.

However, 'applying nursing process in the care of a client displaying maladaptive behavior' got the lowest mean of 4.03 taken as "oftenly practiced." Although the result is high, several factors have been identified that yielded this result. The conduct of self-awareness was implemented to each student before exposure to the hospital. A thorough self evaluation is needed to ensure that the students are well-prepared and geared up for the exposure to the hospital. In addition, a good knowledge-based background is needed for the students to create a good nursing care plan for the patients. This would help the students to reduce their anxiety and fear. Long term planning is also needed for nursing process to be implemented. Thus, time limitation is also an identified factor.

Table 3. **Skills in Psychiatric Nursing**

Indicators	Rating						Mean	Interpretation
	0	**1**	**2**	**3**	**4**	**5**		
Applies nursing process in the care of a client displaying maladaptive behavior	0	0	2	13	41	19	4.03	*Often Practiced*
Utilizes Therapeutic Use of self prior in building nurse patient relationship	0	0	2	12	35	26	4.13	*Often Practiced*
Formulates goals and objectives of the nurse-client relationship	0	0	1	11	33	30	4.23	*Often Practiced*
Identifies the phases of the therapeutic nurse-client relationship	0	1	1	11	29	33	4.23	*Often Practiced*
Alleviates anxiety before the first nurse-client interaction	0	0	3	12	36	24	4.08	*Often Practiced*
Introduces self to client as a helper/facilitator	0	0	1	7	24	43	4.45	*Often Practiced*
Establishes rapport with the client	0	1	0	5	19	50	4.56	*At All Times Practiced*
Assesses client's feelings and perceptions	0	0	0	7	30	38	4.41	*Often Practiced*
Communicates with patient therapeutically	0	0	4	7	29	35	4.27	*Often Practiced*
Chooses the appropriate therapeutic communication responses in communication exchanges with client	0	0	0	12	28	35	4.31	*Often Practiced*
Comprehends the importance of confidentiality in nurse-patient exchange	0	0	0	6	37	32	4.35	*Often Practiced*
Establishes broader comfort zones while developing communication skills	0	0	0	10	37	28	4.24	*Often Practiced*
Participates, observes and/or conducts the different psychiatric therapies	0	0	4	7	25	39	4.32	*Often Practiced*
Evaluates nursing activities in each phase of the nurse-client relationship	0	0	1	11	36	27	4.19	*Often Practiced*
Documents and records Nurse-client interactions accurately	1	0	2	7	30	35	4.32	*Often Practiced*
Mean							**4.27**	***Often Practiced***

2.2 Attitudes towards Psychiatric Nursing

The highest mean among the indicators garnered a mean of 4.47 interpreted as oftenly practiced is 'adhering to patient's rights.' This shows that respect for each patient is observed by the students despite the patients underlying mental and emotional instability.

Table 4. **Attitudes Towards Psychiatric Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Identifies own feelings, concerns and needs prior in undertaking psychiatric health nursing related experiences	0	0	1	9	28	37	4.35	*Often Practiced*
Accepts self before conducting therapeutic nurse-client relationship	0	0	1	9	23	42	4.41	*Often Practiced*
Appreciates the significance in the use of therapeutic communication techniques	0	0	0	12	31	32	4.27	*Often Practiced*
Upholds rules of the hospital on the confidentiality of patient's admission & care	0	0	2	6	34	33	4.31	*Often Practiced*
Accepts patient's displaying maladaptive behaviors	0	0	4	13	25	33	4.16	*Often Practiced*
Recognizes client's feelings towards self and others	0	0	1	10	28	36	4.32	*Often Practiced*
Appreciates the need in the promotion of personal care and hygiene to the client	0	0	3	6	32	34	4.29	*Often Practiced*
Submits requirements on time	0	1	3	12	25	34	4.17	*Often Practiced*
Confers respect to the medical personnel	0	1	4	4	19	47	4.43	*Often Practiced*
Adheres to patient's rights	0	1	1	9	15	49	4.47	*Often Practiced*
Mean							**4.32**	*Often Practiced*

Accepting patients displaying maladaptive behaviors is the least "oftenly practiced" with a mean of 4.16. All indicators are oftentimes practiced

with an average weighted mean of 4.32. Student nurses found this area as the most challenging experience in the affiliation program. They are not fully prepared for the situations and conditions posed in the hospital given the psychiatric health problems of the patients.

3.1 Skills in Orthopedic Nursing

Table 5 shows the frequency distribution and mean of the fifteen specific indicators under the skills practiced in Orthopedic Nursing. Among the different indicators, 'demonstrating skills in setting up balanced skeletal traction on a model accurately' got the highest mean with a value of 4.28 and is perceived as "oftenly practiced" implying that the students have acquired basic knowledge and skills in setting up a balanced skeletal traction. The students were tasked to demonstrate the setting up of a balance skeletal traction in their duties at the Philippine Orthopedic Center as one of the requirements. Another is that clinical instructors together with the staff nurses demonstrated the proper procedure and techniques in setting up such traction. 'Assisting in plaster cast application' garnering the mean of 3.57 though interpreted as "oftenly practiced" is the skill not demonstrated by the students. The students were not allowed to assist in plaster cast application in compliance to the hospital's policies and the students were only asked to observe the procedure.

It is noted that all mean values in Table 5 fall under the range 3.57-4.07 with an average weighted mean of 3.92 indicating that all fifteen indicators are oftentimes practiced by the students. The level of knowledge that the students have acquired during the classroom lectures on Orthopedic Nursing was adequate to prepare them in handling the patients with various orthopedic related problems at the Philippine Orthopedic Center.

A number of respondents answered 0 or "not practiced" in several indicators such as 'assisting in plaster cast application', 'maintaining special attention to pressure or irritated areas', and 'observing turning of patient'. This is attributed to hospital policies that allow students to observe only and that their stay with the patients was short and therefore they were not able to provide special attention to patients with pressure areas.

Table 5. **Skills in Orthopedic Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Utilizes nursing process in the care of client with musculo-skeletal dysfunctions	0	2	1	15	34	23	4.00	*Often Practiced*
Establishes rapport in the care of client with musculo-skeletal dysfunctions	2	0	4	15	29	25	4.03	*Often Practiced*
Promotes safety to patient with musculo-skeletal dysfunctions	1	2	4	10	29	29	4.07	*Often Practiced*
Promotes personal care and hygiene	2	3	4	14	30	22	3.88	*Often Practiced*
Renders direct nursing care to patient with plaster casts and skeletal traction	6	4	3	15	29	18	3.78	*Often Practiced*
Demonstrates skills in setting-up balanced skeletal traction on a model	0	3	1	5	29	37	4.28	*Often Practiced*
Encourages exercises to patient with plaster cast	5	2	6	18	26	18	3.74	*Often Practiced*
Provides support (i.e. feet board, sandbags, and pillows)	4	3	6	8	28	26	3.96	*Often Practiced*
Assists in plaster cast application	12	7	5	12	23	16	3.57	*Often Practiced*
Observes turning of patient as indicated	7	2	3	16	26	21	3.90	*Often Practiced*
Maintains special attention to pressure or irritated areas	7	5	3	12	23	25	3.88	*Often Practiced*
Applies splints, slings correctly	2	5	3	15	26	24	3.84	*Often Practiced*
Maintains patient's position conducive to recovery	5	4	4	13	22	27	3.92	*Often Practiced*
Communicates with patient therapeutically	1	3	1	13	30	27	4.04	*Often Practiced*
Documents and records observations accurately	5	5	2	12	22	29	3.97	*Often Practiced*
Mean							**3.92**	***Often Practiced***

3.2 Attitudes towards Orthopedic Nursing

In Table 6, the frequency table and mean of nine specific indicators show the attitudes towards Orthopedic Nursing. Among the indicators, conferring respect to the medical personnel and adhering to patient's rights got the highest mean value of 4.42. This suggests that these indicators are "oftenly practiced" ascertain the fact that the students' attitudes toward the medical personnel and their respect of patient's rights were significantly improved. They have established good rapport with the other members of the medical team in the different affiliating hospitals and have a good regard of the patient's rights. The clinical instructors always reiterated to the student nurses even before the start of the affiliation program that they should carry a sense of professionalism in communicating with the patients as well as with other medical personnel.

Conversely, 'providing psychological and emotional support throughout the medical procedures' got the lowest mean value of 3.87 though still indicates as 'oftenly practiced' suggests that the students' main concerns in the Philippine Orthopedic Center were to take care of patients with orthopedic or neurologic related problems and they were not often there to support the clients undergoing medical procedures. They were mainly there to take care of patients with skeletal tractions and to observe patients with other orthopedic related illnesses.

All mean values are oftentimes practiced ranging from 3.87 to 4.42 with the average weighted mean of 4.12. Student's ability relative to Orthopedic Nursing was markedly increased because of the trainings given to them in the classroom and clinical settings. It is also observed that there are students who answered a 0 rating or "not practiced" to the indicator 'accepting that feelings of patients with spinal cord injury'. This is due to the reason that the students were not allowed to handle patients who have a severe orthopedic problem such as patients with spinal cord injury which employs the need for specialized nursing skills and therefore specialized nursing training. But this is understandable given the level of nursing care required for such condition and that student nurses were not yet trained and exposed to such specialized nursing care.

Table 6. **Attitudes Towards Orthopedic Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Provides psychological and emotional support throughout the medical procedures	4	3	0	20	28	20	3.87	*Often Practiced*
Provides privacy in the care of clients with musculoskeletal dysfunctions	4	3	1	15	26	26	4.00	*Often Practiced*
Develops self-confidence in the care of client with fractures	4	1	3	13	27	27	4.07	*Often Practiced*
Recognizes physical and psychosocial stresses experienced by client with musculo-skeletal dysfunctions	4	1	3	18	24	25	3.97	*Often Practiced*
Build-up the morale of the bedridden client towards self-care	6	1	2	13	30	23	4.04	*Often Practiced*
Accepts feelings of patient with spinal cord injury	7	2	2	9	25	30	4.16	*Often Practiced*
Expresses concerns for clients with orthopedic problems	4	1	3	8	34	25	4.11	*Often Practiced*
Confers respect to the medical personnel	2	1	0	8	22	42	4.42	*Often Practiced*
Adheres to patient's rights	3	1	1	8	19	43	4.42	*Often Practiced*
Mean							**4.12**	***Often Practiced***

4.1 Skills in Surgical Nursing

Table 7 shows the frequency distribution and mean of specific indicators under the skills practiced in Surgical Nursing. Among the ten indicators, 'checking and monitoring pre-operative and post-operative vital signs accurately' got the highest mean value of 4.48 interpreted as "oftenly practiced." Checking vital signs is one of the most basic concepts that any student nurse should know. This is practiced not just in the surgical aspect of nursing but in all past exposures of the students especially in the differ-

ent wards of the hospitals. As also shown in Table 1, checking vital signs accurately got the highest mean value. This denotes that student nurses are well trained on the basic skill in nursing. 'Assisting surgeons competently' got the lowest mean value of 4.15. This is attributed to the affiliating hospitals policies on prohibiting student nurses from performing certain tasks. They do not allow the students to assist in some operations and the students are only observers. Assisting surgeons have been the responsibilities of the staff nurses. Surgical operations, given their delicate complex nature, require expert nursing that only staff nurses can provide. Another viable reason is that students actually are not given classroom and clinical trainings relative to Surgical Nursing.

Table 7. **Skills in Surgical Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Observes the principles of surgical aseptic techniques	4	0	0	6	27	38	4.45	*Often Practiced*
Provides personal care and hygiene to client prior to surgery	7	1	2	10	21	34	4.25	*Often Practiced*
Provides comfort in performing surgical procedures	5	0	2	6	32	30	4.29	*Often Practiced*
Performs skin preparation prior to surgery	7	3	1	7	21	36	4.26	*Often Practiced*
Administers pre-op medications as Indicated	7	1	2	10	26	29	4.18	*Often Practiced*
Checks and monitors pre and post-op vital signs accurately	6	0	2	5	20	42	4.48	*Often Practiced*
Reassures patient's safety and comfort before, during and after the surgical procedure	5	1	0	10	23	36	4.33	*Often Practiced*
Assists surgeons competently	8	0	2	11	29	25	4.15	*Often Practiced*
Checks the types and number of instrument used before and after surgery	7	0	1	14	15	38	4.32	*Often Practiced*
Documents treatments and observations accurately	7	1	2	12	18	35	4.24	*Often Practiced*
Mean							**4.30**	***Often Practiced***

The table shows that all mean values fall under the range 4.15 - 4.48 and that these indicators are "oftenly practiced" with an average weighted mean of 4.30. This implies that the students' surgical skills have improved since they were able to study and perform some operations that enhanced their skills in the surgical setup. It is also observed that there are students who answered a zero (0) rating or "not practiced" to some indicators such as 'assisting surgeons competently,' 'providing personal care,' 'skin preparation prior to surgery,' 'administering per operation medications,' 'checking of the instruments' and 'documenting treatments.' This is due to the hospital stating that these indicators are to be performed only by the staff nurses or with their supervision.

4.2 Attitudes towards Surgical Nursing

Table 8 shows the frequency distribution and mean of the 10 indicators on attitudes of students towards surgical nursing. 'Adhering to patient's rights' got the highest mean with a value of 4.63 taken as "at all times practiced." They have a high regard for the patients' rights from their previous exposures. Recognition and respect to the rights of patients is actually taken as a basic attitude as observed in the Fundamentals of Nursing. They were also trained to have a surgical conscience. On the other hand, 'providing psychological and emotional support to preoperative clients' got the lowest mean value of 4.03 which is still interpreted as 'oftenly practiced.' It is in such indicator where the pre-operative, operative, and post-operative nursing stages of surgical nursing take place. Providing psychological and emotional support to patients who would undergo a surgical procedure or an operation is taken as one of the responsibilities of a nurse.

Table 8 showed that all mean values fall under the category "oftenly practiced" except for one 'adhering to patient's rights' which is "prcticed at all times." This is because the students were obliged to know the patients' rights and they were trained to have a high regard for these rights ever since their first exposure to the clinical area. In general, the average weighted mean value of 4.32 indicates that the attitudes of the student nurses towards the surgical aspect of nursing is enhanced by their exposure to the different hospitals given the various cases of patients.

Table 8. **Attitudes Towards Surgical Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Establishes rapport with the client	4	0	2	9	30	30	4.24	*Often Practiced*
Provides psychological and emotional support to pre-op clients	4	0	1	17	32	21	4.03	*Often Practiced*
Provides privacy before, during and after the performance of surgical procedure	4	0	1	7	23	40	4.44	*Often Practiced*
Develops self-confidence in the care of surgical client	3	0	1	8	30	33	4.32	*Often Practiced*
Participates on the pre and post duty endorsement	6	1	1	17	22	28	4.09	*Often Practiced*
Utilizes proper communication in dealing with client	4	1	3	7	29	31	4.21	*Often Practiced*
Expresses concerns to clients in providing direct surgical nursing care	4	0	0	9	32	30	4.30	*Often Practiced*
Confers due respect to the patient who will undergo surgery	3	0	0	5	26	41	4.50	*Often Practiced*
Adheres to patient's rights	3	0	1	5	14	52	4.63	*At All Times Practiced*
Documents observations accurately before, during and after surgery	5	0	2	9	19	40	4.39	*Often Practiced*
Mean							**4.32**	***Often Practiced***

5.1 Skills in Medical Nursing

Table 9 shows the frequency distribution and mean of the different indicators under the skills practiced in Medical Nursing. Among all the specified indicators, 'handling of needles and syringes with extra care, placing of used needles in a labeled, puncture-resistance container, and not bending or breaking it by hand to prevent from infection' got the highest mean of 4.67 interpreted as "practiced at all times," implying that the students were able to perform universal precautions of infection control in handling varied patients in terms of needles and syringes. 'Use of high-efficiency disposable mask' got the lowest mean of 4.11. One rea-

son could be that students do not usually use disposable masks. Students have variations in approaching masking. Most students prefer to use washable ones. Furthermore, students' knowledge in proper handling and disposing of disposable masks are not well enforced by their clinical instructors.

Table 9. **Skills in Medical Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Plans what to do before the initial patient contact	0	0	0	10	33	32	4.29	*Often Practiced*
Observes universal precautions in the care of client with communicable and/or contagious diseases	0	0	1	7	18	49	4.53	*At All Times Practiced*
Washes hands immediately after contact with each patient and after every contact with materials that may be contaminated	0	0	1	4	21	49	4.57	*At All Times Practiced*
Uses high-efficiency disposable mask when indicated	0	1	4	12	27	31	4.11	*Often Practiced*
Uses gown when required to prevent soiling	1	0	2	8	17	47	4.47	*Often Practiced*
Uses disposable, single-use gloves when indicated by patient's conditions	0	0	2	6	21	46	4.48	*Often Practiced*
Handles needle and syringes with extra care and place used needles in a labeled, puncture-resistance container and by not bending or breaking it by hand to prevent from infection	0	0	0	3	19	53	4.67	*At All Times Practiced*
Handles bed linens and fomites with care	0	0	1	9	28	37	4.35	*Often Practiced*
Teaches client proper personal hygiene and the signs and symptoms of infection	0	0	1	11	31	32	4.25	*Often Practiced*
Documents treatments and observations accurately	0	0	2	5	29	39	4.40	*Often Practiced*

Mean	**4.41**	***Often Practiced***

It can be noticed that most of the means range from 4.11 to 4.48 with the average weighted mean of 4.41 denoting that the indicators are "oftenly practiced". This can be attributed to the idea that based on the identified indicators, students have sufficient knowledge on medical nursing in the context of infection control. The theories learned in the classroom should be enforced in the clinical setting through the application of theories to skills. There is a need to develop more skills among students relative to Medical Nursing. Hence, extensive clinical exposure is necessary to improve such skills.

5.2 Attitudes towards Medical Nursing

Table 10 presents the respondents' attitudes towards Medical Nursing. Among all the indicators, 'active listening without interruptions' got the highest mean of 4.33. This suggests that this indicator is "oftenly practiced" which demonstrates that the students promote an open flow of communication towards all the members of the health care team. Student nurses are trained to establish connection and to show their sympathy through listening to the ideas, stories, and struggles of the patients thereby developing a social bond between student nurses and patients resulting in better delivery of health care. This is even considered as a basic skill as denoted in the Fundamentals of Nursing.

Alternatively, 'providing encouragement to the patient faced with prospect prolonged convalescence' got the lowest mean value of 4.19 and still indicates that it is "oftenly practiced". Patients who faced prolonged convalescence limit their social interaction because of the disease process itself. Patients in the said condition manifest signs and symptoms that contribute to patient's inability to interact i.e. whenever they are in great pain. Alongside with this observation, students also limit their interaction with the patients who are in pain. They would just visit the patients if they are to take the vital signs and most of the time they just stay in the nurses' station. All of the indicators ranged from 4.19 to 4.33 with the average weighted mean of 4.25 denoting "oftenly practiced." A valid reason for this is that students have variations in approaching patients. Each patient needs individualized health care needs, thus the students need to adjust to meet the demands of

the patients especially in enhancing their psychological aspects.

Table 10. **Attitudes Towards Medical Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Develops trusting relationship with the client and family	0	0	2	7	39	27	4.21	*Often Practiced*
Shows sensitivity to patient's feelings, avoids showing repulsion	0	1	2	7	28	37	4.31	*Often Practiced*
Employs non-judgmental attitude	0	1	1	8	31	34	4.28	*Often Practiced*
Develops self-confidence in the care of client with communicable and/or contagious diseases	0	0	2	11	31	31	4.21	*Often Practiced*
Provides encouragement to the patient faced with prospect prolonged convalescence	0	1	0	11	35	28	4.19	*Often Practiced*
Employs active listening without interruptions	0	1	1	9	25	39	4.33	*Often Practiced*
Expresses concerns to clients in providing direct nursing care	0	1	1	10	33	30	4.20	*Often Practiced*
Accepts client's feelings and thoughts without judgment	0	1	2	11	22	39	4.28	*Often Practiced*
Includes patient in decision-making	1	0	1	13	25	35	4.27	*Often Practiced*
Encourages family to communicate feelings, expression of support and affection	0	0	3	13	23	36	4.23	*Often Practiced*
Mean							**4.25**	***Often Practiced***

6.1 Skills in Maternal Health Nursing

Table 11 presents the frequency distribution and mean of ten identified indicators under the skills practiced in Maternal Health Nursing. Among the ten specified indicators, 'providing comfort measures before, during, and after delivery' got the highest mean of 4.41.This suggests that this indica-

tor is "oftenly practiced." As a part of clinical exposure, students are asked

Table 11. **Skills in Maternal Health Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Assess the health status of pregnant client	5	1	1	9	28	31	4.24	*Often Practiced*
comprehensive physical assessment (Leopold's)	7	1	5	20	23	19	3.79	*Often Practiced*
Interprets deviations from normal finding in the physical assessment, diagnostic and laboratory examinations	5	2	0	16	28	24	4.03	*Often Practiced*
Utilizes assessed data in order to prioritize nursing diagnosis	5	0	2	9	32	27	4.20	*Often Practiced*
Plans care of patient utilizing evidence- based nursing research	5	0	3	10	26	31	4.21	*Often Practiced*
Safely and knowledgeably administers prescribed medications and treatments including alternative complementary	5	0	2	9	20	39	4.37	*Often Practiced*
Reassures patient's safety and comfort before, during, and after delivery	5	0	3	6	21	40	4.40	*Often Practiced*
Provides comfort measures before, during, and after delivery	5	0	2	6	23	39	4.41	*Often Practiced*
Revising the nursing care plan as needed	5	0	3	5	30	32	4.30	*Often Practiced*
Accurately reports and documents findings in a clinical practice	5	0	4	5	23	38	4.36	*Often Practiced*
Mean							**4.23**	***Often Practiced***

to perform pre-partal, intra-partal, and post-partal care for the patients. It implies that students are able to carry out their designated tasks during their clinical exposure. In contrast, 'performing systematic and comprehensive

physical assessment (Leopold's Maneuver)' got the lowest mean of 3.79 and still described as "oftenly practiced." Most of the time, students were not allowed to do Leopold's Maneuver. Trained nurses, midwives, and doctors are the ones performing the procedure. Students are only allowed to perform this procedure in community-based setting.

All of the specified indicators ranged from 3.79 to 4.41 with the average weighted mean value of 4.23 which marked them as "oftenly practiced." One reason could be the students' individual differences in providing and performing nursing procedures in the health care setting. Individual client requires individualized health care needs. There are certain procedures that were only performed to five out of ten patients. Definitely, given this case, not all specified indicators for Maternal Health Nursing will be performed always. There are seven students that were not exposed to the said area.

6.2 Attitudes towards Medical Health Nursing

Table 12 presents the respondents' attitudes towards Medical Health Nursing in the clinical setting. The indicator 'establishes rapport with the client and adheres to patient rights" got the highest mean as "oftenly practiced" with a value of 4.41. Similar to Fundamentals of Nursing and Surgical Nursing, such indicator shows that students were able to do open nurse-patient interaction through exchange of ideas and concepts and in doing this interaction, patients' rights are taken with great consideration. During a nurse-patient interaction, it is necessary for the nurse to respect the rights of the patients. It is a fundamental need that the nurse knows these rights. For instance, a patient shares a confidential matter to the nurse and the nurse carries on that responsibility of taking that issue as private as possible, as a show of respect to the patient.

On the other hand, 'providing health maintenance and family-based care as well as a assisting the physician competently' got the lowest mean but still interpreted as "oftenly practiced" with a value of 4.09. It is still relatively high. Though some students may not have interacted with the family members and most of them are not allowed to assist during medical procedure especially if it is the physician's decision, the attitudes towards for

Medical Health Nursing are still oftentimes observed.

Table 12. **Attitudes Towards Medical Health Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Actively participates in planning and coordinating culturally sensitive inter-disciplinary care	5	0	2	8	35	25	4.19	*Often Practiced*
Provides appropriate client education	5	0	0	13	34	23	4.14	*Often Practiced*
Establishes rapport with the client	5	0	0	8	25	37	4.41	*Often Practiced*
Provides health maintenance and family-based care	5	0	3	14	27	26	4.09	*Often Practiced*
Efficiently and effectively utilizes available resources in the care of the clients to achieve outcomes	5	0	2	12	29	27	4.16	*Often Practiced*
Expresses concerns to clients in providing direct Maternal nursing care	5	0	2	12	26	30	4.20	*Often Practiced*
Assists the physician competently	5	1	2	13	28	26	4.09	*Often Practiced*
Adheres to patient's rights	5	1	1	6	22	40	4.41	*Often Practiced*
Provides psychological and emotional support	5	0	3	11	25	31	4.20	*Often Practiced*
Mean							**4.21**	***Often Practiced***

All the specified indicators ranged from 4.09 to 4.41 interpreted as "oftenly practiced" having the average weighted mean of 4.21. This implies that students are able to carry out maternal care with proper attitudes appropriate to be rendered and shared to the patients.

7.1 Skills in Pediatric Nursing

There were ten indicators included under the assessment of skills in Pedi-

atric Nursing. As shown in Table 13, the majority of the indicators were rated "oftenly practiced" by the respondents. There were only two indicators with a qualitative rating of practiced at all times and these are: 'reassure newborn's safety in performing immediate newborn care' and 'observes sterile technique in performing cord dressing.' A mean of 4.44 was disclosed for the ten given skills in Pediatric Nursing. It represents that these indicators were "oftenly practiced."

Table 13. **Skills in Pediatric Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Prepares needed materials and equipment correctly before performing immediate newborn care	3	0	0	7	22	43	4.50	*Often Practiced*
Performs Physical assessment utilizing APGAR Score thoroughly	6	0	2	7	29	31	4.29	*Often Practiced*
Suction newborn with aspiration precaution	5	1	1	5	24	39	4.41	*Often Practiced*
Applies ophthalmic ointment correctly	4	0	3	8	23	37	4.32	*Often Practiced*
Obtains anthropometric measurements accurately	4	0	2	7	20	42	4.44	*Often Practiced*
Observes sterile technique in performing cord dressing	4	0	0	5	25	41	4.51	*At All Times Practiced*
Reassures newborn's safety in performing immediate newborn care	4	0	2	5	15	49	4.56	*At All Times Practiced*
Administers Vitamin K on right route	4	0	2	7	20	42	4.44	*Often Practiced*
Observes and reports immediately any untoward signs and symptoms of fetal depression	3	0	2	6	22	42	4.44	*Often Practiced*
Documents and records pertinent findings	3	0	2	5	23	42	4.46	*Often Practiced*
Mean							**4.44**	***Often Practiced***

The highest rating given by the respondents was 'they reassure newborn's

safety in performing immediate newborn care' with a mean of 4.56. It implies that this skill was properly inculcated to students before their exposure to the clinical setting. This also signifies that students developed a strong foundation regarding the implementation of safety precaution at all times in clinical premises. Also, with the continuous guidance of their clinical instructors, they were able to maintain and meet the expected safety for the patients covered under Pediatrics. On the other hand, the lowest rating of the respondents was on the indicator which states that respondents "perform physical assessment utilizing APGAR (Appearance, Pulse, Grimace, Activity, and Respiratory Status) score thoroughly" with a mean of 4.29. APGAR scoring is only applicable to newborn patients whereas Pediatric Nursing includes patients' aged 0-18, therefore students not exposed to the Delivery Room were less likely to encounter or perform APGAR scoring.

7.2 Attitudes towards Pediatric Nursing

Table 14. **Attitudes Towards Pediatric Nursing**

Indicators	Rating						Mean	Interpretation
	0	1	2	3	4	5		
Develops self confidence in the care of the newborn	3	1	0	5	24	42	4.47	*Often Practiced*
Accedes to the policies of the Neonatal Intensive Care Unit	3	0	1	5	18	48	4.57	*At All Times Practiced*
Expresses concerns to infant's status in providing immediate newborn care	3	0	0	6	20	46	4.56	*At All Times Practiced*
Collaborates with the health team in any procedure to be performed at the Neonatal Intensive Care Unit	3	0	1	4	21	46	4.56	*At All Times Practiced*
Provides health maintenance and family-based care	3	0	0	10	25	37	4.37	*Often Practiced*
Mean							**4.51**	***At All Times Practiced***

Table 14 presents the respondents' attitudes towards Pediatric Nursing

during the said affiliation program. As reflected in the table, out of the five indicators given, adherence to the policies in the Neonatal Intensive Care Unit (NICU) got the highest mean with 4.57 qualitatively interpreted as "at all times practiced." It implies that students were properly oriented with each hospital's policies and protocol specifically in NICU and all other areas before having their duty on their specified area. On the other hand, the indicator "provides health maintenance and family-based care" got the least mean of 4.37 and interpreted as "oftenly practiced" attitude during the summer affiliation. 'Provides health maintenance and family-based care' is 'oftentimes practiced' because of some factors affecting its provision to patients including the students' ability in interacting with the family members thus continuity of health care is not assured. There are also times in which a student happens to handle a patient in a short course of time so health maintenance and family-based care are not given much emphasis.

The table revealed three out of five indicators are "at all times practiced" implying that students adequately understand their capacity and are aware of what is expected of them in handling pediatric patients. The general weighted mean value of 4.51 revealed that these indicators were "at all times practiced."

Problems Encountered

In the conduct of the Intensive Clinical Program of Aquinas University of Legazpi, the students did encounter problems affecting the overall effectiveness of the program.

In table 15, twenty-five (25) indicators were identified and rated by students according to what they perceived as the most pressing to the least pressing. The indicators were grouped according to: (a) Student or Personal Factor, (b) Teacher Factor, (c) Clinical Areas, and (d) Policies and Guidelines.

Under student or personal factor, three indicators were identified: (a) 'Absences and tardiness of students in reporting for duty,' (b) 'Lack of skills in performing clinical procedures,' and (c) 'Inadequate knowledge on nurs-

ing concepts, theories and procedures.'

The identified problems as perceived by the respondents related to teacher factor were: (a) 'Inadequate knowledge on nursing concepts, theories and procedures,' (b) 'Lack of skills in performing clinical procedures', (c) 'Favoritism of some clinical instructors and leniency in dealing with other students,' (d) 'Absences and tardiness of clinical instructors in reporting for duty,' (e) 'Laxity of Clinical Instructor in supervising and/or monitoring the performance of students,' (f) 'Excessive workloads and requirements of Clinical Instructor,' (g) 'Unwarranted time set by some Clinical Instructors in the submission of requirements,' (h) 'Inadequate qualified Clinical Instructors to take charge of related learning experience and (i) 'Unconstructive attitude of Clinical Instructors towards student affiliates.'

Nine indicators were classified as problems occurring in the clinical area as perceived by the respondents. These include: (a) 'No areas provided where students could conduct pre and post conferences,' (b) 'Attitudes of Staff Nurses, physicians, and other hospital support personnel,' (c) 'Staff Nurses were not oriented on the BSN Curriculum,' (d) 'Insufficient hospital facilities and supplies,' (e) 'Too strict Chief Nurses and staff nurses,' (f) 'Scarcity of cases to handle in order to enhance the knowledge and skills of the students,' (g) 'Limited exposure on sophisticated and modern hospital equipment and facilities to augment students skills,' (h) 'Uncooperative hospital staff to the related learning experience (RLE) of the student affiliates,' and (i) 'Overcrowded ward/unit due to numerous school affiliates assigned in the same area.'

Under policies and guidelines, six indicators were identified as follows: (a) 'Lack of coordination between the school and hospital Staff regarding activities of the students,' (b) 'On the spot hospital policies without proper coordination with the school administrators,' (c) 'No orientation conducted to the Hired Clinical Instructors on the adopted BSN curriculum of the College,' (d) 'Lack of information dissemination on curriculum adopted by the College,' (e) 'Limited support of the College in taking actions on the problems encountered by the students in clinical practice,' and (f) 'Different Clinical Instructors assigned in one group of students per shift.'

Arranging the indicators from the most pressing to the least, 'Favoritism of some clinical instructors and leniency in dealing with other students' ranks first and qualitatively interpreted as 'moderately pressing.' Respondents claimed that due to favoritism, students were not graded or evaluated fairly. In connection with this, those students perceived as favorites or are more popular were given priorities.

Conversely, 'staff nurses not oriented on the BSN Curriculum' ranked last and perceived by the respondents as 'less pressing problem.' The result presented that this indicator was not a grave threat to students. Though the staff nurses and the nursing students are part of the health care team, each has a different level of focus in the health care setting. Also, the students and the staff nurses do not always mingling together. Staff nurses may not be concerned with the orientation on the BSN curriculum as long as the students carry out the proper handling techniques on the clinical setting. Since staff nurses underwent a BSN curriculum during their time, they are familiar and oriented with the general competencies required for the conduct of hospital duties in clinical setting.

Table 15. **Problems Encountered by the Students in Relation to the Conduct of Its Training in Different Affiliate Hospitals**

Indicators	Rating					Mean	Rank	Interpretation
	1	2	3	4	5			
No areas provided where students could conduct pre and post conferences	7	23	30	7	8	2.81	*5*	*Moderately Pressing*
Attitudes of Staff Nurses, physicians and other hospital support personnel	16	23	25	8	3	2.45	*18*	*Moderately Pressing*
Staff Nurses not oriented to the BSN Curriculum	22	31	13	5	4	2.17	*25*	*Less Pressing*
Lack of coordination between the school and hospital Staff regarding activities of the students	19	26	20	8	2	2.31	*23*	*Less Pressing*
Insufficient hospital facilities and supplies	17	18	23	11	6	2.61	*20*	*Moderately Pressing*

Too strict Chief Nurses and staff nurses	16	25	21	8	5	2.48	*26*	*Moderately Pressing*
Indicators	**Rating**					**Mean**	**Rank**	**Interpretation**
	1	**2**	**3**	**4**	**5**			
On the spot hospital policies without proper coordination with the school administrators	18	25	21	6	5	2.40	*20.5*	*Less Pressing*
Absences and tardiness of students in reporting for duty	17	22	19	8	9	2.60	*11.5*	*Moderately Pressing*
Inadequate knowledge on nursing concepts, theories and procedures	9	25	28	6	7	2.69	*8*	*Moderately Pressing*
Lack of skills in performing clinical procedures	14	26	25	9	1	2.43	*19*	*Less Pressing*
Scarcity of cases to handle in order to enhance the knowledge and skills of the students	11	15	22	19	8	2.97	*4*	*Moderately Pressing*
Limited exposure on sophisticated and modern hospital equipment and facilities to augment students skills	9	18	19	18	11	3.05	*2*	*Moderately Pressing*
Absences and tardiness of clinical instructors in reporting for duty	18	26	20	5	6	2.40	*20.5*	*Less Pressing*
Uncooperative hospital staff to the related learning experience (RLE) of the student affiliates	17	22	22	9	5	2.51	*15*	*Moderately Pressing*
Favoritism of some clinical instructors and leniency in dealing with other students	6	22	19	17	11	3.07	*1*	*Moderately Pressing*
Laxity of Clinical Instructor in supervising and/or monitoring the performance of students	12	24	26	8	5	2.60	*11.5*	*Moderately Pressing*
Excessive workloads and requirements of Clinical Instructor	11	18	29	9	8	2.80	*6*	*Moderately Pressing*

Unwarranted time set by some Clinical Instructors in the submission of requirements	11	25	16	16	7	2.77	*7*	*Moderately Pressing*
Indicators	**Rating**					**Mean**	**Rank**	**Interpretation**
	1	**2**	**3**	**4**	**5**			
No orientation conducted to the Hired Clinical Instructors on the adopted BSN curriculum of the College	24	24	13	8	6	2.31	*23*	*Less Pressing*
Overcrowded ward/unit due to numerous school affiliates assigned in the same area	10	21	17	10	17	3.04	*3*	*Moderately Pressing*
Lack of information dissemination on curriculum adopted by the College	14	22	26	7	6	2.59	*13*	*Moderately Pressing*
Inadequate qualified Clinical Instructors to take charge of related learning experience	12	27	22	9	5	2.57	*14*	*Moderately Pressing*
Unconstructive attitude of Clinical Instructors towards student affiliates	13	24	30	6	2	2.47	*17*	*Less Pressing*
Limited support of the College in taking actions on the problems encountered by the students in clinical practice	9	33	13	13	7	2.68	*9*	*Moderately Pressing*
Different Clinical Instructors assigned in one group of students per shift	23	23	16	9	4	2.31	*23*	*Less Pressing*
Different Clinical Instructors assigned in one group of students per shift	23	23	16	9	4	2.31	*23*	*Less Pressing*
Limited support of the College in taking actions on the problems encountered by the students in clinical practice	9	33	13	13	7	2.68	*9*	*Moderately Pressing*
Different Clinical Instructors assigned in one group of students per shift	23	23	16	9	4	2.31	*23*	*Less Pressing*
Mean							***2.60***	***Moderately Pressing***

Proposed Measures

The study also determined the measures that could be proposed to improve the Summer Affiliation of the nursing students. One of which is there should be an objective way of evaluating student's performance during the summer affiliation using rubrics as tools for rating. The ICP as summer affiliation must consider longer period of time for clinical duties to ensure improvement and mastery of desired clinical competencies and at the same time more and better exposure to sophisticated and advance equipment and facilities. There should be equal exposure of the students to all affiliating agencies. The capability and competitiveness of the Clinical Instructors to assist students in their clinical exposure and develop personal growth as nursing students was also proposed as one of the measures. The college should also develop a system to effectively disseminate important information to the students. The Clinical Instructors must establish standard requirements. Warranted time must also be considered in the submission of requirements. The students and Clinical Instructors must develop discipline and punctuality with strict provision of rules and regulations during duty hours. There should be consideration between the staff and chief nurses to the students such that cooperation between them is developed. And, there should be an orientation program for hired clinical instructors with regard the BSN curriculum.

Recommendations

To improve the Intensive Clinical Practice of the Nursing students in Aquinas University, the following are recommended: 1) Enhance the development of the students' clinical skills and attitudes in order to attain the highest level of competency; 2) Intensify clinical exposure to enhance the skills of the students; 3) Expose students to highly specialized area in the clinical setting to improve the student's clinical skills; 4) Evaluate the students after every shift to ensure learning; 5) Give proper orientation program to students and clinical instructors to enhance their knowledge and to familiarize them on different areas in the hospital; 6) Highly competent Clinical Instructors to handle students in the clinical setting; 7) Strictly implement rules and regulations during duty days; 8) Give students more opportunities to handle unusual cases to further develop their skills when dealing with these types of patients; 9) Enhance the performance of the clinical instructors by providing series of trainings and seminars as regards to nursing concepts; and 10) Give more co-curricular activities for the

students to enhance their learning.

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CORRELATION OF RELATED LEARNING EXPERIENCE (RLE) PERFORMANCE IN THE CLASSROOM AND CLINICAL SETTINGS OF THE LEVEL 2 GENERIC NURSING STUDENTS OF AY 2008-2009

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Objectives

The paper aimed to establish the correlation of Related Learning Experience (RLE) Performance in the Classroom and Clinical Settings of the second year Generic Nursing students of Academic Year 2008-2009. Primarily, it argues that there is a strong degree of relationship between classroom RLE and clinical RLE performance and students who perform satisfactorily in the classroom RLE also perform satisfactorily in the clinical RLE. The students are able to perform what is learned in classroom RLE to actual situation and this is due to the fact that nursing ideas, facts, principles, theories and processes learned in classroom RLE are applied in the clinical practice. Moreover, the students who performed satisfactorily in their classroom RLE were able to apply the knowledge, skills, and attitude (KSA) that they have learned in the classroom to the actual patient care. Hence, students should enhance their performance through proper motivation and different learning styles in order to attain an excellent performance in the classroom RLE; more hospital exposure of the students to situations where they could practice their cognitive and technical skills is recommended.

Keywords: Student's Classroom RLE Performance, Clinical Setting Performance, Correlation

Related Learning Experience (RLE)

Student's RLE is the most vital part in the Nursing Curriculum since it is the heart and core of nursing education. Through clinical practice, the students acquire experience in patient care and master the practical art of nursing. It is also expected that, clinical instructors should employ a variety of teaching strategies to enhance the learning experience of students so that good performance will be realized.

The Bachelor of Science in Nursing (BSN) Curriculum is a competency based and community oriented curriculum. This curriculum aspires to develop and train students to become professional nurses who will be able to provide safe, intelligent, and effective nursing services to individuals, their families, and the community at large and, furthermore, to develop students to be responsible citizens and members of society.

According to Venzon (1994), the Nursing Curriculum includes all the planned learning opportunities, learning activities and experiences in the classroom, laboratories, hospitals, public health agency and communities where students knowledge, attitude, skills and values in relation to health care.

Nursing students have the responsibility to learn the academic theories and clinical skills needed to provide nursing care. The clinical setting presents unique challenges and responsibilities while caring for human beings in a variety of health care environments.

The paper aimed to establish the correlation of RLE performance in the classroom to the RLE performance in the clinical setting of the second year Generic Nursing students of AY 2008-2009. It also sought to answer the following questions:

1. What is the classroom RLE performance of the second year Generic Nursing students during the first and second semesters of AY 2008-2009?

2. What is the clinical RLE performance of second year Generic Nursing students in Summer of AY 2008-2009?

3. What is the degree of relationship between the classroom and the clinical RLE performance of second year Generic Nursing students during the academic year 2008-2009?

4. What implications can be derived from the findings?

Performance

Academic performance, is the result of the students' hard work in a given subject. In order to raise academic performance one should focus and concentrate on having a right mind-set of enhancing academic performance so that one can learn more effectively. Improving academic performance does not only need focus; it also needs a bit of confidence that one can be smarter. Moreover one must learn how to relax in order to maximize his ability to absorb academic information, understand and communicate it. These are keys to a more improved academic performance.

Academic performance is determined through term examinations, quizzes, class demonstrations, and class participation. These could also determine the ability of the students to respond to their chosen field of endeavor.

Academic knowledge gets one ahead in a competitive world. Students, therefore, exert their utmost effort to achieve their desired academic performance.

Sharon O' Dair (2007) stated that, academics perform in many settings but the most important of which is the classroom, where the principal audiences are the students, the printed page, one's peers. Related to performances in both of these settings, however, are performances in a gathering of like-

minded people who test out ideas upon one another through informal socializing and the formal presentation of peers.

Alcala stated in her study in 2001, that clinical practice is very important in the development of students' competencies for they can perform what is learned in the classroom to actual nursing situation. She recommended an increase in the clinical exposure of the students to situations where they could practice their cognitive and technical skills.

Methodology

The paper used the descriptive correlational research design as it aimed to discover the relationship between the RLE performance in the classroom and that in the clinical setting. The respondents are the second year students of the Aquinas University College of Nursing Generic Program AY 2008-2009. The records from the Office of the College of Nursing and Health Sciences served as the primary data which were treated using the Statistical Package for Social Sciences (SPSS) version 13 to provide accurate statistical analysis, and interpretation. Frequency, percentage, and the mean were used. The Pearson Product Moment Correlation Coefficient was used to determine the degree of relationships between the variables.

Table 1 shows the average grade of the respondents in the four RLE subjects. RLE subjects consist of Introduction to Nursing Practice SLE (N100A.1) and Related Learning Experience (RLE)/Skills Laboratory Experience (SLE) (HC 101.1) during the first semester, and Introduction to Nursing Practice SLE (N100B.1) and Related Learning Experience (RLE)/Skills Laboratory Experience (SLE) (HC102.1) during the second semester.

The Table 1 shows the frequency distribution of the RLE performance in the classroom setting of the second year nursing students enrolled during the academic year 2008-2009. It can be deduced from the data that half (50%) of the respondents have grades ranging from 85 to 89 and 46% of them have grades ranging from 80 to 84 in their RLE performance in the classroom setting. On the other hand, only 3% of the respondents have

grades ranging from 90 to 94 and the remaining 1% of the respondents have a grade of 75 to 79 in their RLE in the classroom setting. In terms of classroom performance, half of the respondents have satisfactory performance in their RLE. This means that they have acquired the knowledge needed in actual RLE.

Table 1. **Frequency Distribution of RLE Performance in the Classroom Setting**

Class	Adjectival Interpretation	Frequency	Percentage
75-79	*Poor*	01	01
80-84	*Fairly Satisfactory*	04	03
85-89	*Satisfactory*	109	94
90-94	*Very Satisfactory*	02	02
Total		**116**	**100**

Table 2 shows the RLE performance in the clinical setting which consists of the average of the respondents in their RLE subject, the NCM 100.1 taken during the summer term of academic year 2008-2009.

Table 2. **Frequency Distribution of RLE Performance in the Clinical Setting**

Class	Adjectival Interpretation	Frequency	Percentage
75-79	*Poor*	01	01
80-84	*Fairly Satisfactory*	53	46
85-89	*Satisfactory*	58	50
90-94	*Very Satisfactory*	04	03
Total		**116**	**100**

Table 2 shows the frequency distribution of RLE performance in the clinical setting of the generic nursing students enrolled in academic year 2008-2009. It can be inferred from the data that majority (94%) of the respondents have grades ranging from 85 to 89 and 3% of them have grades from

80 to 84 in their RLE performance in the clinical setting. On the other hand, 2% of the respondents have grades ranging from 90 to 94 and the remaining 1% of the respondents has a grade of 75-79 in their RLE performance in the clinical setting. In terms of clinical performance, most of the respondents have satisfactory performance in their RLE.

Relationships of Classroom RLE to Clinical Performance

The Clinical Instructor should set goals and help students achieve maximum growth and development. There is a fundamental difference between prepositional knowledge-the knowing that-and the ability to perform something-the knowing how.

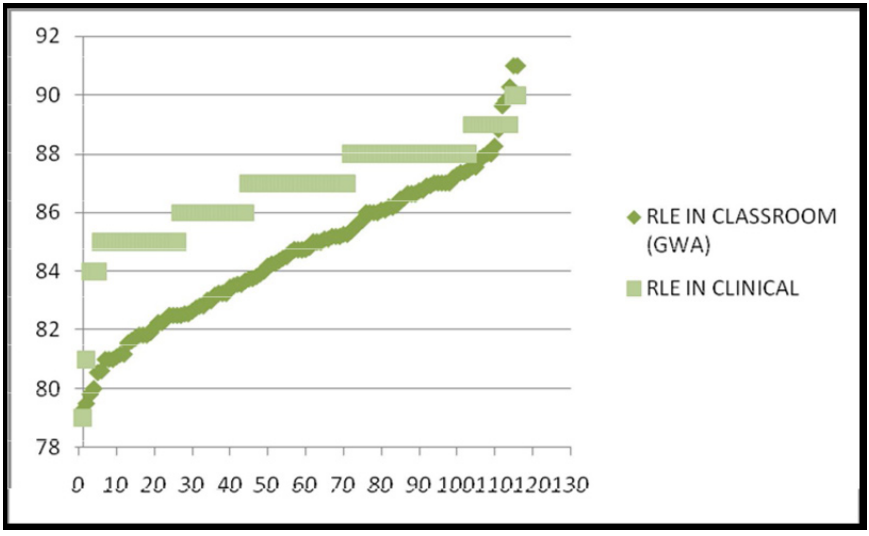
The study determined the relationship of classroom RLE to clinical performance by using linear relationship as shown in Figure 1. The study plotted the respondents on the X-axis and the RLE performance in the classroom and clinical settings are plotted on the Y-axis. Based on the data presented, it showed that there is a strong positive degree of relationship between the RLE performance in the classroom and clinical settings of second year generic nursing students enrolled in AY 2008-2009. The finding suggests that students who perform satisfactorily in classroom RLE also perform satisfactorily in the clinical setting. Therefore, the relationship of RLE performance in the classroom setting is directly proportional to the RLE performance in the clinical setting and this is due to the fact that what they have learned in the classroom is being applied in actual care.

The correlation between classroom RLE and clinical RLE shows a result of 0.480 which suggests that a strong degree of relationship exists between classroom RLE and clinical RLE. This suggests that classroom RLE is a strong indicator of the clinical RLE.

The relationships of classroom RLE to clinical performance are supported by studies. Gregorio (1987) stated that the formulation of objectives of any learning experience for the student should stimulate him to make maximum use of his capabilities and potentials. The study of Bitare (2001) is also consistent with the classroom-based RLE as basis of ideal health

care but not always in the actual locale. According to her, it is a philosophy of learning founded on the premise that a learner constructs his own understanding of the world he lives in by reflecting on his experiences. With this, the students first absorb the new information imparted by their professors through the process of deliberation and awareness.

Figure 1. **Linear Relationships between the RLE Performance in the Classroom and Clinical Settings**



The acquired facts and data are being transformed into ideas. These ideas would then progress to deeper intellectual insights. The experiences which are considered as everyday life situations and events inside the campus as well as exposure in the hospital could be disregarded or valued upon as a response to the impact created right away. If valued, these become a prominent manifestation of self, thus, creates a pattern of behaviors.

The study is also supported by the theories of Henderson and Cratty. Henderson's Nursing Education and Practice Theory emphasizes learning by doing, speedy performance, technical competence, and successful mastery of the nursing procedures. The nurse must be knowledgeable, must be

skilled in practicing individualized human care, and must be a scientific problem solver. It is through practice that students learn to develop their skills. Cratty's Learning and Performance Theory that would influence learning and performance presents general factors in human performance including level of aspiration, task persistence, and ability to analyze task mechanics in learning and performance. According to her, it includes specific ability traits associated with success in motor performance and then highest level is found. Factors specific to a given task such as practice conditions, past experience and unique movement patterns are required. She believed that, the effective instructor should consider the three levels of factors and their mutual influence on the activity to be learned, which are modifiable in a short period of time and which are not. Instruction should be organized in a meaningful manner. Before the actual exposure of the students to the hospital and community setting, the students must be prepared through orientation, familiarization on and classroom discussion of concepts. Students must given different activities in the classroom to assess their readiness to perform the actual nursing care in the hospital and in the community.

The paper argues and establishes the correlation of RLE performance in the classroom to the RLE performance in the clinical setting of the Second Year Nursing Students of AY 2008-2009. In order to substantiate such correlation, the following were drawn from the findings gathered by the study:

Half of the respondents have grades ranging from 85 to89 in their RLE performance in the classroom setting. In terms of classroom performance, half of the respondents have satisfactory performance in their RLE. The majority of the respondents have grades ranging from 85 to 89 in their RLE performance in the clinical setting. In terms of clinical performance, most of the respondents have satisfactory performance in their RLE. Correlation Coefficient of 0.480** is significant, thus, indicative of a strong degree of relationship between classroom RLE and clinical RLE performance. This finding suggests that students who perform satisfactorily in the classroom RLE also perform satisfactorily in the clinical RLE. Classroom RLE and clinical RLE are congruent. The correlation of theoretical knowledge to clinical RLE is evident. The result implies that the students are able to perform what is learned in classroom RLE to actual situation.

The student's future competence as a nurse practitioner depends to a large extent upon the quality of instruction provided during the clinical practice period. It is where students can apply and retrieve concepts presented in class and develop the skills and judgment which will be required of them as they practice nursing. Along this line, clinical instructors should employ a variety of teaching strategies to enhance the learning experience of students so that good performance will be realized. Competencies depend on the students' attitude as well as on other factors involved in teaching-learning such as educators, hospital, staff and curriculum. These factors must be interwoven to enhance, improve and uplift the competency of students in RLE.

Learning, according to Perkins (1964), is most effective when it is meaningful and is related to individual needs, perception, and interests of the learner, when it begins where the learner is, and when it perceives the learner as enhancing his own self-concept.

Conclusion

All students passed their classroom RLE except for one (1) student who performed poorly. This means that they have acquired the knowledge needed in actual RLE. All the respondents passed the clinical RLE. This implies that the respondents are able to apply what they have learned in classroom RLE to the actual practice in the clinical care. The results imply a strong degree of relationship between RLE performance in the classroom and actual practice in the clinical area. This is due to the fact that nursing ideas, facts, principles, theories, and processes learned in classroom RLE are being applied in the clinical practice. And the learned theories in classroom RLE are integrated to actual care. This implies that the respondents have satisfactory performance in classroom RLE and are able to apply the knowledge, skills, and attitudes they have learned in the classroom to actual patient care.

The paper wanted to emphasize that clinical instructors play a great part in the students' learning. They should provide the students with theories, knowledge and ideas, which should be discussed and explained well in the

classroom setting thus, exposure to a certain area must be done not only once but as many times as possible to a particular area to acquire more skills and knowledge while being exposed to that setting. To be skilled means to practice and experience the work many times. It is the integration of learned knowledge and attitude into practice in the hospital and community setting that makes students work efficiently and effectively.

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CORRELATION OF RELATED LEARNING EXPERIENCE (RLE) PERFORMANCE IN CLASSROOM AND CLINICAL SETTINGS OF LEVEL II LADDERIZED NURSING STUDENTS

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Abstract

The constant change in human responses and its interrelationships with the society is a big influence in the continuous development of nursing education. The academe is likewise constantly challenged to produce skilled nurses. This study aimed to identify the relationship between the performance of nursing students in the courses pertaining to the RLE in the classroom and in the clinical setting. Specifically, it identified the degree of correlation and significance between the two variables. It involved 82 students in Level II ladderized nursing program of AUL-College of Nursing for SY 2007-2008 and SY 2008-2009. The study revealed an improvement in the performance of the students in the classroom RLE from fair to satisfactory for the two consecutive semesters. However, the clinical RLE performance remained fair for the two semesters. A positive moderate correlation between the classroom and the clinical RLE performance is shown by the scatterplot diagram after subjecting the raw data to Pearson's product moment correlation and testing the hypothesis using t-test. The study recommends effective and appropriate teaching-learning activities, availability of equipment and facilities for training and opportunities for instructors to improve in their craft.

Keywords: related learning experience, clinical performance, correlation

Continuous Development of Nursing Education

The nursing profession has its own history to boot. From the lowly attendant of the sick during the intuitive period, the development of nursing activity as a profession to rank against other professions was seen in the contemporary period. This was brought about by the flourishing of the scientific aspect of nursing, which actually continues up to the present time. The development of the profession and its significance in healthcare has spanned decades and gained the interest of many.

In the Philippines, the Bachelor of Science in Nursing (BSN) curriculum has undergone several revisions spearheaded by the Commission on Higher Education (CHED). This has left nursing schools to implement two or more curricula in a semester. Currently, there are two curricula being implemented: CMO No. 30 (Series of 2004) and CMO No. 14 (Series of 2009). The country has also seen the mushroom-like sprouting of schools of nursing after the career has been found luxurious especially when practiced in other countries. Indeed, the BSN program has been demanded by young people and their families alike.

The BSN Program

Conceptually, the goal of this program is to produce professional nurses who can serve people, young or old, in any health status i.e., healthy or ill) and in any health setting (i.e., in a health care facility, at home or in the community. The constant change of human responses is the primary reason for the continuous change of the nursing education as well. Moreover, the various settings where nurses can work necessitates that the program has a multidisciplinary approach.

The program provides students with specific knowledge, skills and attitude that can be gained only through a well-organized nursing curriculum that includes classroom and laboratory instruction as well as clinical application and

practice (Vibar, 2007). The knowledge-base of nursing education is gained through didactic of theoretical classroom experience. Since it is impossible for nurses to acquire a safe level of skill through empirical means (i.e., exposure and observation) alone, actual application of such knowledge has to be gained through clinical practice in hospital, health agencies and community settings. Such experiential application of learned knowledge in actual situations is referred to as Related Learning Experience (RLE).

Related Learning Experience: Clinical

Generally, the clinical RLE prepares nursing students for the professional practice. This particular portion of the curriculum provides students with actual patients in a real setting on an 8-hour shift. They apply nursing principles and concepts with the policies of both the school and the institution guiding their decisions and actions. They work with the nursing staff as well as the nursing administrators. Beyond these, the students are required to submit various paper works such as nursing care plans, case studies and documentation reports. In every step, students have a clinical instructor who facilitates learning by helping them assimilate principles and concepts with actual experiences.

The RLE also prepares the students with the basic nursing skills needed in dealing with patients in a real setting. This may also serve as an opportunity for an ongoing assessment of students having their clinical RLE with the aid of a clinical instructor who can identify the weaknesses of the students in their performance of the nursing skills and introduce measures toward the improvement of these skills.

CHED has identified the required number of hours to be rendered by students in a hospital and a community setting. In a hospital setting, the students may be assigned in the general ward and specialty areas, such as the delivery room, operating room, emergency room, or the outpatient department. In the community, the students may render duty in the rural health center, barangay health station, birthing center, or visit families in their households.

In this study, clinical RLE pertains to Midwifery 102.1 and Midwifery 103.1. M102.1, entitled Midwifery Practice 2 with RLE/ SLE, deals with

the concepts of (1) complication of pregnancy, its causes and management; (2) family planning inclusive of NFP reinforcement and continuation; as well as commonly accepted, safe artificial modes of family planning; and (c) care of infant/ children. M103.1, Midwifery Practice 3 with RLE/SLE, discusses the legal aspects of Midwifery practice. It includes career development and current trends and issues affecting health care and midwifery practice. It also provides enhancement of the practice of the midwifery skills which includes strategies of health teaching and education of clients (CMO No. 33 Series of 2004).

Related Learning Experience: Classroom

These midwifery courses support clinical RLE. Theories and principles of health care are thoroughly discussed in the classroom. Instructors prepare the syllabus and implement appropriate teaching strategies which may include lecture, debate, film viewing, and case studies. These teaching strategies are complemented with the use of LCD projectors, computers, television and other instructional technology.

In this study, classroom RLE pertains to Midwifery 100.1 and Midwifery 101.1. M100.1, entitled Foundations of Midwifery Practice with RLE/ SLE plus the Competencies of Caregiving IB, provides the student basic knowledge, skills and attitudes in the care of individuals and their families. This includes comfort measures applied to individual clients and families. Embedded in this course are the competencies in Caregiving. *The Basic competencies* include: 1) participating in workplace environment; 2) working in team environment; 3) practicing career professionalism; and 4) practicing occupational health and safety procedure. *The Common competencies* cover 1) implementing and monitoring infection control policies and procedures; and 2) responding effectively to difficult/ challenging behavior. The *Core competency includes* preparing hot and cold meals/ food. M101.1, entitled Midwifery Practice I with RLE/ SLE, deals with concepts of normal pregnancy, labor and delivery. Concepts related to Natural Family Planning and Responsible Parenthood may already be introduced. It includes intravenous insertion, vaginal examination and suturing (CMO No. 33 Series of 2004).

Aiming for Competence

Globally, nursing is viewed as both a science and an art - a body of proven, organized and systematic knowledge and a soul of smooth, coordinated and ethical practice (Astrero, *et.al.*) An ideal modern nurse possesses equilibrium of cognition, action and emotion in an attempt to uphold the nursing principles of knowledge, skills and attitude. Moreover, s/he exercises flexibility in applying these principles at all times to provide customized care for the client who seek and deserve a humanistic and quality health care.

The Filipino nurse has been a popular choice of foreign clients, that is, both the patients and health care institutions. They are known to be smart, gentle and harmonious workers. The demand of other nations for Filipino nurses has been ongoing for more than a decade. The country exports nurses to the United States, London, the Middle East, and other countries. The Filipinos regard this opportunity highly. In his paper entitled, "The Brain Drain Phenomenon and Its Implications to Health," Galvez-Tan, *et. al.* (2005) revealed that since 1994, more than 100,000 nurses have left the country to work abroad. The financial returns have been evident and have been enjoyed for many years by Filipino families across the country.

Presently, over 370 universities and colleges in the country offer the four-year course BSN program in response to the nursing career opportunities abroad. However, the increase in nursing schools is not equivalent to the increase in number of qualified nurses who pass the national Nursing Licensure Examinations (NLE) offered by the Professional Regulation Commission (PRC). In the same article by Galvez-Tan, *et. al.* (2005), they mentioned the continuous decline in the average passing rates among nursing graduates. Between the 1970s and 1980s, the passing rate ranged from 80 to 90 %. But beginning 1994, the passing mark has declined and by the advent of the new millennium, the average ranged from 44% to 53%. In November 2008 the passing rate was only 44.51%.

The low NLE passing rate of the country for a prolonged period is assumed to have a direct implication on the performance of the new generation of Filipino nurses. Consequently, the BSN program has to be evaluated to

determine its effectivity in producing knowledgeable and highly skilled nurses for whom the Filipinos are known world wide.

The study is anchored on the following theories: Van Sell-I's Theory of Nursing Knowledge and Nursing Practice, Benner's Professional Socialization Theory and Klausmeier's Theory of Retention and Transfer.

Problem Statement

This study attempted to assess the RLE component of the BSN program during the second semester, S.Y. 2008-2009. It identified the degree of correlation of RLE performance of the Level II ladderized nursing students between their classroom and clinical RLE. It hypothesized that there is no correlation such that student performance in the classroom and in the clinical setting do not influence each other. Specifically, the study sought answers to the following questions:

1. What is the classroom RLE performance of the Level II Ladderized Nursing Students of AUL – CNHS?

2. What is the clinical RLE performance of Level II Ladderized Nursing Students of AUL – CNHS?

3. What is the degree of correlation between the classroom and the clinical RLE performance of Level II Ladderized Nursing Students of AUL – CNHS?

4. What measures can be proposed to enhance the classroom and clinical RLE performance of level II Ladderized Nursing Students of AUL – CNHS?

Methodology

This study used the descriptive correlation method of research. In this study, the relationship between the classroom RLE performance and the clinical RLE

performance, were tested for degree of correlation and significance. However, it did not infer cause-and-effect relationships. The study is non-experimental since it is conducted in a natural setting – the classroom and clinical areas.

The ladderized nursing students Batch 2007 of AUL-CNHS were considered the population of the study. The Official List of Enrolled Students from the Registrar's Office served as the sampling frame. A sample of 82 students was included considering reasons for exclusion such as dropping from the roll, not giving consent and having incomplete grades.

Grades of the students for Midwifery (M) 100.1 and M 101.1 were treated as the Classroom RLE performance. These courses were taken the previous year (1st and 2nd Semesters AY 2007-2008). It included ratings for return demonstration of basic nursing skills, term examinations, short quizzes, and the objective skills practical examinations (OSPE).

Grades for M 102.1 and M 103.1 were treated as the Clinical RLE. These courses were taken at the current year the study was done (i.e., 1st and 2nd Semesters, AY 2008-2009). It included ratings for the eight rotations in the hospital or community submitted by respective clinical instructors.

The grades were categorized and interpreted as follows:

Excellent	90-94
Very Satisfactory	85-89
Satisfactory	80-84
Fair	75-79
Failed	<75

The mean grades of the students in the various courses were computed and interpreted as follows:

Advanced	90-94
Proficient	85-89
Basic	80-84
Below Basic	75-79
Far Below Basic	<75

(Source: California Modified Assessment)

The degree of correlation between classroom and clinical RLE performance was computed through the Pearson's Product Moment Correlation (r). This is the most common method by which the relationship between two variables is quantified. Computed data was interpreted as none, weak, moderate, or perfect. Significance of the correlation was further done to determine the probability of r occurring by chance alone. Hypothesis testing was done using the t-test.

Findings

The data gathered in determining the performance of students in the classroom RLE were collated and ranked as shown in Table 1. Around one-third (n=37) rated satisfactory by getting a grade between 75-79%. However, the students' performance improved the following semester. More than half of the students (n=42) rated very satisfactory in M101.1 with grades ranging from 80-84%. Moreover, there were only two students who failed in this course than in the previous semester where twelve students got a grade below 75% in M100.1.

Table 1. **Classroom RLE Performance Among Level II Ladderized Nursing Students, Aquinas University of Legazpi, SY 2007-2008**

Range	M 100.1		M 101.1	
	f	*Rank*	*f*	*Rank*
90-94	10	**4**	2	**3.5**
80-84	23	**2**	42	**1**
75-79	37	**1**	36	**2**
< 75	12	**3**	2	**3.5**
Total	*82*		*82*	
Mean	**84.06**			

The performance of students in the clinical RLE were likewise collated and ranked. Similar results were discovered in both courses. Table 2 shows that the majority of the students performed satisfactory in M102.1 (n=43) and M103.1 (n=42). It is also noteworthy to highlight that no student failed in these courses.

Table 2. **Clinical RLE Performance Among Level II Ladderized Nursing Students, Aquinas University of Legazpi, SY 2008-2009**

Range	M 102.1		M 103.1	
	f	*Rank*	*f*	*Rank*
90-94	0	**3.5**	3	**3**
80-84	39	**2**	37	**2**
75-79	43	**1**	42	**1**
< 75	0	**3.5**	0	**4**
Total	*82*		*82*	
Mean	**84.63**			

The sample population of Batch 2007 of nursing students of the Ladderized BSN Program achieved mean grades of 83.59% and 84.54% for M 100.1 and M101.1, respectively, with a difference of 0.95%. Thus, their classroom RLE performance can be described as basic. On the other hand, this particular group achieved mean grades of 84.49% and 84.87% for M 102.1 and M103.1, respectively, with a difference of 0.38%. Their clinical RLE performance is similarly described as basic.

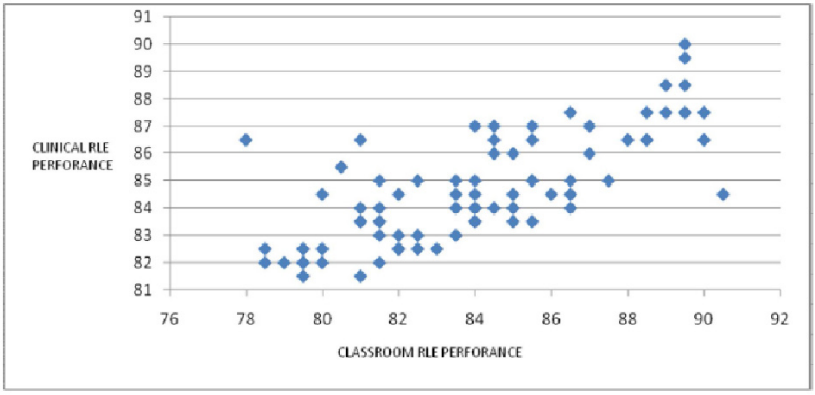

Figure 1. **Correlation Between Classroom and Clinical RLE Performance Among Level II Ladderized Nursing Students, Aquinas University of Legazpi, SY 2007-2008 and SY 2008-2009**

A moderate correlation between the RLE performance in classroom and clinical settings among the Level II ladderized nursing students was identified by this study with an $r = 0.607$ and tested at $\alpha = 0.01$ level of significance. The scatterplot diagram further supports the positive relationship of the variables being tested.

Table 3 shows the distribution of data after statistical treatment.

Table 3. **Correlation of Classroom and Clinical RLE Performance Among Level II Ladderized Nursing Students, Aquinas University of Legazpi, AY 2007-2008 and AY 2008-2009**

Pearson Correlation (Sig. (2-tailed)	M100.1-Classroom	M101.1-Classroom	Classroom Average	M102.1-Clinical	M103.1-Clinical	Clinical Average
M100.1-Classroom	1	0.794	0.963	0.610	0.710	0.592
M101.1-Classroom	0.794	1	0.928	0.546	0.652	0.552
Classroom Average	0.963	0.928	1	0.615	0.723	0.607
M102.1-Clinical	0.610	0.546	0.615	1	0.655	0.776
M103.1-Clinical	0.710	0.652	0.723	0.655	1	0.783
Clinical Average	0.592	0.552	0.607	0.776	0.783	1

To improve the classroom and clinical RLE performance of Level II ladderized nursing students, the following were proposed: 1) dedication to learning and training; 2) use of varied teaching strategies; 3) accurate evaluation of student performance; and 4) availability of Student's Competency Profile.

Analysis

Student performance in the classroom RLE courses improved from fair to satisfactory with almost a full score of increase in the mean grades. Such

finding can be attributed to gain of knowledge and understanding because of constant exercise, deliberation and reflection of the cognitive component (Smith, 1999). The three steps in learning is also reflected by this result. This pertains to acquisition, retention and integration of information in which learning was attained and improved (Klausmeier, 1962).

The students performed fairly in the clinical RLE. There was a steady result for the two semesters when M102.1 and M 103.1 were offered. There was little improvement of 0.38% in the mean grade which was not enough to change the adjectival rating. The finding is attributed to stability of rational thinking, adaptation and practice due to the repeated exposure in the clinical settings (Slerry, 2003). Likewise, this is supported by Benner's theory which assumes that in the initial stage, performance is limited. But with further experiences, a student's clinical abilities are honed and improved. The role of the instructor is also deemed important. From a teacher-centered approach in the classroom, this aspect of learning turns to a student-centered approach so that the instructor merely guides the students in acquiring facts and figures to develop his concept and understanding and apply principles in the clinical area (Nettina, 2006).

The positive and moderate correlation as shown by the scatterplot diagram and the tests for correlations agrees with Van Sell's formulation that nursing knowledge (i.e., classroom RLE performance) and nursing practice (clinical RLE performance) are directly proportional with each other. To quote the author, "as Nursing Knowledge increases, Nursing Practice also increases and vise versa". This negates the hypothesis made by this study.

Recommendations

Primarily, there is an urgent need to design effective and appropriate teaching-learning activities to promote meaningful experiences towards the development of a nurse in training. The mix of didactic and empiric methods is still believed to work towards the achievement of this particular goal. Moreover, actual patients of particular cases may support the learning of students in the classroom.

Ensuring the availability of equipment and facilities for training is equally significant. It is believed that the practical component of nursing is the fruit of experiential learning. This includes the materials for skills laboratory as well as the affiliation of nursing schools with agencies or hospitals.

To be able to provide quality nursing education, it is also imperative that instructors should attend trainings to update themselves, as well as participate actively in research, to help them improve their teaching strategies and enrich their course contents.

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