University of the Philippines Manila
COLLEGE OF NURSING

Implementing Family Health Nursing Care

Jeremiah Carlo V. Alejo, RN, MCD, MD

Nursing Process in Family Health

- The main framework in nursing practice and the means by which nurses work with client-partners
- Phases:
    1. Establishing a working relationship
    2. Assessment
    3. Diagnosis
        1. Presence of Wellness Condition, Health threat, Health Deficit, or Foreseeable Crisis
        2. Performance of Family Health Tasks
    4. Planning of Outcomes and Interventions
    5. Implementation
    6. Evaluation

Developing the Intervention Plan

"… in community health nursing, the nurse deals mostly with problems within the domain of human behavior or human response to health and illness…Much of the nurse's effort are ***directed at effecting change in the behavior of clients to achieve optimum health***." (Maglaya, 2009)

Goal of the family Nursing Interventions:

Minimize or eliminate the possible reasons for or causes of a family's inability to perform the health tasks

Family Health Tasks
(Freeman and Heinrich, 1981, and Bailon and Maglaya, 1978)

1. Recognize the presence of a wellness state or health condition or problem
2. Make decisions about taking appropriate action
3. Provide nursing care to the sick , disabled, dependent, or at-risk members
4. Maintain a home environment conducive to health maintenance and personal development
5. Utilize community resources for health care

Beliefs about the Health Problem (Wright and Leahey, 2013)

A. Beliefs:
    A. diagnosis, etiology, prognosis, and treatment treatment;
    B. mastery, control and influence; religion and spirituality;
    C. places of illness in lives and relationships, roles of family members, role of healthcare professionals
B. Influence of the family on the health problem: resource utilization and medication and treatment
C. Influence of the health problem on the family
D. Strengths related to the health problem at present
E. Concerns related to the health problem at present

Second- Level Assessment

TABLE 19.1 Categories of Data Collection for Family Health Assessment

Assessment Categories	Family Strengths and Self-care Abilities	Family Stresses and Problems	Family Resources
1. Family demographics			
2. Physical environment			
3. Psychological and spiritual environment			
4. Family structure/roles			
5. Family functions			
6. Family values and beliefs			
7. Family communication patterns			
8. Family decision-making patterns			
9. Family problem-solving patterns			
10. Family coping patterns			
11. Family health behavior			
12. Family social and cultural patterns			

Unique Function of the Nurse in Family Health Care

Assist the family cope effectively with health problems by increasing its capability to preform the health tasks.

Calgary Family Intervention Model

Domain of Family Functioning	Outcome and Interventions
Cognitive	**Goal:** change in the way the family perceives its health problems so that members can discover solutions
Affective	**Goal:** reduce or increase intense emotions as needed to facilitate problem-solving efforts
Behavioral	**Goal:** help the family interact with and behave differently in relation to one another

Developing the Intervention Plan

Types of Nursing Interventions:

1. **Developmental** – aims to improve the capability of the client to act on their own
2. **Facilitative** – aims to remove barriers to care
3. **Coordinative/supportive** – aims to make services readily available and accessible
4. **Clinician/supplemental** – aims to provide services that the family can not do

Developing the Intervention Plan

Types of Nursing Interventions:

1. **Developmental** – aims to improve the capability of the client to act on their own
2. **Facilitative** – aims to remove barriers to care
3. **Coordinative/supportive** – aims to make services readily available and accessible
4. **Clinician/supplemental** – aims to provide services that the family can not do

Problems during the Implementation Phase (Maglaya, 2009)

1. Use of patterned or cannes approaches when working with families

2. Inadequate appreciation of social and cultural factors or realities

3. Inadequate or limited repertoire of intervention techniques and skills

Case Management

- a collaborative to ensure, coordinate, and integrate care and services for patients, in which a ***case manager evaluates, plans, implements, coordinates, and prioritizes services on the basis of patients' needs in close collaboration with other health care providers.*** (Hudon, et.al. 2019)

- a health care process in which a professional helps a patient or client develop a plan ***that coordinates and integrates the support services that the patient/client needs*** to optimize the healthcare and psychosocial possible goals and outcomes. (Giardino and De Jesus, 2023)

Case Management

- a collaborative to ensure, coordinate, and integrate care and services for patients, in which a ***case manager evaluates, plans, implements, coordinates, and prioritizes services on the basis of patients' needs in close collaboration with other health care providers.*** (Hudon, et.al. 2019)

- a health care process in which a professional helps a patient or client develop a plan ***that coordinates and integrates the support services that the patient/client needs*** to optimize the healthcare and psychosocial possible goals and outcomes. (Giardino and De Jesus, 2023)

Case Management: Components (Lukersmith, et. al, 2016)

1. Case-finding
2. Establishing rapport
3. Assessment
4. Planning
5. **Navigation –** facilitating safe and effective connections to service across settings
6. Provision of care
7. Implementation

*__Brokering –__ connecting a patient to needed services and to coordinate between different service providers

Case Management: Components (Lukersmith, et. al, 2016)

8. **Coordination** – navigating the system of providers and resources needed, referral, facilitating multi-disciplinary collaborations.
9. Monitoring
10. Evaluation
11. Feedback
12. Education/information
13. Advocacy
14. Supportive counselling
15. Administration
16. Discharge/disengagement
17. Community service development

Case Management: Components (Lukersmith, et. al, 2016)

8. **Coordination** – navigating the system of providers and resources needed, referral, facilitating multi-disciplinary collaborations.
9. Monitoring
10. Evaluation
11. Feedback
12. Education/information
13. Advocacy
14. Supportive counselling
15. Administration
16. Discharge/disengagement
17. Community service development

Case Management: Related processes (Giardino and De Jesus, 2023):

1. ***Care management*** - a program composed of a broad set of activities and tasks that include the healthcare-related aspects of case management but ***also extends to a wide array of services, supports, benefits, and entitlements*** to which the patient/client may have access within a benefit plan

2. ***Care Coordination*** – in population health context, a means for an organization or institution to manage the many need of a population of patients, often by *determining specific subgroups who should receive case management services*

3. ***Disease management*** – case management directed at particular patient groups who all share a common condition.

Case Management: Principles (Hunt, 2005):

1. Involve clients and families in assessing their level of functioning
2. Determine the resources and services necessary to maximize quality of interventions provided to improve the quality of life of clients
3. ***Involve clients and families in identifying, exploring, and accessing available resources***
4. ***Have clients and families identify the most appropriate referral for their needs***
5. ***When making referrals and coordinating access to services, provide information to facilitate the client's navigation of the health system***
6. Act as an advocate or troubleshooter as necessary
7. Evaluate the client's and family's progress towards health outcomes
8. Revise or modify plans accordingly

Specific Interventions Commonly Used

1. **Direct patient care**
2. **Case management**
3. **Client and Family Health Education**
4. **Family Counseling and/or Therapy**

Client and Family Health Education

- Begins only when the family members express an interest and recognize a need (Readiness to learn).
  - Need to learn – information perceived as needed or relevant for immediate application
  - Readiness to learn – involves such factors as emotional state, abilities, and potential

- directed ***towards developing the family's competencies to perform the health tasks***
  - Includes cognitive, psychomotor, and atffective competencies

Client and Family Health Education

- ***Begins only when the family members express an interest and recognize a need*** (Readiness to learn).
  - Motivation – the desire to learn
  - Need to learn – information perceived as needed or relevant for immediate application
  - Readiness to learn – the demonstration of behaviors or cues that reflect the learner's motivation at a specific time; involves such factors as emotional state, abilities, and potential

- directed ***towards developing the family's competencies to perform the health tasks***
  - Includes cognitive, psychomotor, and atffective competencies

Client and Family Health Education: The Process

- Assessing the Client's Learning Needs and Characteristics
- Diagnosing the Learning Needs of the Clients
- Planning:
    - Determining Teaching Priorities
    - Setting Learning Outcomes
    - Choosing and Organizing the Content
    - Selecting the Teaching Strategies
- Implementing the Teaching Plan
- Evaluating the Teaching-Learning Process

Client and Family Health Education: The Process

Guidelines in Choosing and Organizing the Content

1. The content to be taught is determined by the learning objectives

2. New learning must be based on previous knowledge and experiences.
    1. Facilitate analysis and processing of information based on their grasp of their lived experiences
    2. Involve the family in determining the content based on the health tasks they need to perform
    3. Use examples the family is familiar with

Client and Family Health Education: The Process

Guidelines in Choosing and Organizing the Content

3. If the client has no prior knowledge or experience regarding the identified learning needs, it is necessary to include basic information regarding the topic in the learning contents. Develop objectives for content that are added in the teaching plan.
4. Proceed from simple to complex.
5. Content should be:
    - Accurate
    - Current
    - Based on learning outcomes
    - Adjusted for the learner's characteristics
    - Consistent
    - Selected with consideration of time and resources

Client and Family Health Education: The Process

Guidelines in Selecting the Teaching Strategies

1. Teaching activities should help the family develop their competencies in performing the health tasks.
2. Provide experiential learning activities, including role playing exercises
3. Provide opportunities for small group discussions
4. Ensure clarity
5. Ensure mastery by adequate evaluation, feedback, monitoring and support.

Specific Interventions Commonly Used

1. **Direct patient care**
2. **Case management**
3. **Client and Family Health Education**
4. **Family Counseling and/or Therapy**

Counseling

- Refers to providing support, helping another find solutions to problems, generally guiding someone to be better (Lapena, 2014)

- Two elements: education and psychological support (Neri, 2014)

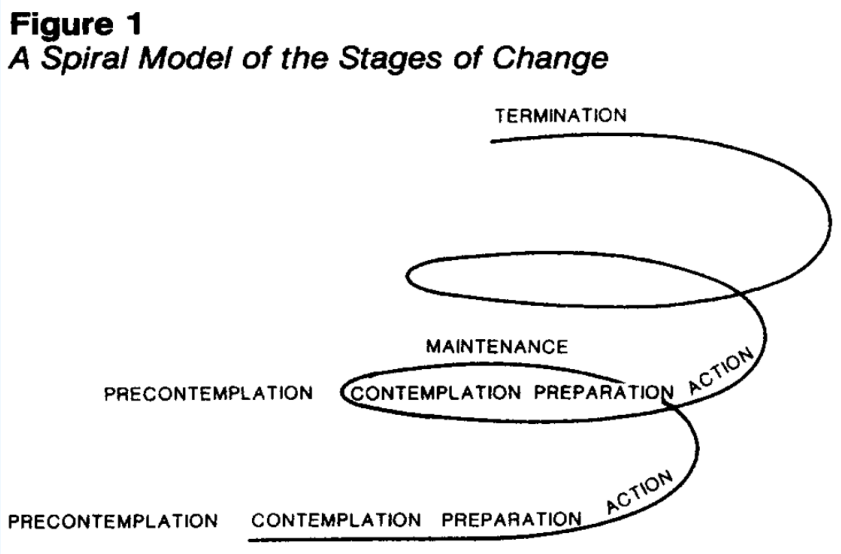
- Aids in dealing with the psychosocial impacts of an illness (Dionisio, 2014):

- Patients and families consult for two reasons: the physical symptom and the anxiety arising from the symptom
- Anxiety may prevent families from learning/absorbing information.
- Emotions, including anxiety, is rooted in perceptions which may be more easily addressed.

Counseling for Behavior Change

Transtheoretical Model
(Prochaska,et al., 1992)– describes different stages of readiness to change:

1. Precontemplation – no desire to change the behavior
2. Contemplation – considers changing the behavior
3. Preparation – concrete plans
4. Action
5. Maintenance



Counseling for Behavior Change

Step 1: Define the behavior

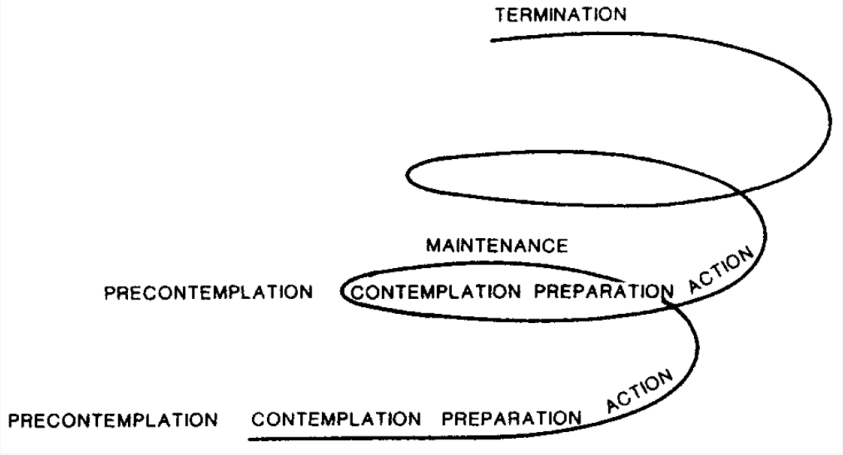
Step 2: Understand the context of the problem behavior

Step 3: Identify barriers and resources to change

Step 4: Strategize with the patient/family and anticipate difficulties

Step 5: Implement the plan and continuously monitor until the targets are achieved

Figure 1
A Spiral Model of the Stages of Change



Family Therapy (Neri, 2014)

- Focuses on ***family patterns*** directly related to the medical problem
- Involves:

1. Establishing rapport
2. Ventilation – every member should have an opportunity to articulate perceptions and feelings regarding the problem
3. Awareness of strength – to see hope or feel something in the situation to facilitate objective thinking about the situation
4. Identifying needs
5. Action plan – specifying behaviors needed from each member of the family
6. Follow-up