EMBEDDING AND SPREADING OF 2012 NATIONAL NURSING COMPETENCY STANDARDS

MONOGRAPH 2
Embedding and Spreading of 2012 National Nursing Core Competency Standards

MONOGRAPH 2
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The completion of the 2012 National Nursing Core Competency Standards (NNCCS) in June 2012 and its promulgation by the PRBON on July 27, 2012 was indeed very timely as this complemented the implementation of the three government initiatives - ASEAN Mutual Recognition Arrangement (MRA), Philippine Qualifications Framework (PQF) and the ASEAN Qualifications Reference Framework (AQRF) emphasized by the Professional Regulation Commission. As conceptualized, the ASEAN MRA on Nursing Services focuses on the recognition of qualifications, PQF focuses on the development of qualifications, and AQRF focuses on the comparability of qualifications across borders to facilitate the mobility of professionals within the ASEAN Economic Community.

Three important features of PQF were considered in the 2012 NNCCS nationwide Implementation (embedding and spreading) plan:

- Shift to outcomes-based education and use of learning outcomes
- Implementation of quality assurance mechanisms
- Ensuring international alignment of qualifications

Nurses assume three roles as identified in the 2012 NNCCS. The various responsibilities served as the basis for the development of the eleven (11) program outcomes currently utilized in the development of the following:

- Outcome-based Basic Nursing Education Program in the Philippines through the Commission on Higher Education (CHED)
- Standards of the Professional Nursing Practice in various settings in the Philippines
- Continuing Professional Development in Nursing
- Modification of job descriptions in nursing practice
- Draft of the Outcome-based Test Framework which serves as the basis for the development of the Course Syllabi, Table of Specifications (TOS) and test questions for the “entry level” nursing practice in the Philippine Nursing Licensure Examination
- National Nursing Career Progression Program (NNCCP) for nursing practice in the Philippines
- Other related evaluation tools in various practice settings in the Philippines

Currently, two documents serve as the basis for ensuring proper implementation of the Nursing Core Competency Standards:

1. **The 2012 National Nursing Core Competency Standards (NNCCS).** This was promulgated by the Professional Regulatory Board of Nursing (PRBON) on July 27, 2012 after an extensive and comprehensive review of the nursing core competency standards. The use of a competency-based framework and creation paradigm starting in 2009 led to the identification of the three roles of the nurse: (1) Beginning Nurses' Role on Client Care, (2) Beginning Nurses' Role on Management and Leadership and (3) Beginning Nurses' Role on Research.

2. **The “National Nursing Core Competency Standards Training Modules” for Master Trainers in Nursing Education and Practice.** This was prepared by nursing experts from the academe, service and community published through a grant from the International Labour Organization (ILO) through its DWAB project issued to the Commission on Higher Education – Technical Committee on Nursing Education (CHED-TCNE).

To ensure nationwide embedding and spreading of the 2012 NNCCS, the Monograph 2 was collaboratively developed by the PRBON with their partners. Two Instructional design templates for embedding and spreading 2012 NNCCS were developed for the four types of clients in the home and community setting. These modules serve as part of the Training of Trainers (TOT) resource package to prepare Master Trainers/Implementation Facilitators in the integration of the 2012 NNCCS on specific types of clients in appropriate academic or service settings. Likewise, two models are presented to serve as exemplars for the embedding and spreading of NNCCS in nursing education and service. These were developed by nursing leaders from the University of the Philippines Manila College of Nursing, the WHO Collaborating Center for Leadership in Nursing Development, and the St. Luke's Medical Center.

Monograph 2 is the third reference material intended to serve as a guide for the nationwide embedding and spreading of 2012 NNCCS. This is being posted on-line at the PRC website initially but will later be printed for nationwide reference.

ANGELINE T. CHUA CHIACO
Acting Chairperson
Professional Regulation Commission
The Professional Regulatory Board of Nursing (PRCON) has undertaken an extensive and comprehensive review of nursing core competency standards using competency-based framework and creation paradigm since 2009. The Nursing Core Competency Revisiting Project (NCCRP) was a collaborative activity of the PRBON with nursing partners from the service and academe who are members of various nursing specialty organizations and interest groups, together with the Commission on Higher Education-Technical Committee on Nursing Education (CHED-TCNE), and the UP Manila College as the World Health Organizations’s (WHO) Collaborating Center for Nursing Leadership and Development among others.

The revisiting process included work setting scenario analysis, benchmarking core competency standards with other countries, field validation studies on the nurses’ roles and responsibilities in the hospitals and community settings, integrative review of output from the validation strategies, presentation of validation analysis, core competency validation, public consultation, and then promulgation and publication of the 2012 National Nursing Core Competency Standards (NNCS).

From this extensive study, the three major roles of nurses were defined: 1) Beginning Nurses’ Role on Client Care; 2) Beginning Nurses’ Role on Management and Leadership; and 3) Beginning Nurses’ Role on Research. Various competencies and performance indicators were spelled out from the nurses’ responsibilities as they assumed each role.

With the PRBON taking charge from the initial planning to implementation of the 2012 NNCCS, various committees with specific functions and responsibilities were formed to ensure that guidelines are properly spelled-out in the embedding and spreading of the NNCCS. Ready to use materials and a training curriculum primarily intended for master trainers and implementation facilitators to integrate the 2012 NNCCS into the nursing education and service system were developed.

The International Labour Organizations (ILO) through its DWAB project partnered with the CHED and PRC to implement the subproject through the printing of a book entitled “Nursing Core Competencies Standards Training Modules” prepared by nursing experts from academe, service and community intended for Master Trainers and Implementation Facilitators. These modules ensure the examples, case studies and workplace scenarios were realistic and relevant for the purpose ensuring compliance with the NNCCS. These modules focus on the development of skills on critical thinking, problem solving, and decision-making in applying legal, moral, bioethical principles to nursing care, management and research.

The third reference material for the embedding and spreading of the 2012 NNCCS is this Monograph 2, which showcases: specific modules that will serve as part of the Training of Trainers (TOT) resource package to prepare Master Trainers and Implementation Facilitators in the integration of the 2012 NNCCS on specific types of clients in appropriate academic or service settings; and a precise program design model for the 2012 NNCCS spreading and embedding showing the functional integration between education and service.

The expected outcomes for the models are: 1) the development of training programs for: Nursing Service: Continuing Professional Development, and Nursing Education: Instructional Design for Faculty to embed the 2012 NNCCS; 2) Translation of the 2012 NNCCS Competencies to Standards of Care; 3) Creation of Performance Evaluation Tools; and 4) Development of Job Description.

Monograph 2 will initially be posted online at the PRC Website and will later be printed and circulated nationwide for use as reference.

The end goal of the PRBON with its partners is to be able to implement the NNCCS nationwide through the regional training of master trainers and implementation facilitators, with the full support of the various nursing professional organizations and nursing stakeholders.

YOLANDA D. REYES
Commissioner
Professional Regulation Commission
Sincere gratitude and acknowledgment is hereby given by the Professional Regulatory Board of Nursing to the following for their support, commitment and dedication towards the completion of this project:

To our committed individual partners in nursing education, service and administration who shared their expertise, insights, precious time and resources for the completion of Monograph 2.

To the University of the Philippines Manila College of Nursing (UPMCN) as WHO Collaborating Center for Leadership in Nursing Development and St. Luke’s Medical Center (SLMC) who acceded to our request to undertake this collaborative project to ensure the spreading and embedding of 2012 NNCCS.

To the Professional Regulation Commission (PRC) for their administrative and moral support in carrying out the project to its completion and facilitating its on-line publication through the Information Communication and Technology Department.

To the Association of Deans of Philippine College of Nursing Inc. (ADPCN), UPMCN and St Luke’s Medical Center for allowing us to use their resources for the core group meetings and during actual implementation of the project.

To the other various professional nursing organizations particularly the Occupational Health Nursing Association of the Philippines (OHNAP), Philippine Nurses Association (PNA), Association of Nursing Service Administrators of the Philippines (ANSAP), National League of Philippine Government Nurses (NLPGN), Philippine Nursing Research Society (PNRS), Critical Care Nurses Association of the Philippines Inc. (CCNAPI), Philippine Nursing Informatics Association (PNIA), and the other professional nursing specialty and interest organizations who wholeheartedly supported the project.

To the various institutions who participated in the 2012 NNCCS spreading and embedding project particularly the Philippine General Hospital, Jose Fabella Memorial Hospital, National Center for Mental Health, Research Institute for Tropical Medicine, and the Manila Health Department. Representatives from these Institutions participated in the development of the program design and training for the embedding and spreading of 2012 NNCCS in nursing education and service embarked by the UPMCN as WHO Collaborating Center for Leadership in Nursing Development and have expressed their commitment to implement the expected outcomes for embedding the 2012 NNCCS.

Likewise, the Commission on Higher Education Technical Committee for Nursing Education (CHED-TCNE) for their support in implementing this project.

To all professional nurses who participated in the various activities to ensure the embedding and spreading of the 2012 NNCCS and are committed to make a difference in the care of their clients wherever they practice nursing.

To Lindous Doudley De Guzman Carreon of PRC Graphic Artist, Jose Mari Louis Alforque of Cebu Normal University and Julius Daniel R. Tapang, for the conceptualization, design and pictures of the cover page of Monograph 2.
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Embedding and Spreading of 2012 National Nursing Core Competency Standards

MONOGRAPH 2
A. OBJECTIVE:

Monograph 2 will serve as guide to ensure proper embedding and spreading of the 2012 National Nursing Core Competency Standards (NNCCS) in both nursing education and nursing service (hospital-based and community-based).

B. BACKGROUND

1. LEGAL BASIS

Article III, Sec. 9 (c) of Republic Act No. 9173 known as the “Philippine Nursing Act of 2002”, states that the Professional Regulatory Board of Nursing (PRBON) is empowered to “monitor and enforce quality standards of nursing practice in the Philippines and exercise the powers necessary to ensure the maintenance of efficient, ethical, and technical, moral and professional standards in the practice of nursing taking into account the health needs of the nation”. It is therefore, incumbent upon the PRBON to take the lead in the improvement and effective implementation of the core competency standards of nursing practice in the Philippines to ensure safe and quality nursing care, and maintain integrity of the nursing profession.

2. HISTORICAL BRIEF

DEVELOPMENT OF 2012 NATIONAL NURSING CORE COMPETENCY STANDARDS

Through the years of implementation of the Core Competency Standards of Nursing Practice in the Philippines which was promulgated and adopted in 2005, global and local developments in health as well as nursing developments prompted the PRBON to conduct a “revisiting” of the Core Competency Standards of Nursing Practice. In 2009, a Task Force was created to determine the relevance of the current nursing core competencies to the expected roles of the nurse and to its current and future work setting.

The PRBON embarked on an extensive and comprehensive review of the nursing core competency standards using a competency-based framework and creation paradigm which was conceptualized as early as 2009. The Core Competency Revisiting Project was undertaken as a collaborative activity of the PRBON with nursing leaders from the academe and nursing service institutions, professional and nursing specialty organizations, UPM College of Nursing as WHO Collaborating Center for Leadership in Nursing Development as well as with the CHED-Technical Committee for Nursing Education who composed the Hospital-Based Research Teams and the Community-Based Research Teams.

The process of revisiting the nursing core competencies included work setting scenario analysis, benchmarking with nursing core competencies of other countries, field validation studies on the roles and responsibilities in the hospital and community settings, integrative
review of outputs from validation strategies, presentation of validation analysis and core competency consensual validation. Public hearing on the revised and modified core competency standards of nursing practice were conducted in the cities of Manila, Baguio, Cebu and Davao. Relevant recommendations were integrated for the improvement of the core competency standards in May 2012.

From the lengthy process emerged the Revised Nursing Core Competency Standards emphasizing the three roles of the nurse: (1) Beginning Nurses’ Role on Client Care, (2) Beginning Nurses’ Role on Management and Leadership and (3) Beginning Nurses’ Role on Research. From these roles various responsibilities, competencies and performance indicators were spelled out. Four types of clients of the nurse were likewise identified: (1) individuals with varying age group, gender and health-illness status, (2) healthy and at-risk family, (3) population groups and (4) community.


The PRBON signatories in the Resolution No. 24 Series of 2012 were:
- Carmencita M. Abaquin, RN, Ph.D., Chairperson;
- Members:
  - Yolanda C. Arugay, RN, Ph.D.
  - Leonila A. Faire, RN, MAN
  - Betty F. Merritt, RN, MN
  - Perla G. Po, RN, MN
  - Amelia B. Rosales, RN, Ph.D.
  - Marco Antonio C. Sto. Tomas, RN, MAN

PRINTING OF MONOGRAPH 1 - 2012 NNCCS was undertaken by the PRBON and copies were distributed to our nursing partners, the various nursing professional organizations, academic institutions and hospitals, UPMCN as WHO Collaborating Center for Leadership in Nursing Development and CHED-TCNE.

The printed Monograph 1 (2012 NNCCS) contained the following:
- Foreword by then PRC Chairperson, Hon. Teresita R. Manzala
- Promulgation
- Annexes:
  - Introduction and Legal Bases of the Project
  - Competency-based Framework in Curriculum Design
  - Processes Involved in Revisiting the Nursing Core Competencies
  - Significance of the 2012 NNCCS
  - The Various Responsibilities of the Nurse as They Assume the Three Roles of a Beginning Nurse
  - Conceptual Framework of the 2012 NNCCS And Its Description
  - Detailed Descriptions of the Competencies and Performance Indicators for each of the Nurses’ Responsibilities as well as the related Key Areas of Responsibilities
  - Consolidated Members of the Task Force
TRAINING MODULE DEVELOPMENT - the International Labour Organization through its DWAB project partnered with the CHED and PRC to implement the subproject entitled “Nursing Core Competencies Training for Master Trainers in Nursing Education and Practice.” CHED obtained a grant from the ILO which was funded by the European Union. The training modules were prepared by nursing experts from the academe, service and community to ensure that examples, case studies and scenarios in the workplace were realistic and relevant and to ensure compliance with the NNCCS. Likewise, the modules focused on the development of skills such as critical thinking, problem solving, decision making in applying legal, moral, bioethical principles to nursing care, management and research. The modules are primarily intended for the Master Trainers and the Implementation Facilitators.

The printed NNCCS Training Modules contained the following pertinent information:

- Foreword by ILO Director Lawrence Jeff Johnson
- Preface by CHED Chairperson Patricia B. Licuanan
- Acknowledgement
- Contributors
- Introduction - 3 Modules
- The Spread and Embed Framework of the Training on NNCCS - in Module 1 page 5
- Beginning Nurse’s Role on Client Care - 14 Modules
- Beginning Nurse’s Roles on Leadership and Management - 9 Modules
- Beginning Nurse’s Role on Research - 3 Modules
- Summary

3. SIGNIFICANCE OF THE 2012 NNCCS

The completion of the 2012 NNCCS in June 2012 and its promulgation by the PRBON on July 27, 2012 was indeed very timely as it complemented the implementation of the three government initiatives: ASEAN Mutual Recognition Arrangement (MRA) that focused on the recognition of qualifications, Philippine Qualifications Framework (PQF) that focused on the development of qualifications and ASEAN Qualifications Reference Framework (AQRF) that focused on the comparability of qualifications across borders to facilitate the mobility of professionals which is the aim of ASEAN Economic Community 2015.

Three important features of PQF were considered in the 2012 NNCCS nationwide Implementation (embedding and spreading) plan:
- Shift to outcomes-based education and use of learning outcomes
- Implementation of quality assurance mechanisms
- Ensuring international alignment of qualifications

The various responsibilities of nurses as they assume the three roles identified in the 2012 NNCCS served as the basis for the development of the 11 program outcomes that are currently utilized in the development of the following:
- Outcome-based Basic Nursing Education Program in the Philippines through the CHED
- Standards of the Professional Nursing Practice in various settings in the Philippines
- Continuing Professional Development in Nursing
- Modification of job descriptions in nursing practice
- Draft of the Outcome-based Test Framework which serves as the basis for the development of the Course Syllabi, Table Of Specifications (TOS) and test questions
for the “entry level” nursing practice in the Philippine Nursing Licensure Examination
♦ National Nursing Career Progression Program (NNCCP) for nursing practice in the Philippines
♦ Any other related evaluation tools in various practice settings in the Philippines

4. CREATION OF THE VARIOUS COMMITTEES TO FACILITATE EMBEDDING AND SPREADING OF THE 2012 NNCCS.

The PRBON created seven (7) committees to ensure proper implementation of the 2012 NNCCS. Responsibilities and functions were spelled out. Chairpersons and members of the various committees were also suggested. Several meetings of the committees were held to develop the cascading guidelines.

The committees are:
1. Oversight and Steering
2. Selection
3. Program, Design and Training
4. Resource Generation
5. Logistics
6. Information, Communication and Media Relations
7. Continuous Quality Improvement and Research

4.1. PRBON AS OVERSIGHT AND STEERING COMMITTEE

RESPONSIBILITY: Ensures effective and efficient implementation of the operational plan by providing direction and oversight execution of the functions of the different committees. In the process of implementation, the Steering and Oversight Committee reserves the option of revising, modifying or improving the statement and coverage of committee functions as provided for in the course of implementation of the 2012 NNCCS. PRBON project lead in turn ensures that all the committees function collaboratively.

FUNCTIONS:
1. Create the following other committees:
   a. Selection Committee
   b. Program Design and Training Committee
   c. Resource Generation
   d. Logistics Committee
   e. Information, Communication and Media Relations Committee
   f. Continuous Improvement Committee
2. Assign one PRBON to each of the above committees for oversight and steering functions:

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<thead>
<tr>
<th>COMMITTEES</th>
<th>ASSIGNMENT OF PRBON</th>
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<tbody>
<tr>
<td>a. Selection Committee</td>
<td>• Gloria B. Arcos</td>
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<td>d. Information, Communication and Media</td>
<td>• Glenda S. Arquiza</td>
</tr>
<tr>
<td>e. Relations Committee</td>
<td>• Florence C. Cawaon and Perla G. Po</td>
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<td>f. Continuous Improvement Committee and Research</td>
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3. Determine functions and responsibilities of each committee
4. Formulate policies and procedures regarding selection and appointment of committee chairpersons
5. Appoint committee chairperson and members
6. Approve qualified participants as recommended by the selection committee
7. Approve instructional modules and other activities related to program design and training program recommended by the program design and training committee
8. Approve collaborative activities recommended by the resource generation and logistics committee.
9. Approve and implement accordingly recommendations on regular evaluation reports submitted by the continuous improvement and research committee
10. Develop Memorandum of Agreement (MOA) with national partners
11. Have MOA signed with national partners as needed
12. Provide job audit over all created committees and the appropriate internal and external accounting and auditing procedures

4.2. SELECTION COMMITTEE

RESPONSIBILITY: Ensures participants are qualified based on set criteria, policies and procedures.

FUNCTIONS:
1. Develop selection criteria for the following participants
   • Implementation Resource Persons (IRPs); Master Trainers (MTs) and Implementation Facilitators (IFs)
   • Sponsoring agencies
2. Formulate policies and application procedures with corresponding templates on the following:
   • application forms
   • notification of acceptance
   • invitation letter
   • commitment contract
3. Process application for IRPs, MTs, IFs and sponsoring agencies.
4. Conduct screening of applicants
5. Select qualified applicants
6. Inform applicants of acceptance of applications
7. Have commitment contract accomplished taking into consideration legal requirements.
8. Develop action plan taking into consideration the above functions with the following:
   • Expected Outcomes
   • Specific Strategies
   • Resources and materials needed
   • Budget
9. Submit budget to Logistics Committee
   Chair: Remedios L. Fernandez
   Members: Marie Therese A. Pacabis
            Edna O. Imperial
            Elsa V. Castro
4.3. RESOURCE GENERATION COMMITTEE

RESPONSIBILITY: Ensures adequate planning and organizing of all funding resources required for the effective and efficient implementation of the 2012 NNCCS

FUNCTIONS:
1. Formulate policies and prepares project proposals/concept paper related to resource generation activities
2. Establish linkages with local and national funding agencies and private sector for the support of the effective and efficient implementation of the 2012 NNCCS
3. Establish linkages with local and international experts for the support of research undertakings in collaboration with the Research Committee
4. Explore creative ways of generating funds for the support of the effective and efficient implementation of the 2012 NNCCS
5. Ensure accountability in terms of project commitment, completion and fund management in collaboration with the Logistics Committee
6. Manage excess money through the creation of a National Nursing Core Competency Standards Trust Fund.
   Chair: Eularito A. Tagalog
   Members: Mercy M. Castillo             Paulita B. Cruz
             Glenda B. Vargas

4.4. LOGISTICS COMMITTEE

RESPONSIBILITY: Ensures adequate planning and organizing of all resources, supplies, materials and expenses required for the effective and efficient implementation of the 2012 NCCS from selection of participants to evaluation of the whole implementation program.

FUNCTIONS:
1. Develop an action plan taking into consideration its functions with the following:
   • Expected Outcomes
   • Specific Strategies
   • Resources and materials needed
   • Budget
2. Prepare an overall budget based on the budget submitted by all of the committees
3. Prepare a budget for the implementation of the following programs:
   • Full program for training MTs and IFs leading to a certification to train other IRPs for education, nursing service in the hospital and the community.
   • Imbedded program for training MTs and IFs leading to a certification to facilitate implementation of the 2012 NCCS in the sponsoring institution/agencies (may be a school, hospital, industrial institution, or others).
4. Ensure accountability in terms of project commitment, completion and fund management in collaboration with the Resource Generation Committee
5. Develop a system of receipt and disbursement of all payments during the implementation of the training programs appropriately proposed and accepted by the Steering and Oversight Committee in an “internal accounting and auditing rules and procedures” aligned with the BON contracted external auditor.
6. Report regularly to Steering and Oversight Committee Policies and Procedures
   Chair: Mila Delia M. Llanes
   Members: Paulita B. Cruz
4.5. PROGRAM DESIGN AND TRAINING

RESPONSIBILITY: Have a program designed and implemented related to the training of Master Trainers (MTs) who in turn will train Implementation Facilitator (IFs).

FUNCTIONS:
1. Design the following programs:
   • Full program for training of MTs and IFs leading to a certification to train other IFs for education, nursing service in the hospital and the community
   • Embed program for training MTs and IFs leading to a certification to facilitate implementation of the 2012 NCCS in the sponsoring institution/agencies (may be a school, hospital, industrial institution, or others)
2. Develop instructional modules (syllabus, workbook, power point presentations, workshop activities, handouts for each program
3. Formulate an evaluation method to determine effectiveness of each program as well as achievement of desired outcomes on the participants
4. Design training certificates
5. Develop plan to produce and track training certificates to prevent fraud
6. Have all instructional modules and other related activities and documents approved by the Steering and Oversight committee
7. Implement the designed program for the training of MTs and IFs according to the standards set in the program
8. Coordinate with the Selection committee regarding the characteristics of selected qualified participants
9. Collaborate with the Logistics committee regarding venue, expenses to be incurred in the development of materials, etc.
10. Develop action plan taking into consideration the above functions with the following:
   • Expected Outcomes
   • Specific Strategies
   • Resources and materials needed
   • Budget
11. Submit budget to Logistics Committee
   Chair: Araceli O. Balabagno
   Co-Chair: Annabelle R. Borromeo
   Members: Araceli S. Maglaya Luz Barbara P. Dones
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            Elizabeth R. Roxas Jenniffer T. Paguio
            Arnold B. Peralta Gisella A. Luna

4.6. INFORMATION, COMMUNICATION AND MEDIA RELATION

RESPONSIBILITY: Ensure effective and efficient information and communications management appurtenant to the implementation of the 2012 NCCS.

FUNCTIONS:
1. Design the appropriate information and communications framework accepted and implemented by the Steering and Oversight Committee
2. Develop Information and Communications Policies based on the accepted Information Communication (I.C.) Framework
3. Cause the adoption of an Integrated Information and Communications Plan embodying the Central I.C. programs, and wherever appropriate, the committee-related I.C. needs and program designs. The plan shall take into consideration the following:
   • Expected outcomes
   • Specific strategies
   • Resources and materials needed
   • Budget
4. Determine applicable and cost effective use of any or all media-technologies to facilitate implementation of the I.C. Plan towards a nationwide implementation of the 2012 NCCS.
5. The I.C. Plan shall include applicable evaluation procedures in the appropriate “score carding system” and submit regular reports to the Board of Nursing
6. Submit budget to Logistics Committee.
   Chair: Nilda B. Silvera
   Members: Kristian R. Sumabat
            April Juliette Espinosa-Sumabat
            John Francis L. Faustorilla, Jr.
            Jan Michael M. Herber

4.7. CONTINUOUS QUALITY IMPROVEMENT AND RESEARCH COMMITTEE

CONTINUOUS QUALITY IMPROVEMENT

RESPONSIBILITY: Ensure effective and efficient implementation of the 2012 NNCCS through a system for continuous improvement proposed and approved by the Steering and Oversight Committee

FUNCTIONS:
1. Design, propose a NNCCS Continuous Improvement Plan for the effective and efficient system of implementing the 2012 NNCCS
2. Conduct monthly, quarterly and annual evaluation of all activities related to the 2012 NCCS implementation in the academe, health institutions and community settings
3. Determine a system of data collection from evaluation of all training and related implementation programs
4. Collaborate with the Information and Communications Committee and all other committees relative to the implementation of a “feedback system” regarding 2012 NCCS implementation
5. Identify areas requiring corrective and improvement measures and collaborate and recommend strategies to concerned committees
6. Collaborate with the Research Committee in identifying problem areas which necessitate the conduct of research study
7. Submit evaluation reports to the Steering and Oversight Committee
8. Submit budget to Logistics Committee
   Chair: Marilyn D. Yap
   Co-Chair: Deogracia M. Valderrama
   Members: Cora A. Anonuevo
RESEARCH

RESPONSIBILITIES: Ensure effective and efficient implementation of the 2012 NNCCS through identification of possible problems/issues that necessitates the conduct of a research study in collaboration with Continuous Improvement Committee and approved by the Steering and Oversight Committee

FUNCTIONS:
1. In collaboration with the Continuous Improvement Committee identify problem areas which may be a source or necessitate the conduct of a research study.
2. Initiate and lead in the conduct of a research project if and when approved by the Steering and Oversight Committee
3. Collaborate with the Resource Generation Committee for needed resources
4. Submit budget to Logistics Committee
5. Submit evaluation reports to the Steering and Oversight Committee

Chair: Erlinda C. Palaganas
Members: Cora A. Anonuevo
Teresita I. Barcelo

5. PLANS FOR THE 2012 NNCCS IMPLEMENTATION SPREADING AND EMBEDDING

The development of Monograph 2 was planned to facilitate the embedding and spreading of 2012 NNCCS. This includes:

- Specific modules that can serve as part of the Training of Trainers (TOT) resource package to prepare Master Trainers/Implementation Facilitators in the integration of the 2012 NNCCS on specific types of clients in appropriate academic or service settings
- A precise program design model for the 2012 NNCCS embedding and spreading
- A model for functional integration between education and service to facilitate the spreading and embedding of 2012 NNCCS

The expected outcomes for the models include:

- Development of training program for NURSING SERVICE: continuing professional development
- Development of training program for NURSING EDUCATION: Instructional design for faculty to embed the 2012 NNCCS
- Translation of 2012 NNCCS Competencies to Standards of care
- Creation performance evaluation tools
- Development of job descriptions

6. MODELS FOR EMBEDDING OF 2012 NNCCS FOR NURSING EDUCATION AND NURSING SERVICE

Two concrete collaborative plans were developed and submitted to specific institutions and positive responses were obtained:

6.1. A Program Design and Training Model for the Embedding of 2012 NNCCS in nursing education with the University of the Philippines Manila College of Nursing (UPMCN) in its role as WHO Collaborating Center for Leadership in Nursing Development and A Model for Functional Integration of Education and Service with Philippine
General Hospital Department of Nursing and other partners from other Institutions. (c/o Dean Lourdes Marie S. Tejero through CECSP headed by Prof. Luz Barbara P. Dones)

6.2. A Program Design and Training Model for the Embedding of 2012 NNCCS in nursing education with St. Luke’s Medical Center Department of Nursing Service with Trinity University of Asia College of Nursing and community partners and with ANSAP demonstrating the functional integration between nursing education and service. (c/o Dr. Annabelle R. Borromeo)

PREPARED BY:

HON. CARMENCITA M. ABAQUIN, RN, PhD
Chairperson, PRBON and Project Lead for 2012 NNCCS
II. INSTRUCTIONAL DESIGN TEMPLATES FOR EMBEDDING AND SPREADING OF 2012 NNCCS FOR THE FOUR TYPES OF CLIENTS IN THE HOME AND COMMUNITY SETTING

Specific modules were developed that can serve as part of the Training of Trainers (TOT) resource package to prepare Master Trainers/Implementation Facilitators in the integration of the 2012 NNCCS on specific types of clients in the home, the school, health center/clinic in the rural villages, urban areas/settlements and industrial/occupational settings comprising Community Health Nursing Practice.

The first module was developed as an instructional design template model for the embedding and spreading of 2012 NNCCS by the Master Trainer/Implementation Facilitators for 2012 NNCCS considering the family as client in the home, the school, health center/clinic in the rural villages, urban areas/settlements and industrial/occupational settings.

The second module is an instructional design template model for the embedding of the 2012 NNCCS by the Master Trainer/Implementation Facilitators considering the population group and community as clients in the home, the school, health center/clinic in the rural villages, urban areas/settlements and industrial/occupational settings.

A. The National Nursing Core Competency Standards on Client Care: The Family
Araceli S. Maglaya

The NNCCS: Creating a Context for Change

Through the years since the competency-based curricular design was adopted in 1981 as the organizing framework of the Bachelor of Science in Nursing Program, the nursing core competencies have been regularly reviewed and updated to ensure responsiveness to the ever-changing health and health care scenarios and expanding boundaries of Nursing as a practice discipline. As a specific example related with the coverage of the NNCCS for this module on the family as client-partner, family nursing practice methodology has not been precisely understood, translated, and enacted as nursing competencies in work-settings driven by individual-focused care.

The most recent nursing core competency revisit was initiated in 2009, by the Professional Regulatory Board of Nursing (PRBON) in partnership with nurse-leaders from academic and health service institutions, professional and nursing specialty groups. Completed in June 2012 and promulgated by the PRBON in July 2012, the National Nursing Core Competency Standards (NNCCS) aim to respond to the challenges of quality assurance in nursing practice and ensure alignment of training outcomes with job and work-setting realities, requisite/s or expectations. The NNCCS support the recognition of comparability of qualification across borders of work opportunities.
With the recent mandate to ensure Outcomes-Based Education (OBE), the timely completion of the NNCCS puts Philippine Nursing in the mainstream to help concretize the ASEAN initiative on effective and efficient recognition of skills and qualifications within and between countries. The ASEAN Qualifications Reference Framework (AQRF) orchestrates the movement to design appropriate National Qualifications Framework (NQF) among the Southeast Asian nations based on a common qualification reference framework. The Philippine Qualifications Framework (PQF), which was instituted in October 1, 2012, requires a competency-based assessment of qualification recognition. It mandates the Professional Regulation Commission (PRC) and the Commission on Higher Education (CHED) to review the framework and contents of the licensure examination of each profession and align them with that of the PQF (Section 7 of Executive Order no. 83 dated October 1, 2012). Within this perspective, the NNCCS enhance precision in OBE.

The simultaneous implementation of the OBE, AQRF and PQF components and activities underscores the importance of and complements the trailblazing direction being taken by the PRBON, Technical Committee on Nursing Education (TCNE) of CHED, the University of the Philippines Manila- College of Nursing (UPM-CN) and other committed partner-institutions and organizations. The partnership direction focuses on a nationwide series of Training of Trainers (TOT) to ensure appropriate implementation of the NNCCS in nursing education and other work-settings.

Towards this goal, the module serves as part of the TOT resource package to prepare master trainers expected to facilitate the integration of the 2012 NNCCS on the family as client into appropriate service or academic system. Specifically, the master trainer’s functions include: (1) train implementation facilitators who will implement the NNCCS in their unit, department, or organization; (2) perform site assessments and determine performance gaps; (3) prepare, train, and provide process consultation to the unit, department, or organization implementing the NNCCS.

This module, on the NNCCS related with the family as client, specifies how to enhance the implementation of the NNCCS through the use of critical thinking and inquiry-based methods and tools to systematically operationalize the discipline of the art and science of nursing and nursing care, explicated as performance indicators of specific NNCCS. They provide the structure and guide on how to use and translate knowledge to ensure sound reasoning, with an awareness of the whole, to support effective and efficient decision making and appropriate action for client-centered care. The NNCCS on the family as client, with specific and appropriate performance indicators, are presented sequentially by component or phase of the nursing process. For each set of NNCCS on the family as client-partner, appropriate concepts, nursing practice framework/s, methods, tools, and guidelines are described to illustrate the scope and depth of specific competencies the beginning nurse is expected to perform, why she is expected to perform them and how these competencies are demonstrated, based on corresponding performance indicators.

The last section of the module specifies competency appraisal activities as opportunities for the master trainer to determine performance of expected training outcomes enumerated as module objectives. These competency appraisal activities include development, implementation, evaluation of an NNCCS-based instructional/training design, and appropriate evaluation methods and tools to determine achievement of specific sets of NNCCS on the family as client-partner. These activities will be supported and complemented by appropriate mentoring and coaching opportunities to enhance the master trainer’s capability to perform expected functions, guided by specific decisions, polices, and actions necessary to facilitate full implementation of the NNCCS on family care in appropriate work-settings.
Separate modules on the NNCCS related with health education, disaster preparedness/management, psychosocial adaptation (mental health) and similar client-centered NNCCS, provide appropriate/applicable frameworks/s, methods and tools on care of all types of clients: the individual, family, population group, and community as client-partners.

The NNCCS on the beginning nurse’s roles as manager/leader and researcher complete the competency perspective on how family health care can be fully supported and/or established in the work-setting. The master trainer will undergo training opportunities on these NNCCS through specific modules as learning packages, beyond this module on the family as client-partner.

**Module Objectives as Training Outcomes**

1. Describe the NNCCS on the family as client based on the performance indicators.
2. Specify what and how an instructional activity will be carried out to guide students or nurse-trainees on how to apply the knowledge component/topic or concept to carry out the NNCCS on care of the family as client.
3. Identify appropriate nursing practice tools, guidelines and/or frameworks on the care of the family as client.
4. Describe teaching-learning strategies/activities to guide students and/or nurse-trainee through critical thinking in inquiry-based nursing practice.
5. Illustrate evaluation methods and tools to determine achievement of specific sets of NNCCS on the family as client.
6. Specify decisions, policies, and actions necessary to facilitate implementation of NNCCS in appropriate work-settings (e.g. nursing education, service, policy institutions, and organizations).

**Critical thinking in Inquiry-based Approach to NNCCS**

Safe and quality human care anchored on the ethico-legal requisites of nursing practice defines the discipline of the art and science of the profession. Through critical thinking and inquiry-based approach, the standards of nursing practice are enshrined as expert caring, expected in every nurse-client encounter, for each present moment of the working relationship.

Nursing practice standards are used and translated as realities of the “lived experience” of the family as client, whose perspective becomes a critical context to be considered in the working-learning arena to promote, sustain or change any human reality towards wellness and efficient adaptation.

Within this practice requisite, critical thinking and inquiry-based practice provide the components of the TOT for the NNCCS on two perspectives. First, critical thinking and inquiry-based practice are the sources and foci of the performance indicators of the NNCCS. Second, they provide the structure and guide to develop the capability of beginning nurses to perform expected roles with corresponding functions and tasks, through the NNCCS.
To cover the boundary and terrain of the critical-thinking perspective and inquiry-based practice, the following references can be included as literature review:

  Critical Thinking Applied to Nursing
  St. Louis: Mosby-Year Book, Inc.

  Holistic Nursing Practice. 7(3): 21-27

  Knowledge Translation in Everyday Nursing. From Evidence-Based to Inquiry-Based
  Practice. Advances in Nursing Science. 3(4): 283-295

The suggested references explain major concepts on critical thinking and inquiry-based approach to guide selection of appropriate teaching strategies, learning resources and tools on the NNCCS: They are summarized in this module for ease of reference (see appropriate tables).

Critical thinking and theory-based practice as explicated by Brix (1993) underscore the expectation of “expertise” on the part of the trainer, as coach and mentor, of the beginning nurse performing the role on client care. The trainer, as model of critical thinking, is expected to be able to select appropriate nursing practice framework, methods and tools based on such criteria as appropriateness, effectiveness, efficiency, coherence and congruence of the application of the nursing process on client care by component or phase of the nursing practice methodology. Based on critical thinking and expertise on care of the family as client, the trainer, faculty or staff development coordinator can efficiently select books and other learning resources designed to develop role-generated, work-setting-based nursing competencies on client care. The trainer’s expertise can be maximized to help students and nurse trainees use or translate knowledge from content-based books into competency-based teaching-learning situations. But, the trainer/faculty who is not competent to demonstrate the discipline of the art and science of nursing practice in family care has the proclivity for emphasizing “memory work” among students/nurse trainees, having been used to content-focused, eclectic-oriented compilation of handouts or internet-accessed materials printed as books.
The Family: Client and Partner in Human Care

Crucial to the trainer’s expected functions on the NNCCS in family health care is the use of a nursing practice framework rooted on a deep understanding of the characteristics and behavior of the family as a dynamic, functioning unit. Anchored on appropriate theoretical perspectives which provide directions to help the nurse organize observations, focus inquiries, and design, implement and monitor the application of the nursing process, family nursing practice is best operationalized through a systematic, cohesive and coherent framework with nursing practice methods and tools congruent with each major family concept, and component or phase of the nursing process.

The following books and journal article are examples of references which can provide several perspectives to help the trainer determine the need to select appropriate nursing practice framework, guidelines, methods and tools, based on comprehensiveness, clarity, precision, and congruence with the requisites for sound reasoning and accurate decision making related with nursing assessment, planning, intervention, and evaluation in family nursing practice:


| Critical Thinking Applied to Nursing  
(Miller and Babcock, 1996) | Implications on the NNCCS:  
The Family as Client-Partner |
<table>
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<tbody>
<tr>
<td>Interaction Model</td>
<td>Working with the Family as Client</td>
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</table>
| ● Interacting partners bring in the interchange as context of the interaction the following:  
  ○ Frames of Reference  
  ○ Attitudes  
  ○ Assumptions  
  ● Purposeful and Goal-Oriented Interaction Process Attained through Validation, Clarification, and Precision/Accuracy of:  
    ○ Focus  
    ○ Use of Language  
    ○ Evidence  
    ○ Reasoning  
      • Based on valid (true), pertinent, and adequate premises as evidences.  
      • Conclusion is based on true and adequate premises  
  ● Output as Shared Reality:  
    ○ Conclusions  
    ○ Implications  
    ○ Feedback  |
| Nurse-Family Working Relationship based on respect, trust, and shared decision making to achieve:  
  ● Common Focus: Enhancing the family’s competence on health care, maintaining a safe environment and sustaining resource use/access  
  ● Clarity of use of communication techniques; shared “meanings”  
  ● Agreement on evidences (e.g. assessment data) generated from systematic and appropriate data collection methods and tools as bases for inferences/conclusions (e.g. nursing diagnosis)  
  ● Effective and appropriate conclusions based on sound reasoning (e.g. congruence between nursing interventions, evaluation parameters and nursing diagnosis).  
  Processes and Outcomes of the Working Relationship are based on:  
    ● Strength of evidence/s to support the conclusions regarding nature and extent of client change  
    ● Desirability of outcomes  
  Consequences of working relationship and outcomes of care are anticipated  
  Re-planning of care is done with family as client-partner, based on feedback generated from family’s analysis of learning process and outcomes. |
Inquiry-based Knowledge Use and Translation in Nursing Practice
(Doane and Varcoe, 2008, 2005)*

Knowing-In-Action: Translating theory/research knowledge across complexity of nursing situations for
competent, safe, and ethical practice.

- Picking out clues which seem relevant to the present moment, examining what it is they appear to
indicate, while simultaneously responding to possibilities for action (Reason, 2001)
- Active inquiry: Questions and answers arise through and in the everyday realities of complex situations.
- Looking toward the primary constituents: the people (clients and co-workers), contexts, theoretic
knowledge, meaningful purpose, excellence of practices and effectiveness of outcomes in terms of
people’s health, healing experiences, and ultimately, health outcomes.
- Nurse, as an inquirer, enters into each situation experiencing theory and evidence in relation to that
which it opens up in terms of understanding, interpretation, selection, and action.
- All attention, all knowing, all acting and gathering of evidence are based on implicit theory fragments of
“What act is timely now?” (Reason and Torbert, 2001)
- Informed and competent actions (knowing, relating, and acting) are responsive to particular moments
of nursing practice, valuing client’s perceptions of lived experiences as human response to health,
ilness, health care or learning and behavior change.
- Knowledge use and translation as relationally-contexted (meaning-based) to address complex realities
involving interactional processes and to make the nurse’s ways-of-being, knowing and acting more
responsive, efficient and effective in working with clients: “How might (this) theory and evidence inform
and enlarge the possibilities for being with and responding to this particular client in this specific
situation?”
- Bringing together more effectively multiple forms of knowledge (empirical, ethical, esthetic, contextual)
which evoke commitment, engagement, and response-ability for nurse’s clinical decision making and
competent action.

*Reference: G.H. Doane and C. Varcoe. Knowledge Translation in Everyday Nursing: From Evidence-Based to Inquiry-

Working Relationship: Interaction Requisite for Inquiry-Based Practice

A working relationship anchored on trust, respect, and shared decision making creates an interaction
context which encourages validation of frames of reference and assumptions between the family
and the nurse. This enhances “shared meanings” and accurate interpretation of perceptions and
beliefs about the family’s response to health and adaptation realities and options. It also increases
possibilities for clear, precise, accurate, consistent, complete, and relevant data as bases for
client care. The interaction context lays the foundation of a systematic approach to comply with
the requisites of critical thinking to achieve discipline in operationalizing the art and science of
nursing. Family health nursing practice is a phenomenological experience on caring and coping
with caregiving. Within this perspective, the working relationship enhances opportunities for the
family to take over health care, when the objectives and expectations have been achieved. It
supports the family as it takes charge of maintaining health among its members or managing the
condition/situation with confidence and competence. It prepares the family to handle situations
which necessitate referral to another resource facility/health service or termination of the nurse-family relationship, as when there’s a need for the family to transfer residence outside of the nurse’s geographical assignment, or when there’s a change in the nurse’s caseload coverage. In institution-based realities, the presence of the family is “attachment” support of hospitalized children. It facilitates early recovery, especially when family participation in the care is sustained throughout the working relationship. Developing the family’s competence supports readiness for successful termination of the nurse-family working relationship, when the hospitalized member gets discharged. Respect and trust enhance clarity of the nature, purpose, and expectations of the working relationship, including shared decision making on setting appointments and termination date, as circumstances allow.

Table 1 presents the list of performance indicators of the NNCCS on establishing a working relationship with the family as client. It specifies the components and requisites for partnership towards increasing the family’s competence as functioning unit to promote and maintain health and wellness among its members.

<table>
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<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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| 1.1. Establishes rapport with the family and/or support system ensuring adequate information about each other as partners in a working relationship | 1. Shares pertinent information about oneself as nurse-partner.  
2. Addresses with respect and trust the family’s concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship. |
| 1.2. Formulates with the client-partner the objectives and expectations of the nurse-client working relationship | 1. Explains nature and purpose of client-partner working relationship.  
2. Prepares with the family a list of objectives and expectations. |
| 1.3. Maintains shared decision making and family’s participatory capability throughout the nurse-client working relationship | 1. Assess the family’s participatory capability.  
2. Determines strategies to ensure shared decision making and family participation throughout the working relationship.  
3. Carries out appropriate strategies to ensure continued participation of the family. |
| 1.4. Enhances the family’s readiness for taking over/being in-charge when objectives and expectations have been achieved or when the situation necessitates termination of the working relationship | 1. Assesses the family’s readiness for taking charge of the condition or situation.  
2. Uses strategies to prepare the family for being in-charge/taking over when objectives/expectations have been achieved or when the situation necessitates termination of the nurse-family working relationship.  
3. Supports the family as it takes charge of maintaining health or managing the condition/situation (e.g. taking over with confidence the care of a family member, or competence on implementing prevention and control measures). |
NNCS on Nursing Assessment: The Family as Client-Partner

Nursing assessment is the first major partnership reality of the nurse and the family, where an appropriate nursing practice framework, based on the essence, characteristics and tasks of the family as a functioning unit, is a crucial teaching-learning guide to develop the student's/nurse-trainee's competencies on family care, as measured by the performance indicators. Table 2 presents the NNCS and corresponding performance indicators on the data-gathering phase of nursing assessment with the family as client-partner.

Table 2. NNCS on Data-gathering in Family Nursing Assessment

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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<tr>
<td>2.1 Develops the data gathering plan with the family, specifying methods and tools</td>
<td>1. Uses strategies to develop/enhance the skills of the family to participate in developing/specifying the methods and tools for data gathering.</td>
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<tr>
<td>2.2 Obtains assessment data utilizing appropriate data - gathering methods and tools guided by the type of client and work setting requisites.</td>
<td>1. Conducts a comprehensive and systematic nursing assessment of the family, as client within an interdisciplinary framework. 2. Generates, with the family, the assessment data using appropriate data gathering methods and tools guided by work-setting requisites (e.g. family health history, health assessment of family members, assessment of home and environment, other assessment related protocols such as laboratory and diagnostic procedures/reports; and assessment of family competence)</td>
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Explicit illustrations/examples of specific assessment methods and tools based on a family health nursing practice framework are systematically presented in Chapter 2 (Assessment in Family Health Nursing Practice, pp. 50-75) of the book Nursing Practice in the Community, 5th ed., (Maglaya, A.S. [Ed], 2009). The methods and tools describe what assessment data to gather (Table 2.1 Assessment Data Base in Family Nursing Practice, pp.65-67), and how to gather them in two (2) levels of assessment (Data Gathering Methods and Tools, pp.58-62). First-level assessment includes methods and tools to determine specific conditions or problems classified as wellness condition/state, health threat, health deficit and/or foreseeable crisis/stress point. Second-level assessment specifies the methods and tools to determine the gaps in, deficiencies on, barriers and/or factors related to the family's performance of the health tasks on each condition or problem identified. After data analysis during the second-level assessment, a statement of nursing diagnosis is made. It specifies the reason for the family's inability to perform specific health tasks to fully establish and/or provide adequate support to maintain wellness behavior, prevent disease, minimize or eliminate threats/hazards, and/or manage/address health deficits and foreseeable crises or stress points.

These methods and tools ensure family-centered data collection for accurate, adequate, and valid data analysis (Fig 2.1 The Assessment Phase in Family Health Nursing Practice: The Critical Thinking Approach, p.56). They describe how to translate the family perspective as condition/s or relationships related with performance of family health tasks to sustain health, wellness, better adaptation options among its members (Data Analysis, pp.62-63).
The critical thinking process guides the trainer on how to create teaching-learning situations to help the students and/or nurse-trainees on data analysis, specifically on the performance indicators shown in Table 3.

### Table 3. NNCCS on Data Analysis in Family Nursing Assessment

Beginning Nurse’s Function on Client Care: Assess with the family. as client, its health condition and/or competence.

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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| 3.1 Analyzes data gathered | 1. Groups assessment data by condition or category using appropriate nursing practice framework on the family as client.  
2. Relates data with each other to determine patterns, recurring themes, or processes.  
3. Compares data, patterns, recurring themes with norms/standards, clinical/health indicators or research findings, using algorithms and standard protocols. |
| 3.2 Synthesizes data gathered | 1. Interprets data gathered.  
2. Draws inferences from data gathered by specifying the nature, magnitude/extent and sources of/reasons for the alterations (e.g. pathophysiology, psychopathology), gaps, deficiencies and/or barriers to opportunities for change/improvement, health promotion, wellness, disease prevention, problem/disease management, and rehabilitation. |

Through the use of a coherent and systematically designed organizing framework in family nursing practice, students and/or nurse trainees learn how to sort assessment data, group related data, distinguish between relevant and irrelevant assessment data, identify patterns, recurring themes or processes, compare these with norms, standards, health indicators, and finally, draw inferences and derive valid conclusion/s (as nursing diagnoses) supported by adequate and accurate assessment cues as evidences. Table 4 specifies the performance indicators related with nursing diagnosis.

Chapter 2 of the book Nursing Practice in the Community, 5th ed., (Maglaya, A.S. [Ed], 2009) illustrates these processes (Nursing Diagnosis: Family Nursing Problems, pp.63-65). Using a specific assessment tool as example of a list of nursing problems in family nursing practice, Chapter 2 explains the organizing framework (pp. 64-65) and presents A Typology of Nursing Problems in Family Nursing Practice (pp. 67-72).

The next components of the application of the nursing process on the family as client are anchored on the specificity of the nursing diagnosis as family human response, which identifies the factors associated with the condition, reasons for its existence, or barriers related to the performance of the health tasks of the family as a functioning unit. The nursing care plan, implementation of interventions and evaluation of results are directed at enhancing the family’s competence as a functioning unit by reducing or eliminating the barriers to the performance of the family health tasks.
Table 4. NNCCS on Deriving the Nursing Diagnosis: The Family as Client

<table>
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<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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<tr>
<td>4.1 Specifies the family’s status/condition/problems to be addressed identifying reasons (etiology) for the existence of the condition or problem</td>
<td>1. Identifies the factors associated with the condition/s or reasons for the existence of the problem.</td>
</tr>
<tr>
<td></td>
<td>2. States nursing diagnosis/nursing problem.</td>
</tr>
<tr>
<td></td>
<td>3. Seeks concurrence with the family regarding the condition/s or problems to be addressed.</td>
</tr>
</tbody>
</table>

The specificity of the performance indicators of the NNCCS guides the trainer on the accurate implementation of a competency-based training design. The students and nurse-trainees are mentored on how to reduce, if not prevent, the use of content-oriented nursing interventions (which usually overwhelm the family with information) without concern for precise learning outcomes as family competencies.

The next section on the application of critical thinking in inquiry-based nursing assessment in family health care illustrates how to analyze the use of methods and tools to ensure sound reasoning for a valid nursing diagnosis. The evidences (as assessment cues) must adequately support the conclusion (stated as nursing diagnosis), and, that, the nursing diagnosis must follow from the evidences. The section also identifies teaching-learning tools and guidelines as examples on how to train students on the NNCCSS using a competency-based instructional design and standards of clinical supervision.

**Application of Critical Thinking in Inquiry-Based Nursing Assessment on Family Care**

Teaching-learning strategies on the work-setting-generated, role-focused NNCCS on client care are best carried out within an interaction arena involving the client (e.g. the family) and the student and/or nurse-trainee. These are specified in the training design as supervised practicum or field experience. While analysis of a hypothetical situation may be considered as initial opportunity to learn the application of the nursing process (as intermediate competency of a course) on the family as client, the trainer must ensure that the family case write-up provides adequate data to guide the trainees on how to analyze these as bases for sound reasoning and accurate decision making. In the absence of an opportunity to generate or validate assessment data within an interaction reality, between the nurse and the family, there is a possibility that available data, contained in a too condensed family case write-up, are not adequate enough for the trainees (e.g. students/nurse-trainees) to support a nursing diagnosis, supposedly derived from the family case write-up.

An example of a family case write-up presented in a book illustrates the need to analyze the application of the nursing process on the family as client. Using only the assessment data contained in the family case presentation, a nursing diagnosis on effective family coping is stated because the pregnant wife was prodded by her husband to go to the health clinic, after the village health worker went to the community. Without an opportunity taken by the nurse to meet the husband and the wife in conjoint session/s, additional data have not been generated to capture the nomenclature requisite of “effective family coping” as nursing diagnosis, based on concept boundary and complexity. Without such an opportunity to validate each one's perceptions as frames of reference, mental set, beliefs, and predispositions related with the nature and scope of family health care, the process of deriving the nursing diagnosis can appear to be individual-oriented, focusing on the wife, with the husband acting as part of the support system. The
family case write-up created a situation which supported the rest of the data presentation on the nursing care plan, implementation and evaluation, emphasizing content-oriented topics such as pregnancy and preparations for delivery.

The NNCCS as professional competencies become part of the nurse’s discipline on client care only as a result of an adequate opportunity for supervised field experience on the family as client-partner. A sample competency-based instructional design on a nursing course related with the family as client is presented in the monograph, The Competency-Based B.S.N. Curriculum published by the College of Nursing-University of the Philippines Manila in 2006 (Maglaya, A. et.al.[Eds.], pp.184-192). Volume 1 of the same set of monographs contains a write-up on the Standards of Clinical Supervision (page 26). The standards provide the requisites for supervised field experience on the family as client.

NNCCS on Formulating the Nursing Care Plan with the Family

An accurate family nursing diagnosis provides the foundation of the discipline of formulating the nursing care plan. Goals and measurable objectives as expected outcomes are aimed at improving the family’s health condition/situation and competence, by eliminating the etiology/cause of the problem, addressing gaps/deficiencies in, and/or barriers to family competence for wellness, disease prevention, management of health and related problems, rehabilitation and environment protection. With the nursing diagnosis as the basis for formulating the goals and objectives of the nursing care plan, the nursing interventions and evaluation methods and tools (which focus on achieving these goals and objectives) are systematically designed to address the nursing diagnosis. Congruence and alignment of nursing assessment with the nursing care plan are the bases for determining the validity and soundness of the nurse’s decision on what and how to formulate the nursing care plan. This relationship is illustrated in Figure 3.1 on page 78 of Chapter 3 (Developing The Nursing Care Plan) of the book Nursing Practice in the Community 5th ed. (Maglaya, [Ed.] 2009).

Table 5 shows the NNCCS on Formulating the Nursing Care Plan with the Family as Client-Partner. The first performance indicator on priority-setting, based on specific criteria, underscores the importance of effectivity and efficiency in nursing practice. Considering that among a list of conditions/problems of families as caseload of the nurse in a work-setting such as the community, not all the conditions or problems of even a limited number of priority families can be attended to within available resources. Inclusion of the family as part of the criteria for determining priorities among a list of conditions or problems, expands the otherwise limited resources as options for selecting which conditions or problems need to be addressed with immediacy and/or readiness, over others.

An example of a nursing practice tool on priority-setting includes family resources (as part of modifiability criterion) and the family’s perception and evaluation in terms of seriousness or urgency of attention needed or family readiness (salience as criterion). The two other criteria for priority setting include: nature of the condition or problem categorized as wellness state/potential, health threat, health deficit and foreseeable crisis/stress point; and, preventive potential which refers to the nature and magnitude of future problems which can be minimized or totally prevented if intervention is done on the condition or problem under consideration. This tool called Scale for Ranking Health Conditions and Problems According to Priorities is shown in Table 3.1 on page 80 of Chapter 3 of the same book, Nursing Practice in the Community, 5th Ed.

The rest of the performance indicators related with developing the nursing care plan are guide posts to determine what and how to translate the knowledge component into competencies related with formulating the goals and objectives, developing the intervention plan and evaluation scheme.
Using an appropriate nursing practice framework, nursing interventions can focus on pursuing with the family, possibilities for wellness response and disease prevention or management, based on lived-experience of meanings and concerns. Through the intervention plan, the nurse can create a teaching-learning context for enhanced family decision making and confidence to develop and sustain family competence. The intervention plan can specify strategies to catalyze behavior change process. This is done by helping the family feel motivated to initiate the change process and providing the emotional and technical support to help the family sustain the behavior change.

The evaluation plan, specifying criteria/indicators, methods and tools, is the nurse’s guide to determine with the family its progress related with the goals and objectives, which focus on enhancing wellness and healthy lifestyle, and/or reducing/eliminating the gaps, deficiencies and/or barriers to family competence in performing the health tasks. It identifies the evaluation criteria as measurable and flexible indicators to determine achievement of expected family competencies, circumstances/condition or clinical status based on desired or acceptable evaluation standard/s against which actual condition, clinical status or performance is measured.

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<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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| 5.1 Formulates with the family a plan of care to address the health conditions, needs, problems and issues based on priorities | 1. Sets priorities among a list of conditions or problems.  
2. Specifies goals, objectives and expected outcomes of care maximizing the family’s competencies.  
3. Selects appropriate interventions/strategies enhancing opportunities for health promotion, wellness response, prevention of problems/complications, and eliminating gaps/deficiencies in and/or barriers to family competence.  
4. Uses methods and tools to maximize family’s participation in planning appropriate interventions/strategies.  
5. Develops with the family an evaluation plan specifying criteria/indicators, methods and tools.  
6. Collaborates with the family and the inter-professional health care team in developing the plan of care.  
7. Modifies plan of care according to one’s judgment, skill, or knowledge as the family’s needs change. |

The scope and terrain of possible concepts/knowledge to use, translate and enact as competencies on developing the family nursing care plan are explicated in Chapter 3, *Nursing Practice in the Community*, 5th ed., (Maglaya, A.S. [Ed], 2009; pp. 76-95).

**NNCCS on Implementing the Care Plan with the Family**

Participatory and empowerment strategies create opportunities for the family to engage in health promotion, healthy lifestyle/adaptation, wellness, and disease prevention. Within a context of understanding the antecedents and consequences of health, illness, and coping realities, the family develops its competence on disease management, environmental sanitation, environment safety and protection, and health resource use or access. Table 6 presents the NNCCS and specific performance indicators on implementing the care plan with the family as client-partner.

Through the participatory action methodology, the nurse facilitates the family’s experiences on the process of living the “look-think-act” cycles of learning new ways of seeing and thinking in the light of reflection on current experiences, leading to new informed action. The action involves
reconstruction (e.g. “How might we do things differently?”), and evaluation (e.g. “How will we know if things have changed?”) to determine the worth, effectiveness, opportunities, and outcomes of the actions taken. During the implementation phase, the family, as a functioning unit, requires an environment of respect, trust, open-mindedness, shared meanings and coordinated action through communication skills on sending and receiving messages effectively.

A growth promoting relationship develops the family’s competence to recognize and carry out opportunities for wellness, healthy lifestyle/adaptation, health promotion, disease prevention, problem management, environmental sanitation, environment safety and protection, and resource use or access.

Wright and Leahy (2009) explain the need for nurses to select and translate appropriate multiple theories and frameworks to guide their work with families. Considering the complex relationships of family structure, function, and process, nurses must strive to achieve congruence between the theoretical framework (as clinical practice model), the intervention and the outcome measure. By way of example, Wright and Leahy presented six theoretical foundations in their family nursing practice guidelines in Chapter 2, Theoretical Foundations of the Calgary Family Assessment and Intervention Models (pp.19-46) of the book, *Nurses and Families: A Guide to Family Assessment and Intervention*, 5th edition, Philadelphia: F.A. Davis Company.

Specific concepts, methods, and skills on the implementation phase of family health nursing practice and the participatory action methodology are discussed in Chapter 4 (Implementation and Evaluation in Family Nursing Practice pp.97-109), and Chapter 5 (The Participatory Approach and the Participatory Action Methodology: The Nursing Perspective, pp.110-122) of the book, *Nursing Practice in the Community*, 5th ed. (Maglaya, A.S. [Ed].2009). Chapter 5 illustrates how the participatory approach supports family health care through the nurse’s capability to establish and sustain interdisciplinary and interagency collaboration.

Inquiry-based approach is illustrated in Chapter 4 (Box 4.1, page 106) as reflective practice. Through reflection-in-action, the nurse focuses on the family’s responses and understanding the depth of the family’s reality, while simultaneously, being able to analyze how the nurse-family interaction, responses and outcomes can be translated as options to re-construct or re-design what she/he is doing, while she/he is doing it. In inquiry-based reflection-on-action, the nurse reviews or re-evaluates what happened during the nurse-family interaction as critical thinking process to understand the family as client-partner, and the context of the interaction, from a more accurate, appropriate, and complete perspective.

Examples of nursing practice guidelines and protocols related with the performance indicators of NNCCS 6.3 (Table 6) on managing a family caseload are presented in the book, *Nursing Practice in the Community*, 5th Ed. See Sample Two-Way Referral Form in Chapter 3 (Developing the Family Nursing Care Plan, Figure 3.2, pp.88-89); Chapter 10 (Logic Trees for Safe Motherhood and Well-Baby Care, pp. 247-287); Chapter 11 (Nurse-Managed Maternal Care in the Community. pp 288-309); and Chapter 16 (Logic Trees for Common Adult Health Problems, pp.388-418).
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<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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<tr>
<td>6.1</td>
<td>Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access within the context of Primary Health Care.</td>
</tr>
<tr>
<td></td>
<td>1. Determines appropriate participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment safety and protection, health resource generation, use or access.</td>
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<td></td>
<td>2. Creates opportunities to develop the family's competence for promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment safety and protection, and health resource generation, use or access.</td>
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<td></td>
<td>3. Executes appropriate participatory and empowerment strategies.</td>
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<td>6.2</td>
<td>Enhances family competence on health promotion, wellness, healthy lifestyle, health care, health resource access or use and safe environment conducive to health maintenance among its members.</td>
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<td></td>
<td>1. Develops the competence of the family to recognize opportunities for wellness, healthy lifestyle/adaptation, health promotion, disease/problem management and environmental sanitation, environment safety and protection by:</td>
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<td>a. analyzing the factors affecting health, human response, the environment and its resources/realities</td>
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<td></td>
<td>b. determining the relationships among these factors</td>
</tr>
<tr>
<td></td>
<td>c. specifying the health and related conditions/problems which need to be addressed.</td>
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<td></td>
<td>2. Carries out strategies/interventions to help the family decide to take appropriate action on each health condition/problem identified.</td>
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<td></td>
<td>3. Implements competency-building intervention options to help the family provide appropriate care to the dependent, at-risk, vulnerable, sick and/or disabled member/s.</td>
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<td>4. Develops the competence of the family to provide a home environment conducive to health maintenance and personal development.</td>
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<td></td>
<td>5. Carries out participatory and empowerment strategies to enhance the family's competence to use community resources for health care and health maintenance.</td>
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<td>6.3</td>
<td>Manages family caseload to ensure health program/service coverage.</td>
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<td></td>
<td>1. Conducts case detection, tracking, tracing, monitoring, and surveillance. Creates opportunities to develop the family's competence for promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment safety and protection, and health resource generation, use or access.</td>
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<td></td>
<td>2. Conducts health programs and services in the home, clinic, school, and work settings.</td>
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<td>3. Carries out strategies to ensure health program/service coverage based on health program objectives/targets, through health resource availability, access and/or use, especially among marginalized/vulnerable risk groups.</td>
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<td></td>
<td>4. Determines adequacy of health program/service coverage based on updated family registry of priority cases.</td>
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<td>5. Carries out interventions for effective and efficient care of families as clients in the caseload on assigned geographical coverage.</td>
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<td></td>
<td>6. Refers the family as client for appropriate management and assistance for health and medical-related benefits.</td>
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<td></td>
<td>7. Reports notifiable/reportable diseases based on protocol.</td>
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Collaborative relationship with colleagues and other members of the team supports family health care, specifically on referral of the family for appropriate management and assistance. The NNCCS on establishing a collaborative relationship to enhance nursing and other health care services are presented in the monograph 2012 National Nursing Core Competency Standards (Professional Regulatory Board of Nursing, June 2012) under Responsibility 4 on the Beginning Nurse’s Role on Client Care (page 24). To underscore the importance of an integrative perspective in family health care, the competencies and performance indicators on collaborative relationship form part of how the implementation phase on family health care can be made successful. The NNCCS are shown in this section for emphasis.

<table>
<thead>
<tr>
<th>RESPONSIBILITY 4 - ESTABLISHES COLLABORATIVE RELATIONSHIP WITH COLLEAGUES AND OTHER MEMBERS OF THE TEAM TO ENHANCE NURSING AND OTHER HEALTH CARE SERVICES.</th>
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<tbody>
<tr>
<td><strong>COMPETENCY</strong></td>
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| 4.1 Ensures intra-agency, inter-agency, multidisciplinary and sectoral collaboration in the delivery of health care. | 1. Maintains good interpersonal, intra-agency and inter-agency relationship.  
2. Respects the role of the other members of the health team.  
3. Acts as liaison/advocate of the family during decision making by the inter-professional team. |
| 4.2 Implements strategies/approaches to enhance/support the capability of the family and care providers to participate in decision making by the inter-professional team. | 1. Explores views of the family prior to decision making.  
2. Uses strategies/approaches to enhance/support the capability of the family to participate in decision making.  
3. Supports the views of the family and/or care providers. |

**NNCCS on Evaluating Process and Outcomes of Family Health Care**

The participatory approach in evaluating family care supports a holistic perspective in getting as near as possible to the family's reality and lived-experience on developing its competence. Evaluation is done at periodic points during the implementation phase to determine appropriateness or adequacy of intervention/s, presence of barriers to care, and adequacy of support to handle the change process. It determines aspects of the nursing care plan which need revision based on analysis of nurse and family realities in each step of the nursing process, such as changes in health status or condition, need to re-assess for data accuracy and completeness, and emergence of new problems or priorities of the family. Summative evaluation determines if the goals, as specified in the family nursing care plan, are achieved as measured by the outcome criteria and evaluation standards. Based on the family's current situation and/or remaining health needs or problems, the nurse can guide the family in making choices about termination or referral.

Table 7 presents the NNCCS on evaluating the process and outcomes of family care. Specific concepts, methods and tools on evaluation of family care are illustrated in Chapter 4 (Implementation and Evaluation in Family Nursing Practice, pp.103-108) in the book, Nursing Practice in the Community, 5th ed. (Maglaya, A.S. [Ed].2009).
Table 7. NNCCS on Evaluating Process and Outcomes of Care with the Family as Client-Partner

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<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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| 7.1 Evaluates with the family the health status/competence and/or process/expected outcomes of nurse-client working relationship. | 1. Utilizes participatory approach in evaluating outcomes of care.  
2. Specifies nature and magnitude of change in terms of the family’s health condition/competence/processes and outcomes of nurse-family working relationship.  
3. Monitors consistently the family’s progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools, (e.g. family competency indicators) in collaboration and consultation with the family as client-partner.  
4. Revises nursing care plan based on outcomes and standards considering optimization of available resources. |

NNCCS on Documenting Family Care

Documentation procedures and forms are methods and tools of the health institution/agency/health center where the nurse works with families as clients. These documentation methods and tools are part of the standard protocols of the institution’s recording and reporting system. The protocols ensure accuracy, confidentiality, completeness and timeliness of documentation, specifying what should be documented, how to accomplish the records and/or forms, when to accomplish them, and what appropriate terminology to use based on standards. Accuracy and completeness of documentation are supported by recency of “memory” retrieval with timeliness of recording of pertinent information related with processes and outcomes of the nurse-family working relationship, for every nurse-family contact or visit (e.g. home visit / clinic follow-up).

Documentation procedures and record form/s as methods and tools in Family Health Nursing Practice are illustrated in Appendices C1, C2, and C3 of the book Nursing Practice in the Community 5th edition (Maglaya, A.S. [Ed.]). These include Charting Nursing Care, Progress Notes and Client Responses/Outcomes (Appendix C1, page 457), Family Service and Progress Record (pp. 458-460), and Instructions on the Use of the Family Service and Progress Record (FSPR) (Appendix C3, pp. 461-466).

Documentation requisites are specified as performance indicators of the Nursing Core Competency Standards (NNCCS) on documenting processes and outcomes of care with the family as client-partner (See Table 8).

Table 8. NNCCS on Documenting Process and Outcomes of Care with the Family as Client-Partner

<table>
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<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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| 8.1 Documents the family’s responses /nursing care services rendered and processes/outcomes of the nurse-family working relationship. | 1. Accomplishes appropriate documentation forms using standard protocols.  
2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness and timeliness of documentation.  
3. Utilizes acceptable and appropriate terminology according to standards. |
Competency-Appraisal Activities

Having read the module entitled, The National Nursing Core Competency Standards on Client Care: The Family, the future master trainer can determine how well the expected functions can be performed through the objectives as training outcomes specified on page 2 of this module. This competency appraisal section describes opportunities to prepare, implement and evaluate appropriate teaching-learning design, including assessment methods and tools. After going through these opportunities, the master trainer will see the overall perspective on how to facilitate full implementation of the NNCCS on family care in appropriate work-settings.

Through specific decisions, policies and actions, the master trainer can guide implementation facilitators and collaborate with nursing leaders to identify implications of the NNCCS on the content and sequence of the instructional designs of the B.S.N curriculum and training programs as continuing education of the staff in nursing service or implementation policies regarding client care standards or protocols.

The following competency appraisal activities focus on developing, implementing, and evaluating the instructional design on the NNCCS for family as client-partner, with implications for full implementation of the NNCCS on family care in appropriate work-settings:

A. Using an appropriate instructional design worksheet, present an instructional plan for the NNCCS on Family Care, specifying the following:

1. Component sets of NNCCS based on the list of nursing core competencies presented in Tables 1 to 8 in this module.
2. What and how an instructional activity should be carried out to guide students/ nurse trainees/ implementation facilitators on knowledge/concept use and translation to demonstrate the performance indicators of the NNCCS on the family as client-partner.
3. Teaching-learning strategies/activities through critical thinking in inquiry-based nursing practice to guide students/ nurse trainees/ implementation facilitators on the use of appropriate nursing practice framework/s, methods, tools, and guidelines based on the performance indicators of each nursing core competency.

B. Based on specific assessment method, develop appropriate assessment tool/s to determine achievement of performance indicators per nursing core competency on care of the family as client-partner. Guidelines for determining achievement of learning outcomes/competencies are presented on page 27 of Volume 1, The Competency-Based BSN Curriculum (Maglaya, A.S., et al. [Eds.], College of Nursing, University of the Philippines Manila, 2006).

C. Finalize the instructional design and assessment tool/s based on feedback from colleagues and mentor/s during the presentation. The assessment tools serve as guide in designing site assessment tools to determine performance gaps.

D. Implement the instructional design and illustrate the use of the assessment tool/s. Mentoring and coaching opportunities enhance the master trainer’s capability to perform her/his expected function to prepare, train, and provide process consultation to the unit, department, or organization implementing the NNCCS.

E. Determine areas for modification of the training design and assessment tool based on process and outcome indicators.

F. Specify decisions, policies and actions necessary to facilitate full implementation of the NNCCS on family care in appropriate settings.
Next Phase: Training of Implementation Facilitators

Having undergone mentoring and feedback on the instructional design/training program developed, implemented and evaluated by the master trainer, she/he prepares to work with the TOT team to train implementation facilitators in specific work-settings and geographical areas. This is the next phase of the full implementation of the NNCCS on family care. Details of the training design are going to be worked out in partnership with the TOT team as coaches and mentors.
Embedding the NNCCS: Context and Requisites

Complementing the initiatives and requisites of the national and ASEAN competency-based work-setting-driven qualifications reference frameworks, modules as training resource packages explicate the NNCCS on care of the individual, the family, the population group, and the community as client-partners. This module focuses on the NNCCS related with care of the population group and the community as client-partners. It illustrates examples of appropriate concepts, nursing practice framework/s, methods and tools to guide the analysis of multiple factors affecting the health status and care of the community as a complex functioning unit, composed of aggregates or groups of people residing within a defined physical or geographical location or geopolitical boundary, sharing common characteristics, and whose boundaries and composition may change over time. This module also provides examples of application of concepts and appropriate knowledge use and translation on care of population groups whose demographic, epidemiological, biological, socio-cultural-economic, environmental characteristics or realities result to unique patterns of health behaviors and adaptation responses, putting them at varying risks or vulnerability to specific diseases (e.g. infectious diseases and lifestyle problems), disability or social dysfunction. Depending on the epidemiological realities and/or health problems in the community as a geopolitical unit, population groups might be age/maturation-related (e.g. infants, pre-schoolers, school-aged children, adolescents, older persons), occupational (e.g. associated with industrial, mining or farming hazards), culturally determined health care/practices causing specific illnesses, disability, dysfunction, or the result of socio-psychological-economic factors (e.g. poverty, homelessness, addiction).

Critical thinking processes and inquiry-based nursing practice guide selection of appropriate training resources and strategies to support the master trainer’s capability to perform the expected functions related with the full implementation of the NNCCS on care of the population group and the community as client-partners in appropriate work-settings. Specifically, the functions of the master trainer-cum-implementation facilitator (MT-cum-IF) include: (1) trains other implementation facilitators who will implement the NNCCS in their specific unit, department, or organization; (2) performs site assessments and determines performance gaps; (3) prepares, trains, and provides process consultation to the unit, department, or organization implementing the NNCCS on care of the population group and the community as client-partners.

and depth of specific competencies the beginning nurse is expected to perform, why she is expected to perform them, and, Through application of appropriate nursing practice framework/s and concepts generated from well-selected learning resources, the MT-cum-IF can help trainees/students determine the bases of the competencies as

To create learning, coaching, and mentoring opportunities for the MT-cum-IF to perform these functions, this module specifies how to enhance the implementation of the NNCCS through the use of critical thinking and inquiry-based methods and tools to systematically operationalize the discipline of the art and science of nursing and nursing care, explicated as performance indicators of the NNCCS. They provide the structure and guide on how to use and translate knowledge to ensure sound reasoning, with an awareness of the whole, to support effective and efficient decision-making and appropriate action for community-centered care. The NNCCS and performance indicators will be presented sequentially by component or phase of the nursing
The last section of the module specifies competency appraisal activities as opportunities for the master trainer to determine performance of expected training outcomes as module objectives. These competency appraisal activities include development, implementation, and evaluation of an NNCCS-based instructional/training design, including appropriate evaluation methods and tools to determine achievement of specific sets of NNCCS on care of the population group and the community as client-partners. These activities will be supported and complemented by appropriate mentoring and coaching opportunities to enhance the master trainer’s capability to perform expected functions, guided by specific decisions, polices, and actions necessary to facilitate full implementation of the NNCCS on care of the population group and the community as client-partners, in appropriate work-settings. Full implementation of the NNCCS involves: (1) developing the standards of nursing practice and performance evaluation methods and tools, using precise process and outcome indicators; (2) explication of the job descriptions based on the beginning nurse’s roles and corresponding responsibilities; (3) developing appropriate continuing professional development (CPD) programs to support full implementation of NNCCS in specific work-setting, institutions, organizations, or agencies; and (4) developing outcomes-based instructional designs for courses in the B.S.N. program, ensuring systematic and appropriate sequence of didactics and related learning experiences (clinical/field practice) based on the NNCCS.

The NNCCS on the beginning nurse’s roles as manager/leader and researcher complete the competency perspective on how care of the population group and the community as client-partners can be fully supported and/or established in the work-setting. The master trainer will undergo training opportunities on these NNCCS through specific modules as learning packages, beyond this NNCCS module on care of the population group and the community as client-partners.

Module Objectives as Training Outcomes

1. Use the NNCCS on care of the population group and the community as bases for developing course/instructional designs, guided by appropriate nursing practice framework/s, methods, tools, and/or guidelines.

2. Illustrate an inquiry-based nursing practice framework in using the NNCCS as bases for enhancing standards of practice, job description/s, performance evaluation methods and tools, and training designs.

3. Develop a sample training design to guide master trainer-cum-implementation facilitators in embedding the NNCCS in Nursing Education and Nursing Service.
Critical thinking in Inquiry-based Approach to NNCCS

Safe and quality human care anchored on the ethico-legal requisites of nursing practice defines the discipline of the art and science of the profession. Through critical thinking and inquiry-based approach, the standards of nursing practice are enshrined as expert caring, expected in every nurse-client encounter, for each present moment of the working relationship. The standards are used and translated as realities of the “lived experience” of the population group and the community as clients, whose perspective becomes a critical context to be considered in the working-learning arena to promote, sustain or change any human reality towards wellness, effective adaptation, and appropriate and efficient resource use, access, and management as outcomes of collective behavior.

Within this practice requisite, critical thinking and inquiry-based practice provide the components of the TOT for the NNCCS on two perspectives. First, critical thinking and inquiry-based practice are the sources and foci of the performance indicators of the NNCCS. Second, they provide the structure and guide to develop the capability of beginning nurses to perform expected roles with corresponding responsibilities, functions and tasks, through the NNCCS.

To cover the boundary and terrain of the critical-thinking perspective and inquiry-based practice, suggested references found on this page are included as literature review. These references explain major concepts on critical thinking and inquiry-based approach to guide selection of appropriate teaching strategies, learning resources and tools related with the NNCCS on client care. Applying the critical thinking-inquiry-based perspective on care of the community as client-partner, these major concepts are summarized in this module for ease of reference (See appropriate tables).

Suggested References

Critical Thinking Applied to Nursing
St. Louis: Mosby-Year Book, Inc.

Holistic Nursing Practice. 7(3): 21-27

Doane, G.H., and Varcoe, C. (2008),
Knowledge Translation in Everyday Nursing. From Evidence-Based to Inquiry-Based Practice.
Advances in Nursing Science. 3(4): 283-295
Critical thinking and theory-based practice as explicated by Brix (1993) underscore the expectation of “expertise” on the part of the trainer, as coach and mentor, of the beginning nurse performing the role on client care. The trainer, as model of critical thinking, is expected to be able to select appropriate nursing practice framework, methods and tools based on such criteria as appropriateness, effectiveness, efficiency, coherence and congruence of the application of the nursing process on community care by component or phase of the nursing practice methodology. Based on critical thinking and expertise on care of the population group and the community as clients, the trainer, faculty or staff development coordinator can efficiently select books and other learning resources designed to develop role-generated, work-setting-based nursing competencies. The trainer’s expertise is crucial in guiding the students/trainee’s learning towards use of context and meaning-based knowledge to enact appropriately and accurately the NNCCS as “lived experiences” on ways of being, becoming and relating in nursing practice. In contrast, the trainer/faculty who is not competent to demonstrate the discipline of the art and science of working with the population group and the community as client-partners, has the proclivity for emphasizing “memory work” among students/nurse trainees, using content-focused, eclectic-compilation of handouts or internet accessed materials printed as books. This encourages the use of “copy-paste” materials submitted by students/nurse trainees as “ready-made” nursing care plans, without concern about their appropriateness, accuracy and coherence, given the assessment data generated from actual clients and work-settings.

**Collective Behavior in Human Care**

Performance of the expected functions of the master trainer on full implementation of the NNCCS in community health care requires the use of a nursing practice framework rooted on a deep understanding of the multiple factors related with shared socio-psychological-economic-cultural-geographical-epidemiological realities which result to common characteristics and collective behavior of the population group and the community. Appropriate theoretical perspectives provide directions on how the nurse can organize observations, focus inquiries, and design, implement, and monitor the application of the nursing process on the population group and the community as client-partners. Community nursing practice is accurately operationalized through a systematic, cohesive and coherent framework which specifies nursing practice methods and tools congruent with each major community concept and component or phase of the nursing process.

Examples of references as books and journal article on page 45 provide several perspectives to help the MT-cum-IF determine the need to select appropriate nursing practice framework/s, guidelines, methods and tools based on clarity, precision, appropriateness and congruence with the requisites for sound reasoning and accurate decision-making related with nursing assessment, planning, intervention, and evaluation in community nursing practice. The references guide the module reader on the what, why, and how of community-centered care, selecting appropriate concepts, methods and tools based on the nature and level of collective behavior of the population group or community at each phase of the nurse-client working relationship, as boundaries and composition of the people change over time. Shared realities and previous experience/s on working towards collective goal/s or being involved in collective effort can affect each client behavior and characteristics.
**Critical Thinking Applied to Nursing**  
*(Miller and Babcock, 1996)*  

| Interaction Model | Implications on the NNCCS:  
The Community as Client-Partner |
|-------------------|---------------------------------------------------------------|
| ● Interacting partners bring in the interchange as context of the interaction the following:  
  ○ Frames of Reference  
  ○ Attitudes  
  ○ Assumptions  
| ● Community as functioning unit defines the essence and context of the interchange based on unique patterning of perceptions, beliefs and attitudes, opinions, mental set, and disposition. |

| ● Purposeful and Goal-Oriented Interaction Process Attained through Validation, Clarification, and Precision/Accuracy of:  
  ○ Focus  
  ○ Use of Language  
  ○ Evidence  
  ○ Reasoning  
  • Based on valid (true), pertinent, and adequate premises as evidences.  
  • Conclusion is based on true and adequate premises  
| Nurse-Community Working Relationship based on respect, trust, and shared decision making to achieve:  
  ● Common Focus: Enhancing the community’s competence on health care, maintaining a safe environment and sustaining resource use/access  
  ● Clarity of use of communication techniques; shared “meanings”  
  ● Agreement on evidences (e.g. assessment data) generated from systematic and appropriate data collection methods and tools as bases for inferences/conclusions (e.g. nursing diagnosis)  
  ● Effective and appropriate conclusions based on sound reasoning (e.g. congruence between nursing interventions, evaluation parameters and nursing diagnosis). |

| ● Output as Shared Reality:  
  ○ Conclusions  
  ○ Implications  
  ○ Feedback  
| Processes and Outcomes of the Working Relationship are based on:  
  ● Strength of evidence/s to support the conclusions regarding nature and extent of client change  
  ● Desirability of outcomes |

Consequences of working relationship and outcomes of care are anticipated  

Re-planning of care is done with the community as client-partner, based on feedback generated from community’s analysis of learning process and outcomes.
Inquiry-based Knowledge Use and Translation in Nursing Practice
(Doane and Varcoe, 2008, 2005)*

Knowing-In-Action: Translating theory/research knowledge across complexity of nursing situations for competent, safe, and ethical practice.

- Picking out clues which seem relevant to the present moment, examining what it is they appear to indicate, while simultaneously responding to possibilities for action (Reason, 2001)

- Active inquiry: Questions and answers arise through and in the everyday realities of complex situations.

- Looking toward the primary constituents: the people (clients and co-workers), contexts, theoretic knowledge, meaningful purpose, excellence of practices and effectiveness of outcomes in terms of people’s health, healing experiences, and ultimately, health outcomes.

- Nurse, as an inquirer, enters into each situation experiencing theory and evidence in relation to that which it opens up in terms of understanding, interpretation, selection, and action.

- All attention, all knowing, all acting and gathering of evidence are based on implicit theory fragments of “What act is timely now?” (Reason and Torbert, 2001)

- Informed and competent actions (knowing, relating, and acting) are responsive to particular moments of nursing practice, valuing client’s perceptions of lived experiences as human response to health, illness, health care or learning and behavior change.

- Knowledge use and translation as relationally-contexted (meaning-based) to address complex realities involving interactional processes and to make the nurse’s ways-of-being, knowing and acting more responsive, efficient and effective in working with clients: “How might (this) theory and evidence inform and enlarge the possibilities for being with and responding to this particular client in this specific situation?”

- Bringing together more effectively multiple forms of knowledge (empirical, ethical, esthetic, contextual) which evoke commitment, engagement, and response-ability for nurse’s clinical decision making and competent action.


From the nursing practice perspective, the collective health of the population group or the community, as an outcome of shared environment, culture, values, beliefs, mores, resources, proclivities and/or vulnerabilities, is an adaptation response associated with its level of consciousness, openness, and capability to undergo change process through collective effort. This adaptation response describes each population group or community as a unique client affected by its collective health and partnership capability, rooted on the nature and depth of empowerment experiences through time. Boundary semi-permeability of the population group or community, as a functioning unit, protects its sense of identity and wholeness as client-partner, while it maintains a reciprocal-collaborative relationship with its interrelated subsystems, and the intra-agency, inter-agency, and multidisciplinary human resource teams.
The NNCCS and performance indicators specify how the nurse determines which demographic, environmental, socio-cultural-political, biological, epidemiological factors or characteristics and adaptation process affect the collective health states and competence of the population group and the community as clients. Within the perspective of relatedness in partnership, the NNCCS and corresponding performance indicators specify how a working relationship enhances the client’s boundary integrity and boundary semi-permeability rooted in its sense of identity, wholeness, and responsibility. Nurturing respect and trust, and supporting shared decision-making strengthens the client’s sense of meaning and purpose as a functioning unit and client-partner.


Working Relationship: Interaction Requisite in Community Nursing Practice

Community health nursing practice is a phenomenological experience on working with several aggregates or groups of people whose collective health states, needs, concerns, problems, and collective goals are foci of interaction opportunities over time, to improve or enhance the client’s shared realities on wellness, adaptation, and resource development, use, access, and management. The interaction context lays the foundation of a systematic approach as guide on the use of critical thinking process to achieve discipline in operationalizing the art and science of nursing. In order for the nurse to help the clients identify collective goals and orchestrate collective effort, precise interaction contexts require working with several groups or aggregates representing subsystems or segments of physical location/s considering the expanse of the geopolitical and epidemiological boundaries of the population group or the community as client-partners. For each group or aggregate, a working relationship anchored on trust, respect, and shared decision-making creates an interaction context which encourages validation of frames of reference and assumptions between the client and the nurse. This enhances “shared meanings” and accurate interpretation of perceptions and beliefs about the client’s response to health and adaptation realities and options. It also increases possibilities for clear, precise, accurate, consistent, complete, and relevant data as bases for client care. A working relationship based on trust, respect, and shared decision-
making affirms the client’s sense of identity, and sense of meaning and purpose, as a functioning unit. Trust, respect, two-way communication and shared decision-making are ingredients of the rules of engagement in a working relationship which nurture the client’s confidence to unleash its empowering potential to assume its responsibilities, as expression and affirmation of its sense of identity and purpose. Within this perspective, the working relationship enhances opportunities for the client to take over when the objectives and expectations have been achieved. It supports the community group or aggregate as it takes charge of maintaining health among the members or managing the condition/situation with confidence and competence. It prepares the community group or aggregate to handle situations which necessitate referral or termination of the working relationship, as when there’s a need for the community group or aggregate to transfer outside the nurse’s geographical assignment, or when there’s a change in the nurse’s geographical coverage caseload. Table 1 presents the list of performance indicators of the NNCCS on establishing a working relationship with the population group or the community as client-partner. It specifies the components and requisites of partnership towards increasing the client’s competence as functioning unit to improve shared realities in support of wellness, adaptation, and resource access or use.

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
</tr>
</thead>
</table>
| 1.1. Establishes rapport with the client and/or support system ensuring adequate information about each other as partners in a working relationship | 1. Shares pertinent information about oneself as nurse-partner.  
2. Addresses with respect and trust the client’s concerns/needs related to sharing information about oneself to enhance the nurse-client working relationship. |
| 1.2. Formulates with the client-partner the objectives and expectations of the nurse-client working relationship | 1. Explains nature and purpose of client-partner working relationship.  
2. Prepares with client a list of objectives and expectations. |
| 1.3. Maintains shared decision making and client’s participatory capability throughout the nurse-client working relationship | 1. Assess the client’s participatory capability.  
2. Determines strategies to ensure shared decision making and family participation throughout the working relationship.  
3. Carries out appropriate strategies to ensure continued participation of the population group and community as client-partners. |
| 1.4. Enhances the client’s readiness for taking over/being in-charge when objectives and expectations have been achieved or when the situation necessitates termination of the working relationship | 1. Assesses the client’s readiness for taking charge of the condition or situation.  
2. Uses strategies to prepare the client for being in-charge/taking over when objectives/expectations have been achieved or when the situation necessitates termination of the nurse-family working relationship.  
3. Supports the client as it takes charge of maintaining health or managing the condition/situation (e.g. taking over with confidence the care of a family member, or competence on implementing prevention and control measures). |
The NNCCS: Grounds, Processes, and Methods

The discipline of Nursing Practice as science and art, focuses on nurse-client care partnership through transitions, disruptions, and vulnerabilities to create a context for change, enhancing human response for adaptation towards wholeness, wellness, growth, and development. While this module covers the NNCCS on client care primarily with the population group/s and the community as client-partners, the coverage of nurse-client care partnership includes working with four types of clients as functioning units, each with unique boundary permeability as adaptation requisites. To illustrate this context for change, Figure 1 shows how the four types of clients as partners are delineated. It also graphically elucidates how the health of the community is a combined and/or correlated composite of the health of all population groups, all families, and all individuals and each turn is a composite of factors, characteristics and realities affecting the health base of the others.

![Diagram of Four Types of Clients as Partners in Community Health Nursing Practice](image)

Figure 1. CREATING A CONTEXT FOR CHANGE: Four Types of Clients as Partners in Community Health Nursing Practice

To support the implementation of the 2012 National Nursing Core Competency Standards presented in the monograph published by the Professional Regulatory Commission – Professional Regulatory Board of Nursing (June 2012), this module illustrates how performance indicators of the NNCCS related with care of the population group and the community as client-partners can be developed or enhanced. Appropriate nursing practice frameworks and empirically validated concepts explicating the grounds, processes, methods and tools, guide knowledge use, translation and enactment in nursing practice. Specific examples of nursing practice frameworks/models, methods and tools are elucidated in the following chapters of one of the books (Nursing Practice in the Community 5th Edition, A.S. Maglaya [Ed.], 2009) listed on page 48, of this module:
Chapter 1: Community Health Nursing: Context and Practice
Rosalinda G. Cruz-Earnshaw

Chapter 5: The Partnership Approach and the Participatory Action Methodology: The Nursing Perspective.
Araceli S. Maglaya

Chapter 6: Developing Community Competence through the Work Group Approach
Araceli S. Maglaya

Chapter 7: Assessing Community Health Needs.
Luz Barbara P. Dones

Chapter 8: Planning for Community Health Nursing Programs and Services.
Luz Barbara P. Dones

Chapter 9: Nursing Interventions for Community Health Development.
Luz Barbara P. Dones

Chapter 10: Logic Trees for Safe Motherhood and Well Baby Care.
Ma. Corazon S. Maglaya and Araceli S. Maglaya

Chapter 11: Nurse-Managed Maternal Care in the Community.
Ma. Brigette T. Lao-Nario

Chapter 12: Demonstrating Independent Nursing Practice
Ma. Brigette T. Lao-Nario

Chapter 13: Enhancing Competencies on Nutrition for Wellness
Lucila B. Rabuco

Chapter 14: Appropriate Technology of the Prevention and Control of Malnutrition in Early Childhood
Araceli S. Maglaya

Chapter 15: Parasitology in Nursing Practice
Winifreda O. Ubas-de Leon

Chapter 16: Logic Trees for Common Adult Health Problems
Ma. Corazon S. Maglaya and Araceli S. Maglaya

Chapter 18: Enhancing Practice through Community-based Participatory Research
Araceli S. Maglaya

Appendices:
A1 Community Health Nursing Practice Model
C1 Charting Nursing Care, Progress Notes and Client Responses/Outcomes
E Empowerment for Health Promotion/Lifestyle Change
Throughout the rest of this module covering NNCCS from assessment to evaluation, these chapters provide precise processes, methods and tools on how to use and enact knowledge in nursing science and art to enhance critical thinking, diagnostic, reasoning, client competence through participatory and empowerment strategies/interventions and shared decision-making with the population group and the community as client-partners.

Table 2 specifies The NNCCS on Nursing Assessment focusing on diagnostic reasoning to sufficiently support knowledge about the client’s condition/status related with its competence to sustain wellness, or address risks, vulnerabilities, deficits, and anticipated crisis situations.

Table 2. NNCCS on Assessing the Client’s Health Status/Competence.

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 Develops the data gathering plan with the client, specifying methods and tools</td>
<td>1. Uses strategies to develop/enhance the skills of the client to participate in developing/specifying the methods and tools for data gathering.</td>
</tr>
<tr>
<td>2.2.1</td>
<td>2. Generates with the client-partner the assessment data using appropriate data gathering methods and tools guided by work-setting requisites (e.g. epidemiologic and social investigations; assessment of community competence; risk factor assessment; and, assessment of issues of vulnerability: health risks, limited control, powerlessness, disenfranchisement, victimization, disadvantaged status).</td>
</tr>
<tr>
<td>2.2.2 Obtains assessment data utilizing appropriate data gathering methods and tools guided by type of client and work setting requisites.</td>
<td>1. Conducts a comprehensive and systematic nursing assessment of clients within an interdisciplinary framework</td>
</tr>
<tr>
<td>2.2.2</td>
<td>2. Generates with the client-partner the assessment data using appropriate data gathering methods and tools guided by work-setting requisites (e.g. epidemiologic and social investigations; assessment of community competence; risk factor assessment; and, assessment of issues of vulnerability: health risks, limited control, powerlessness, disenfranchisement, victimization, disadvantaged status).</td>
</tr>
<tr>
<td>2.2.3 Analyzes data gathered.</td>
<td>1. Groups assessment data by condition or category using appropriate assessment framework by type of client.</td>
</tr>
<tr>
<td>2.2.3</td>
<td>2. Relates data with each other to determine patterns, recurring themes, or processes.</td>
</tr>
<tr>
<td>2.2.3</td>
<td>3. Compares data, patterns, recurring themes with norms/standards, clinical/health indicators or research findings using algorithms and standard protocols.</td>
</tr>
<tr>
<td>2.2.4 Synthesizes data gathered.</td>
<td>1. Interprets data gathered.</td>
</tr>
<tr>
<td>2.2.4</td>
<td>2. Draws inferences from data gathered by specifying the nature, magnitude/extent, and sources of reasons for the alterations, gaps, deficiencies and/or barriers to opportunities for change/improvement, health promotion/wellness, disease prevention, problem/disease management, rehabilitation.</td>
</tr>
<tr>
<td>2.2.5 Specifies the client’s status/condition/problems to be addressed, identifying reasons (etiology) for the existence of the condition or problem.</td>
<td>1. Identifies the factors associated with the condition/s or reasons for the existence of the problem.</td>
</tr>
<tr>
<td>2.2.5</td>
<td>2. States nursing diagnosis/nursing problem.</td>
</tr>
<tr>
<td>2.2.5</td>
<td>3. Seeks concurrence with the client-partner regarding problems identified</td>
</tr>
</tbody>
</table>

Specific chapters of the book as suggested reference in this section illustrate knowledge use and translation to guide knowledge enactment based on the performance indicators of the NNCCS. Presented in Chapters 6 and 9, literature by Cottrell (1976) and others pursued the community competence framework as example of what available knowledge can be used and translated to
come up with a description of the client’s condition or status in nursing assessment. Issues of vulnerability are also presented in Chapter 9 (pages 242-243) specifying concepts and examples. Chapter 7 illustrates the process of community diagnosis (Figure 7.1). It provides examples of grounds and processes of knowledge generation to determine population group/community health status/condition as consequences of gaps in, issues on, absence of, or inadequacies related with community/group competence to address problems, needs, risks, vulnerabilities, or anticipated crisis. Knowledge use and translation related with demography, vital statistics, and epidemiology as public health tools are illustrated by major concept or tool. Data collection methods (e.g., observation, record review, interviews, focus group discussion), and preparation of data gathering instruments, tools, and/or guide are presented. Actual data collection procedures, data collation, and data presentation are elucidated as well. An example of a segment of data collection plan is illustrated in Chapter 7.

Chapter 5 illustrates how knowledge enactment is done using the participatory action methodology. It describes how the “Look-Think-Act” cyclical process is done with the population group or the community as client-partner. Given the complex factors affecting the adaptation response of each unique client-partner in its ever changing environment as adaptation reality, this participatory action methodology unleashes the empowering potential of both the client and the nurse, to support and sustain adequacy, accuracy, and validity of the knowledge generation process and outcomes of nursing assessment.

NNCCS on analysis and synthesis are essential elements of diagnostic reasoning. Analysis focuses on examination of each of the various elements of information and how they are related. The performance indicator on comparing assessment data with existing norms/standards/health indicators or research findings, enhances the nurse’s competency on analysis. It guides the nurse on what gaps or missing information are needed to form accurate and valid statement/s about the client’s status/condition. Synthesis involves pulling the various pieces of information together to form a coherent whole. Interpretation about the meaning/s of clusters of assessment data is based on integration of interrelationships among the data, reflecting antecedents and consequences of the client’s condition/status as adaptation response. The etiology as second part of the diagnostic statement identifies the factors causing or contributing to the condition/problem. These related factors help the nurse select appropriate interventions to eliminate the etiology. It is important that sufficient information exists to support the second part of the diagnostic statement. Without such data, interventions may be misguided, and fail to eliminate the underlying cause, in which case the nursing diagnosis will likely not be resolved. Participatory and empowerment strategies enhance the opportunities to validate accuracy and validity of assessment data. Shared decision-making with the population group or the community as client-partner maximizes assessment opportunities to gather accurate, appropriate, and reliable information for adequate and valid analysis and synthesis of needed information.

Table 2A presents examples of knowledge use and translation to differentiate the assessment of the two types of clients: the population group and the community. Examples of assessment areas on the community as client include: nature, demographic characteristics and community dynamics relevant to health, health behavior and health-related influences; causes of prevalent health problems; and perceived needs of the community related to health and health care coverage. In contrast, examples of assessment areas on the population group include: major characteristics of population groups and additional attributes which further subdivide these groups by risk association; population differences and complex relationships impinging on the health of specific groups and their effects on the larger community and on availability or use of health resources/services. The risk association perspective in determining health states or conditions of population groups applies not only to general areas on health (such as nutrition, growth and development patterns, health habits, utilization of health care/services) but on condition-specific
areas as well. Examples include health states of maternity clients, chronic illnesses, accidents and disaster-related risks/problems.

The end result of analysis and synthesis specifies the client’s health status/condition or problem, identifying the factors that are causing or contributing to the problem. These could involve deficits in availability or utilization of needed health and related services/resources, or deficits in population group or community competence or practices related with sustaining wellness, health promotion, disease prevention/management, risk reduction or maintaining a safe environment, among others.

Table 2A. Assessment Phase: Examples of Knowledge Use and Translation on the Population Group and Community as Client-Partners

<table>
<thead>
<tr>
<th>COMMUNITY</th>
<th>POPULATION GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Needed:</strong></td>
<td><strong>Data Needed:</strong></td>
</tr>
<tr>
<td>● Demographic Characteristics (e.g. age, sex, race, ethnic, socio-economic distributions, birth rates, life expectancy)</td>
<td>● Demographic subgroups within community-wide data.</td>
</tr>
<tr>
<td>● Physical Environment (e.g. climate, housing and sanitation, water and food supply, educational and working opportunities)</td>
<td>● Physical environments specific to/affecting subgroups/population aggregates</td>
</tr>
<tr>
<td>● Resources (e.g. economic and political/power bases; health and related services, community cohesiveness/competence)</td>
<td>● Lifestyles (e.g. dietary, exercise, use of self-protection measures)</td>
</tr>
<tr>
<td>● Health Behaviors of Population (e.g. values, beliefs, use of services)</td>
<td>● Health perceptions, care patterns</td>
</tr>
<tr>
<td>● Health States (e.g. major causes of illnesses, injury and death by age, sex and geographic distributions, growth and development of infants and children; nutritional states; fertility rates)</td>
<td>● Factors which differentiate vulnerable/risk groups within the community</td>
</tr>
<tr>
<td></td>
<td>● Group leaders/group competence</td>
</tr>
<tr>
<td></td>
<td>● Health services and related resources</td>
</tr>
<tr>
<td></td>
<td>● Differences in population groups by severity of problems identified with implications for health indicators and health services.</td>
</tr>
</tbody>
</table>

| Analysis/Synthesis:                                                        | Analysis/Synthesis:                                                             |
|                                                                            | ● Examining differences in distributions of prevalent community health problems (based on morbidity and mortality rates) and identifying vulnerable/risk population groups by age, sex, education, occupation, social status, culture, lifestyles, family care patterns, among others. |
|                                                                            | ● Specifying sources, causes, antecedents and consequences of vulnerabilities or risks associated with the inter-relationships of environmental, psychosocial and biological factors and processes (requiring knowledge use and translation on health and nursing concepts, methods, and tools related with oxygenation; fluid and electrolyte balance; nutrition and metabolism; perception and coordination; inflammatory and immunologic reactions; psychosocial adaptation, among others). |
|                                                                            | ● Identifying differences in health states and behaviors of population groups in association with community resources, such as opportunities for education, employment, availability of food, safe water supply and sewage system, health care facilities. |
|                                                                            | ● Determining the effects of resources on perceived needs and health behaviors of population groups. |
The rest of the NNCCS with corresponding performance indicators on care of the population groups and the community as client-partners are presented on Table 3.

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
</tr>
</thead>
</table>
| 2.3 Formulates, with client-partner, a plan of care to address the health condition/s, needs, problems and issues based on priorities. | 1. Sets priorities among a list of conditions or problems.  
2. Specifies goals, objectives and expected outcomes of care maximizing client’s competencies.  
4. Uses methods and tools to maximize the client’s participation in planning appropriate interventions/strategies.  
5. Develops with the client-partner, an evaluation plan, specifying criteria/indicators, methods and tools.  
6. Collaborates with the client and the inter-professional health care team in developing the plan of care.  
7. Modifies plan of care according to one’s judgment, skill, or knowledge as client’s needs change. |
| 2.4.9 Implements participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access within the context of Primary Health Care | 1. Determines appropriate participatory and empowerment strategies related to promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access.  
2. Creates opportunities to develop client competence for promotion of health, healthy lifestyle/adaptation, wellness, disease management, environmental sanitation, environment protection and health resource generation, use or access.  
3. Executes appropriate participatory and empowerment strategies. |
| 2.4.9.1 Implements participatory and empowerment strategies for client competence to identify and collaborate effectively in addressing needs and problems related with health resource availability, access or use, environmental sanitation, environment protection, safety and security. | 1. Develops the competence of community work groups:  
a. analyze population and environmental factors/characteristics and realities which generate need to address specific health conditions/situations/patterns.  
b. articulate commitment and opportunities for community improvement on health resource availability, access/use, environmental sanitation, environment protection, safety and security.  
c. handle/address issues and conflicts as creative options for collaboration and shared responsibility for decision-making by generating new ways of analyzing solutions/problems for multiple possibilities/effective solutions.  
2. Carries out participatory and empowerment opportunities to increase client's competence for interaction, decision-making, effective implementation of actions and management of community’s relationship with the larger society for environmental sanitation and environment protection, safety, security and for creating or using appropriate and/or supplementary resources, especially for the marginalized or vulnerable risk groups. |
Table 3. NNCCS on Formulating the Care Plan, Implementing Safe and Quality Interventions, Evaluating and Documenting Process and Outcomes of Nurse-Client Working Relationship

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
</tr>
</thead>
</table>
| 2.4.10 Implements interventions guided by prescribed context of specific health programs/services | 1. Specifies the bases for choice of interventions carried out within existing policies and procedures, or protocols of specific health programs and service.  
2. Performs the appropriate interventions. |
| 2.4.11 Implements appropriate care with the client-partner during the three phases of disaster situations, such as: 1) Pre-incident phase, 2) Incident phase, and 3) Post incident phase. | 1. Participates in the prevention and mitigation of adverse effects of a disaster.  
2. Performs preparedness activities as a member of the multi-disciplinary team.  
3. Executes appropriate nursing interventions in collaboration with the disaster response team.  
4. Provides care and support to those injured, with chronic disease, maladaptive patterns of behavior and disabilities during recovery/reconstruction/rehabilitation period. |
| 2.6 Evaluates with the client-partner the health status/competence and/or process/expected outcomes of the nurse-client working relationship. | 1. Utilizes participatory approach in evaluating outcomes of care.  
2. Specifies nature and magnitude of change in terms of client’s health status/competence/processes and outcomes of nurse-client working relationship.  
3. Monitors consistently client’s progress and response to nursing and health interventions based on standard protocols using appropriate methods and tools, (e.g. client competency indicators and community scorecard) in collaboration and consultation with the client-partner.  
4. Revises nursing care plan based on outcomes and standards considering optimization of available resources. |
| 2.7 Documents the client’s responses/nursing care services rendered and processes/outcomes of the nurse-client working relationship. | 1. Accomplishes appropriate documentation forms using standard protocols.  
2. Adopts appropriate methods and tools to ensure accuracy, confidentiality, completeness, and timeliness of documentation.  
3. Utilizes acceptable and appropriate terminology according to standards. |

Specific chapters of the book Nursing Practice in the Community, 5th Edition (2009) enumerated on page 48 of this module illustrate knowledge use and translation related with nursing practice framework/s, models, processes, methods, and tools. Using the NNCCS performance indicators as expected teaching-learning outcomes, the trainees/students are guided on accurate/appropriate knowledge enactment on formulating a care plan in partnership with the client, implementing safe and quality interventions, evaluating and documenting the processes, nursing care rendered, client’s responses and outcomes of the nurse-client working relationship. Chapter 7 illustrates knowledge use and translation on prioritizing health conditions/problems. Chapter 8 presents examples of knowledge use and translation related with models on community health planning, methods and tools on formulating the plan of care, including developing the evaluation plan on process, impact and outcomes, measuring change outcomes and evaluating community
competence utilizing the participatory approach. Chapter 9 illustrates nursing interventions for community health development to support/sustain health promotion, community participation in health, capacity-building, collaboration, and advocacy.

Condition-specific areas, realities and interventions involving population group are illustrated in Chapters 10, 11 and 12 on such topics as safe motherhood, maternal care, well-child care and health promotion. Nutrition for wellness (Chapter 13), management of malnutrition in early childhood (Chapter 14), parasitology in nursing practice (Chapter 15), and management of common adult health problems (Chapter 16) are examples of concepts, methods, and tools on care of specific population groups.

Within the participatory and empowerment perspectives, NNCCS performance indicators specify the competencies of community work groups to ensure client-centered and outcomes-based implementation of nursing interventions. This perspective will prevent activity-centered nursing services, without concern for outcomes of care as milestones of the discipline of nursing practice. Chapter 6 illustrates knowledge use, translation and processes/methods to facilitate knowledge enactment on developing the population group and community competence through the work group approach. Figure 6.5 presents the conflict resolution model.

Empirically validated family and community empowerment process and outcomes are described in Chapter 18: Enhancing Practice Through Community-based Participatory Research. It describes knowledge generation, use, translation and enactment as participatory approach to evaluation, specifying “What Happened? What is missing? What to do next?”. Given the complexity of client’s adaptation response, this cyclical process leads the nurse and the client back to knowledge generation for re-assessment of processes and outcomes of behavior change towards competence, to improve the client’s condition/status. Chapter 18 describes how the four types of clients addressed the endemicity of malaria in Barangay Danglas, Abra. The participatory and empowerment experiences on assessment, planning, implementation, and evaluation supported the synergistic composite processes of individuals, families, population groups, and the entire community, as they addressed the epidemiological realities/challenges and resource options related with malaria and its prevention and control (see Illustration 18.1, page 440).

Separate modules on the NNCCS on emergency and disaster preparedness, and health promotion, both written by Sheila R. Bonito, are part of the ILO-funded publication prepared through CHED-TCNE (2014).

NNCCS on collaborative relationship with colleagues and other team members reiterate competency performance indicators which promote and sustain partnership as requisite of full implementation of planned change (Table 4). Chapter 5 of the book, Nursing Practice in the Community, 5th Edition (2009), specifies knowledge use, translation and enactment options to enhance interdisciplinary and inter-agency collaboration. It presents the essential ingredients of partnership and skills to achieve the expected outcomes of collaboration. Chapter 18 illustrates examples of empowerment experiences through sustained partnership and collaborative relationship on malaria prevention and control at each appropriate level, from the smaller sectors of the barangay, to the municipality, provincial, regional, and national levels.
Responsibility 4 - Establishes Collaborative Relationship with Colleagues and other Members of the Team to enhance Nursing and other Health Care Services.

<table>
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<tr>
<th>COMPETENCY</th>
<th>PERFORMANCE INDICATORS</th>
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</table>
| 4.1 Ensures intra-agency, inter-agency, multidisciplinary and sectoral collaboration in delivery of health care. | 1. Maintains good interpersonal, intra-agency and inter-agency relationship.  
2. Respects the role of the other members of the health team.  
3. Acts as liaison/advocate of the client during decision-making by the inter-professional team. |
| 4.2 Implements strategies/approaches to enhance/support the capability of the client and care providers to participate in decision-making by the inter-professional team. | 1. Explores the views of the client-partner prior to decision-making  
2. Uses strategies/approaches to enhance/support the capability of the client to participate in decision-making.  
3. Supports the views of clients/families and/or care providers. |
The NNCCS Embedding Framework

Having discussed how the NNCCS systematically guide application of nursing practice methods and tools on knowledge generation, use, translation and enactment within the work-setting requisites and realities, the rest of the quality assurance-related methods and tools can, likewise, be systematically analyzed to ensure that they are based on the same processes and grounds explicating the nursing practice discipline as science and art. Coming from these requisites of epistemological and ontological perspectives, the NNCCS Embedding Framework, presented in this module, focuses on how analysis and decisions regarding standards of practice, job description/s. performance evaluation, and training programs for Continuing Professional Development (CPD) can be systematically done. Starting and ending with the framework component on processes and grounds of nursing practice discipline as science and art, the NNCCS Embedding Framework provides the foundation and outcome-based perspective to ensure coherence, congruence and all inclusiveness in each of and among the expected NNCCS embedding outputs.

Sample training design templates on NNCCS embedding are presented in this module. These templates illustrate the components of training program/s on developing/enhancing standards of nursing practice, job description/s, performance evaluation, and instructional/course designs for CPD of nurses involved in client care and faculty members doing outcomes-based education (OBE) in nursing.
A. EXPECTED OUTCOME 1: Develop training program/s for Continuing Professional Development (CPD) related with the NNCCS on care of the family, population group, and community as client-partners (Nursing Service and Nursing Education).

<table>
<thead>
<tr>
<th>COMPETENCIES (MT-cum-IF)</th>
<th>TEACHING LEARNING STRATEGIES</th>
<th>EVALUATION METHODS / TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assesses the capacity of the Implementation Facilitator (IF) for developing a training program for Continuing Professional Development on the NNCCS related with care of the family, population group, and community as client-partners.</td>
<td>1. Appropriate learning resources on the NNCCS related with the care of the family, population group, and the community as clients can be utilized as context of spreading to embed the NNCCS in work-settings. The module entitled The National Nursing Core Competency Standards on Client Care: The Family (Maglaya, 2014) presents family health nursing practice methods and tools to illustrate the NNCCS by phase of the nursing process. A list of references (bibliography) is provided to guide the MT-cum-IF on how to select and apply appropriate concepts based on nursing practice standards. Another module, National Nursing Core Competency Standards on Care of the Population Group and the Community as Clients (Maglaya, 2015), focuses on developing embedding training programs which enhance congruence and coherence between NNCCS, standards of practice, job description/s, performance evaluation and continuing professional development instructional designs. The module includes a list of references to provide bases for selection and application of appropriate concepts and nursing practice methods and tools generated from the discipline of nursing as science and art.</td>
<td>Worksheets documenting Workshop Outputs as bases for Evaluating Competencies 1, 2, and 3, specifying: a. Trainee’s current nursing practice on care of families, population group and the community as clients in own work-setting based on IF’s realities and experiences; b. Expected competencies on care of the family, population group and the community in own work-setting based on nursing practice standards; c. Continuing Professional Development needs of nurses and faculty members on care of the family, population group and the community as clients (based on a and b); d. Necessary processes, consequences and CE outcomes based on trainee’s realities/ experiences/ issues/ current teaching-learning scenarios related with developing a Continuing Professional Development training program on care of the family, the population groups, and the community as client-partners.</td>
</tr>
<tr>
<td>COMPETENCIES (MT-cum-IF)</td>
<td>TEACHING LEARNING STRATEGIES</td>
<td>EVALUATION METHODS / TOOLS</td>
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<tr>
<td>2. Assesses the current teaching-learning scenarios based on IF’s realities/ experiences related with the NNCCS on care of the family, population group and community as client-partners.</td>
<td>2 and 3. Using trainee’s own work-setting scenario and realities for case analysis, conduct workshop and plenary session to address the following guide questions:</td>
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<tr>
<td>3. Specifies necessary processes, consequences, and outcomes related to the IF’s teaching-learning needs on clinical supervision/guided practicum on care of the family, population group and community as client-partners.</td>
<td>a. What is currently being done as trainee’s nursing practice on care of families, population group and community as clients in own work-setting?</td>
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<tr>
<td></td>
<td>b. What are expected competencies on care of the family, population group and the community as client-partners in work-setting, based on nursing practice standards?</td>
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<tr>
<td></td>
<td>c. What are the continuing professional development training needs of nurses and faculty members on the NNCCS related with care of the family, population group and the community as client-partners (based on a and b)?</td>
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<tr>
<td></td>
<td>d. Describe/specify the necessary processes, consequences, and outcomes based on trainee’s realities /experiences/issues related with developing a Continuing Professional Development NNCCS Training Program on care of the family, population group and community as client-partners.</td>
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</tr>
<tr>
<td>COMPETENCIES (MT-cum-IF)</td>
<td>TEACHING LEARNING STRATEGIES</td>
<td>EVALUATION METHODS / TOOLS</td>
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<td>4. Develops the training/instructional design/course design, specifying;</td>
<td>4. Based on workshop outputs a to d in #2 and #3, conduct workshops and plenary sessions on developing the instructional/training design for Continuing Professional Development of nurses and faculty members on the NNCCS related with the care of the family, population group and the community as client-partners. Using appropriate training design worksheet specify:</td>
<td>Workshop output/Written and Verbal Feedback on CPD Training Design on the NNCCS related with care of the family, population group and the community as client-partners, specifying:</td>
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<tr>
<td>4.1. Appropriate nursing-practice based and desired work setting—scenario generated teaching-learning strategies to enhance the IF’s competencies;</td>
<td>a. Component sets of NNCCS; b. What and how selected instructional activity should be carried out to guide students/nurse trainees/implementation facilitators on knowledge use and translation to demonstrate the performance indicators of component sets of NNCCS; c. Teaching-Learning strategies (e.g. case analysis and guided practicum/clinical supervision on actual client care) through critical thinking in inquiry-based nursing practice to guide students/nurse trainees on the use of appropriate nursing practice frameworks/methods, tools and guidelines within the context of desired work setting scenarios, as requisites of the NNCCS; d. Appropriate evaluation methods and tools based on the NNCCS related with care of the family, population group and community as client-partners.</td>
<td>a. Appropriate teaching-learning strategies based on nursing practice standards and desired work-setting scenarios; b. Precise and appropriate evaluation parameters reflected in evaluation tools to determine achievement of NNCCS based on performance indicators.</td>
</tr>
<tr>
<td>4.2. Evaluation methods and tools to determine achievement of the nursing core competency standards (NNCCS) based on performance indicators.</td>
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<tr>
<td>5. Creates linkages to install partnership and anchor IF teams in designated areas.</td>
<td>5a. Create opportunities to install partnership with IF teams in selected areas. 5b. Provide coaching and mentoring activities to help MT-cum-IF install and sustain partnership with respective institutions to embed NNCCS in CPD programs.</td>
<td>Presence of partnership linkages reflected as MOA or other evidences indicating commitment of IFs’ institutions to embed the NNCCS in CPD programs.</td>
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B. EXPECTED OUTCOME 2: Translate NNCCS to standards of care on the family, population group, and community as clients.

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<thead>
<tr>
<th>COMPETENCIES (MT-cum-IF)</th>
<th>TEACHING LEARNING STRATEGIES</th>
<th>EVALUATION METHODS / TOOLS</th>
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<tbody>
<tr>
<td>1. Assesses the capacity of the Implementation Facilitator (IF) for translating the NNCCS into standards of care on the family, population group and community as clients.</td>
<td>1. Appropriate learning resources on the NNCCS related with the care of the family, population group, and the community as clients can be utilized as context of spreading the embedding NNCCS in work-settings. The module entitled The National Nursing Core Competency Standards on Client Care: The Family (Maglaya, 2014) presents family health nursing practice methods and tools to illustrate the NNCCS by phase of the nursing process. A list of references (bibliography) is provided to guide the MT-cum-IF on how to select and apply appropriate concepts based on nursing practice standards. Another module, National Nursing Core Competency Standards on Care of the Population Group and the Community as Clients (Maglaya, 2015), focuses on developing embedding training programs which enhance congruence and coherence between NNCCS, standards of practice, job description/s, performance evaluation and continuing professional development instructional designs. The module includes a list of references to provide bases for selection and application of appropriate concepts and nursing practice methods and tools generated from the discipline of nursing as science and art.</td>
<td>Performance Evaluation of Competencies 1 and 2 related with translating NNCCS into standards of care based on IF’s work-setting realities and experiences and current teaching-learning scenario using an evaluation tool which specifies: a. Current standards of care being used in own work-setting; b. Bases for standards of care; c. Nature and extent of coverage of standards of care in own work-setting, based on requisites of nursing practice standards; d. What and how to translate nursing practice standards reflecting precise nursing competency performance indicators as standards of care in own work-setting.</td>
</tr>
<tr>
<td>2. Assesses the current teaching-learning scenarios based on IF’s realities/ experiences to translate the NNCCS into standards of care on the family, population group and community as clients.</td>
<td>2. Conduct workshop/s and Plenary Sessions for MT-cum-IF to: a. Specify the scope of nursing practice standards on types of clients reflected as standards of care in own work-setting; b. Determine how to translate the requisites of nursing practice standards into standards of care in own work-setting; c. Specify standards of care, based on nursing practice standards reflecting precise nursing competency performance indicators;</td>
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<tr>
<th>COMPETENCIES (MT-cum-IF)</th>
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<th>EVALUATION METHODS / TOOLS</th>
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<tbody>
<tr>
<td>3. Specifies necessary processes, consequences, and outcomes related to developing standards of care based on NNCCS.</td>
<td>3. Allow opportunities for MT-cum-IF to validate number 2 (a to c), given work-setting realities, experiences and issues. Based on these validation opportunities, conduct workshop/s and plenum for MT-cum-IF to specify necessary processes, consequences and outcomes related with developing standards of care based on NNCCS on care of the family, population group and community as clients.</td>
<td>Evaluation of workshop/written outputs indicating specific: a. Processes and consequences related to capability-building of the MT-cum-IF in developing standards of care on the family, population group and community as clients based on the NNCCS; b. Standards of care as outcomes reflecting: 1. Completeness of translation of NNCCS as standards of care; 2. Appropriateness of translation.</td>
</tr>
<tr>
<td>4. Develops the training/instructional design/course design, specifying: 4.1. Appropriate nursing practice-based and desired work setting scenario-generated teaching-learning strategies to enhance the IF’s competencies to translate NNCCS into standards of care of the family, population group and community as clients. 4.2. Evaluation methods and tools to determine extent of NNCCS translated as standards of care of the family, population group and community as clients based on performance indicators.</td>
<td>4a. Using workshop and plenary session outputs in number 2 and work-setting validation results, conduct workshops, mentoring and coaching activities to guide the MT-cum-IF in developing a training design on translating the NNCCS into standards of care in own work-setting. 4b. In partnership with MT-cum-IF, specify evaluation methods/tools to determine: 1. Appropriateness of choice of teaching-learning strategies generated from desired work-setting-scenarios based on nursing practice standards; 2. Completeness, appropriateness and accuracy of translation of NNCCS into standards of care of the family, population group and community as clients; 3. Translation competency performance of MT-cum-IF.</td>
<td>Evaluation of workshop output/written feedback on the training design to translate NNCCS as standards of care in own work-setting, specifying: a. Appropriate teaching-learning strategies based on nursing practice standards; b. Precise and appropriate evaluation parameters including accurate translation of the NNCCS into standards of care.</td>
</tr>
<tr>
<td>5. Creates linkages to install partnership and anchor FI teams in designated areas to translate NNCCS into standards of care.</td>
<td>5. Reinforce working relationship/s of MT-cum-IF teams with institutions to affirm and sustain their commitment to embed NNCCS into standards of care of the family, population group and the community as clients.</td>
<td>Presence of partnership linkages reflected as MOA or other evidences indicating commitment of IFs’ institutions to embed the NNCCS in standards of care.</td>
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C. EXPECTED OUTCOME 3: Create performance evaluation tool/s on care of the family, population group, and community as clients.

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<tr>
<th>COMPETENCIES (MT-cum-IF)</th>
<th>TEACHING LEARNING STRATEGIES</th>
<th>EVALUATION METHODS / TOOLS</th>
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<tbody>
<tr>
<td>1. Assesses the capacity of the Implementation Facilitator (IF) for developing performance evaluation tool/s based on the NNCCS on care of the family, population group and community as clients</td>
<td>1. Appropriate learning resources on the NNCCS related with the care of the family, population group, and the community as clients can be utilized as context of spreading the embedding NNCCS in work-settings. The module entitled The National Nursing Core Competency Standards on Client Care: The Family (Maglaya, 2014) presents family health nursing practice methods and tools to illustrate the NNCCS by phase of the nursing process. A list of references (bibliography) is provided to guide the MT-cum-IF on how to select and apply appropriate concepts based on nursing practice standards. Another module, National Nursing Core Competency Standards on Care of the Population Group and the Community as Clients (Maglaya, 2015), focuses on developing embedding training programs which enhance congruence and coherence between NNCCS, standards of practice, job description/s, performance evaluation and continuing professional development instructional designs. The module includes a list of references to provide bases for selection and application of appropriate concepts and nursing practice methods and tools generated from the discipline of nursing as science and art.</td>
<td>Evaluation of Competencies 1, 2, and 3, using workshop outputs which specify the following indicators: a. Scope of nursing practice standards on types of clients as bases for developing performance evaluation tools on care of the family, population group and the community; b. Steps in translating the requisites of nursing practice standards into performance evaluation tool/s in own work-setting; c. Performance evaluation indicators reflected on evaluation tool/s based on nursing practice standards; d. Necessary processes, consequences and outcomes related to developing performance evaluation tools based on the NNCCS on care of the family, population group and community as clients.</td>
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</tbody>
</table>

| 2. Assesses the current teaching-learning scenarios based on IF’s realities/ experiences in developing/using existing performance evaluation tool/s on care of the family, population group and community as clients. | 2. Conduct workshop/s and Plenary Sessions for MT-cum-IF to: a. Specify the scope of nursing practice standards on types of clients as basis for developing performance evaluation tools/s on care of the family, population group and community in own work setting; b. Determine how to translate the requisites of nursing practice standards into performance evaluation tools/s in own work-setting; c. Specify performance evaluation indicators to be included in the performance evaluation tool/s, based on nursing practice standards reflecting precise nursing competency performance indicators. | |

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<tr>
<th>COMPETENCIES (MT-cum-IF)</th>
<th>TEACHING LEARNING STRATEGIES</th>
<th>EVALUATION METHODS / TOOLS</th>
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<tr>
<td>3. Specifies necessary processes, consequences, and outcomes related to developing performance evaluation tool/s based on the NNCCS on care of the family, population group and community as clients.</td>
<td>3. Allow opportunities for MT-cum-IF to validate number 2 (a to c), given work-setting realities, experiences and issues. Based on these validation opportunities, conduct workshop/s and plenum for MT-cum-IF to specify necessary processes, consequences and outcomes related with developing performance evaluation tools/s based on NNCCS.</td>
<td>Workshop output on training design, specifying:</td>
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<tr>
<td>4. Develops the training/instructional design/course design, specifying:</td>
<td>4a. Using workshop and plenary session outputs in number 2 and work-setting validation results, conduct workshops, mentoring and coaching activities to guide the MT-cum-IF in developing a training design on translating the NNCCS into performance evaluation tools/s in own work-setting.</td>
<td>a. Appropriate teaching-learning strategies to enhance competency to develop performance evaluation tool/s based on the NNCCS on care of the family, population group and the community as clients.</td>
</tr>
<tr>
<td>4.1. Appropriate nursing practice-based and desired work setting scenario-generated teaching-learning strategies to enhance the IF’s competencies to develop performance evaluation tool/s based on the NNCCS on care of the family, population group and community as clients.</td>
<td>4b. In partnership with MT-cum-IF, specify evaluation methods/tools to determine:</td>
<td>b. Evaluation method and tool/s reflecting indicators on:</td>
</tr>
<tr>
<td>4.2. Evaluation methods and tool/s to determine MT-cum-IF's competency to develop performance evaluation tools, based on NNCCS.</td>
<td>1. Completeness and appropriateness of translation of NNCCS as performance evaluation tool/s on care of the family, population group and community as clients;</td>
<td>1. Completeness and appropriateness of translation of NNCCS as performance evaluation tool/s;</td>
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<tr>
<td>5. Reinforce working relationship/s of MT-cum-IF teams with institutions to affirm and sustain their commitment to embed NNCCS through developing and using appropriate performance evaluation tool/s on care of the family, population group and the community as clients.</td>
<td>Presence of partnership linkages reflected as MOA or other evidences indicating commitment of IFs’ institutions to embed the NNCCS through use of appropriate performance evaluation tool/s</td>
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### D. EXPECTED OUTCOME 4: Develop job descriptions on care of the family, population group and community as clients

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<tr>
<th>COMPETENCIES (MT-cum-IF)</th>
<th>TEACHING LEARNING STRATEGIES</th>
<th>EVALUATION METHODS / TOOLS</th>
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</thead>
<tbody>
<tr>
<td>1. Assesses the capacity of the Implementation Facilitator (IF) for specifying job descriptions on care of the family, population group and community as clients based on the NNCCS.</td>
<td>1. Appropriate learning resources on the NNCCS related with the care of the family, population group, and the community as clients can be utilized as context of spreading the embedding NNCCS in work-settings. The module entitled <em>The National Nursing Core Competency Standards on Client Care: The Family</em> (Maglaya, 2014) presents family health nursing practice methods and tools to illustrate the NNCCS by phase of the nursing process. A list of references (bibliography) is provided to guide the MT-cum-IF on how to select and apply appropriate concepts based on nursing practice standards.</td>
<td>Evaluation of Competencies 1, 2, and 3, using workshop outputs, specifying the following indicators:</td>
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<td>a. Scope of nursing practice standards on types of clients reflected as job description/s in own work-setting;</td>
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<td>b. Methods/steps needed to translate requisites of nursing practice standards into job descriptions in own work-setting;</td>
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<td>c. Precise job descriptions based on nursing practice standards reflecting nursing competency performance indicators;</td>
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<td>d. Necessary processes, consequences and outcomes related with developing job descriptions based on NNCCS on care of the family, population group and the community as clients.</td>
</tr>
<tr>
<td>2. Assesses the current teaching-learning scenarios based on IF’s realities/ experiences in developing/using existing performance evaluation tool/s on care of the family, population group and community as clients.</td>
<td>2. Conduct workshop/s and Plenary Sessions for MT-cum-IF to:</td>
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<tr>
<td></td>
<td></td>
<td>a. Specify the scope of nursing practice standards on types of clients as basis for developing performance evaluation tools/s on care of the family, population group and community in own work setting;</td>
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<td></td>
<td>b. Determine how to translate the requisites of nursing practice standards into performance evaluation tools/s in own work-setting;</td>
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<td>c. Specify performance evaluation indicators to be included in the performance evaluation tool/s, based on nursing practice standards reflecting precise nursing competency performance indicators.</td>
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<tr>
<td>COMPETENCIES (MT-cum-IF)</td>
<td>TEACHING LEARNING STRATEGIES</td>
<td>EVALUATION METHODS / TOOLS</td>
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<tr>
<td>3. Specifies necessary processes, consequences, and outcomes related to developing performance evaluation tool/s based on the NNCCS on care of the family, population group and community as clients.</td>
<td>3. Allow opportunities for MT-cum-IF to validate number 2 (a to c), given work-setting realities, experiences and issues. Based on these validation opportunities, conduct workshop/s and plenum for MT-cum-IF to specify necessary processes, consequences and outcomes related with developing performance evaluation tools/s based on NNCCS.</td>
<td>Workshop output reflected in worksheet as basis for self and group performance specifying the indicators on developing the instructional/training design to translate/embed NNCCS into job description/s: a. Appropriate teaching-learning strategies based on nursing practice standards and desired work setting scenarios; b. Precise evaluation parameters reflected in evaluation tool/s.</td>
</tr>
<tr>
<td>4. Develops the training/ instructional design/ course design, specifying:</td>
<td>4a. Using workshop and plenary session outputs in number 2 and work-setting validation results, conduct workshops, mentoring and coaching activities to guide the MT-cum-IF in developing a training design on translating the NNCCS into performance evaluation tools/s in own work-setting.</td>
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<tr>
<td>4a. Appropriate nursing practice-based and desired work setting scenario-generated teaching-learning strategies to enhance the IF’s competencies to develop performance evaluation tools/s based on the NNCCS on care of the family, population group and community as clients.</td>
<td>4b. In partnership with MT-cum-IF, specify evaluation methods/tools to determine:</td>
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<tr>
<td>4.1. Evaluation methods and tools to determine MT-cum-IF competency to specify job descriptions on the NNCCS related with care of family, population group and community as clients.</td>
<td>1. Completeness and appropriateness of translation of NNCCS as performance evaluation tool/s on care of the family, population group and community as clients; 2. Competency performance of MT-cum-IF on developing performance evaluation tool/s.</td>
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</tr>
<tr>
<td>5. Creates linkages to install partnership and anchor MT-cum-IF teams in designated areas.</td>
<td>5a. Reinforce working relationship/s of MT-cum-IF teams with institutions to affirm and sustain their commitment to embed NNCCS through developing and using appropriate performance evaluation tool/s on care of the family, population group and the community as clients.</td>
<td>Presence of partnership linkages reflected as MOA or other evidences indicating commitment of IFs’ institutions to embed the NNCCS into job descriptions.</td>
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<tr>
<td>5b. Provide coaching and mentoring activities to help MI-cum-IF install and sustain partnership to embed NNCCS in job description.</td>
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Competency Appraisal Activities

Using this module entitled, National Nursing Core Competency Standards on Care of the Population Group and the Community as Clients, the future MT-cum-IF can determine how well the expected functions can be performed through the objectives as training outcomes specified on page 2 of this module. This competency appraisal section describes opportunities to prepare, implement and evaluate appropriate training design/s, including assessment methods and tools. After going through these opportunities, the MT-cum-IF will see the overall perspective on how to facilitate full implementation of the NNCCS on care of the population group and community as client partners in appropriate work-settings. Through specific decisions, policies and actions, the MT-cum-IF can collaborate with nursing leaders, to identify implications of the NNCCS on: (1) the content and sequence of the instructional designs of the B.S.N curriculum and training programs (as continuing professional development of the staff in nursing service); or, (2) implementation policies regarding client care standards or protocols, job description/s and performance evaluation methods and tools.

Use of a systematic approach to develop competencies as learning outcomes (by role, type of client, per course, unit and/or topic), avoids gaps and overlaps in curricular/training/instructional designs. The competency-based framework and the systematic course/instructional design methodology are presented in this section (see pages 67). The following competency appraisal activities focus on developing, implementing, and evaluating instructional/training designs for full implementation of the NNCCS on care of the population group and the community as client-partners in appropriate work-settings:

A. Using an appropriate instructional design worksheet, present an instructional plan for the NNCCS on client care, specifying the following:
   1. Component sets of NNCCS based on the list of nursing core competencies presented in this module.
   2. What and how selected instructional activities should be carried out to guide students, nurse trainees, and faculty members, on knowledge/concept use, translation, and enactment to demonstrate the performance indicators of the NNCCS on care of the population group and the community as client-partners.
   3. Teaching-learning strategies/activities through critical thinking in inquiry-based nursing practice to guide students/ nurse trainees/ faculty members on the use of appropriate nursing practice framework/s, methods, tools, and guidelines based on the performance indicators of each nursing core competency.

B. Based on specific assessment method, develop appropriate assessment tool/s to determine achievement of performance indicators per nursing core competency standard on care of the population group and the community as client-partners. Guidelines for determining achievement of learning outcomes/competencies are presented on page 27 of Volume 1, The Competency-Based BSN Curriculum (Maglaya, A.S., et al. [Eds.], College of Nursing, University of the Philippines Manila, 2006).

C. Finalize the instructional design and assessment tool/s based on feedback from colleagues and mentor/s during the presentation. The assessment tools serve as guide in designing site assessment tools to determine performance gaps.

D. Implement the instructional design and illustrate the use of the assessment tool/s. Mentoring and coaching opportunities enhance the master trainer’s capability to perform her/his expected function to prepare, train, and provide process consultation to the unit, department, or organization implementing the NNCCS.
E. Determine areas for modification of the training design and assessment tool based on process and outcome indicators.

F. Guided by the sample training design templates on NNCCS Embedding, develop/prepare a competency-based training program to guide the MT-cum-IF in performing assigned tasks.

G. Specify decisions, policies and actions necessary to facilitate full implementation of the NNCCS on care of the population group and the community as client-partners in appropriate settings.

*Adapted from the Competency-Based BSN Curriculum, Vol. I, College of Nursing Faculty, University of the Philippines Manila (2006)
DESIGNING INSTRUCTIONAL ACTIVITIES

Instructional Activity

Any teaching or learning activity designed to serve one or more instructional functions to facilitate student progress through a unit of instruction.

Generally focused on helping students develop the skills, knowledge, and/or attitudes required for a particular intermediate or terminal competency.

One or more instructional activity will be needed to facilitate the learning of each intermediate competency identified for an instructional unit.

The Instructional Design Templates for Embedding to Spreading the 2012 NNCCS for the Four Types of Clients (individual, family, population groups and community) in the home and community setting were presented in Section II can serve as part of the Training of Trainers (TOT) resource package to prepare Master Trainers/Implementation Facilitators in the integration of the 2012 NNCCS. The first module was developed as an instructional design template model for the spreading of 2012 NNCCS by the Master Trainer/Implementation Facilitators for 2012 NNCCS considering the family as client while the second module is an instructional design template model for the embedding of the 2012 NNCCS by the Master Trainer/Implementation Facilitators considering the population group and community as clients in the home, the school, health center/clinic in the rural villages, urban areas/settlements and industrial/occupational settings. Other reference materials are found in the National Nursing Core Competency Standards Training Modules.
The first model was developed by the University of the Philippines Manila College of Nursing (UPMCN) for the Embedding and Spreading of the 2012 NNCCS in Nursing Education and the second model was developed by St. Luke's Medical Center as an Exemplar for Embedding NNCCS in a Private, JCIA Accredited, Level 3 Academic Medical Center.

A. THE UPMCN MODEL FOR THE EMBEDDING AND SPREADING OF THE 2012 NNCCS IN NURSING EDUCATION (BSN PROGRAM) AND SERVICE

This model covers the method and processes of the program implementation of the Training for the Embedding and Spreading of the 2012 NNCCS for Nursing Education (BSN Program) which is an Academic Program Improvement Activity for the UPMCN July 27-31, 2015 (Appendix 1).

1. OBJECTIVES AND EXPECTED LEARNING OUTCOMES

The 5-day activity for the “Embedding the NNCCS 2012 for the BSN Program” was conducted to integrate the 2012 National Nursing Core Competency Standards for Nursing Education. This training program was carried out by the UP Manila College of Nursing through the UP Manila Academic Program Improvement (API) in coordination with the Continuing Education and Community Extension Services program.

The activity's main goal was to assist the UPCN faculty and partners, specifically the Philippine General Hospital Department of Nursing preceptors, in integrating the 2012 NNCCS into the curricular design.

Specifically, the expected outcomes are to
1. develop training program for nursing education
2. translate NNCCS to standards of care on the 4 types of clients
3. create performance evaluation tools on the care of the 4 types of client
4. develop job descriptions on the care of the 4 types of clients for nurses in the practice setting.
2. METHOD AND PROCESSES. The following are the highlights of the implementation.

a. Preparation and Scheduling

Preparation for the conduct of the activity was initiated by the request from the Professional Regulatory Board of Nursing (PRBON) to the UP Manila College of Nursing to provide an exemplar on how to conduct a program on embedding the 2012 National Nursing Core Competency Standards. As an active partner of the PRBON and CHED Center of Excellence, the UPMCN accepted the task with the team consisting of faculty members who have been involved in the NNCCS trainings (coaches, mentors and Master Trainers). This was followed by a series of meetings to plan for the program of activities. This was done in close coordination with the PRBON and selected coaches, mentors and contributors to the Training Module, to ensure consistency in the flow of the content and alignment of the activities. Scheduling was done to ensure that the program was done prior to the start of the semester and availability of majority of the faculty members. However, despite planning, some senior faculty members were out of the country and junior faculty members were tasked to assist in the enrolment activities. This limited the available faculty attending each session. This concern was addressed by dividing the faculty according to specialty groups to ensure faculty involvement and partnering with members from the practice setting.

b. Materials and Handouts

Materials, including handouts, references and worksheets, were provided in soft copy during the week’s sessions. Reference materials were also made available such as the ILO-funded Training Modules on the 2012 NNCCS, CHED CMO 14 and 2012 NNCCS (Monograph1). Hard copy of the Training Modules were also given to each partner institution who attended the activity. It was explained that the ILO Training Modules is only a reference on the varied approaches on how to teach some concepts and responsibilities in the 2012 NNCCS since it was developed for the use of Master Trainers and should not be used as the main reference for Nursing courses, specially for the main course content.

c. Selection of Participants and Speakers

Based on the determined activities, the project team ensured that inputs were given by speakers and facilitators with mastery of the content and familiar with the NNCCS. This was done by inviting experts from the PRBON, CHED-TCNE, leaders of specialty groups in Nursing, nurse administrators from the practice setting, and experts in Health Professions Education from the UP Manila National Teacher Training Center for the Health Professions (NTTC-HP).

Participants in the activity included faculty members of the UPCN, preceptors from the different practice settings (UP-PGH, Jose Fabella Medical Center, Manila Health Department, Research Institute for Tropical Medicine, National Center for Mental Health), training and research department members of the UP-PGH, and members of the ADPCN, as participant/observers (Appendix 2, List of Speakers and Participants).
d. Program Flow and Discussions

<table>
<thead>
<tr>
<th>DAY</th>
<th>ACTIVITIES</th>
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| 1   | • Status of the 2012 NNCCS by Hon. Carmencita M. Abaquin, Chairperson-PRBON and Project Lead.  
• The 2012 NNCCS Embedding Framework by Dr. Araceli S. Maglaya, Resource Person and 2012 NNCCS Partner  
• UPCN curricular efforts in the context of Outcomes-Based Education by Prof. Arnold B. Peralta, Head of the Teaching Program.  
• Analysis of Standards of Nursing Care/Practice vis-à-vis NNCCS.  
• The purpose of the workshop was to analyze the Standards of Nursing Care/Practice. This was done by grouping the participants into the different specialties (Adult Health Nursing, Maternal and Child Health Nursing, Mental health and Psychiatric Nursing, Nursing Administration, and Community Health Nursing), since the UPMCN faculty members were grouped into the above specialties. This enhanced focus on the standards being presented and facilitated application in the different courses.  
• Speakers presented the Standards of Care of their institutions and the participants discussed whether the said standards reflected the 2012 NNCCS in terms of the setting and types of clients, nursing competencies, professional learning and development, policies and procedures, and performance appraisal measures applied in the institution.  
• The workshop revealed that majority of the practice settings did not have documentation of Standards of Care. Among those were the Manila Health Department and the National Center for Mental Health.  
• Specific administrative policies, job descriptions and tasks assigned to nurses in the practice setting are available.  
• From these sources of information, the participants were able to answer the guide questions.  
• Presenters from the different practice settings have established partnerships during the workshop to help in the development of their Standards of Care (Appendix 3, Summary of Workshop 1). |
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<tr>
<th>DAY</th>
<th>INPUTS</th>
<th>DISCUSSION / WORKSHOP</th>
<th>OUTPUT / RESULTS</th>
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<td>2</td>
<td>• A talk on Selecting Teaching–Learning (TL) Strategies in varied settings by Prof. Jenniffer T. Panguio, who described the use of the University’s Virtual Learning Environment (UVLe). Suggested activities were given based on examples from different institutions and references on health professions education, use of social media and web-based platforms, &amp; modalities in line with OBE. - the Flipped classroom. Suggestions from the participants were also discussed and the application to the practice settings for training and CPD of nurses were also explored. Concerns were raised on the ethical guidelines on the use of social media in teaching. The participants were encouraged to consider the examples presented in formulating the TL strategies in their respective instructional designs.</td>
<td>• Discussion with Specialty Mentors and Development of Instructional Designs. » The intent of these discussions was to have experts in the different concepts and fields of nursing practice highlight ways to present their assigned topic in the context of the NNCCS Responsibilities and Performance Indicators and Outcomes-based Education. Content was not the focus as the participants were considered content experts themselves and resources are available. Exemplars of concepts covered were given to show how these can be taught. » Topics on concepts of research, leadership and management were discussed in the plenary since they apply to all areas of nursing practice and would be very useful for the instructional design development of each specialty. » Break-out session: Participants were divided into specialty groups and were assigned a mentor who gave inputs on how to teach the concept assigned to them. ○ Adult Health Nursing: Dr. Araceli O. Balabagno ○ Community Health Nursing: Dr. Araceli S. Maglaya and Prof. Luz Barbara P. Dones ○ Maternal and Child Health Nursing Dr. Teresita I. Barcelo and Prof. Arnold B. Peralta ○ Mental Health and Psychiatric Nursing: Hon. Betty F. Merritt ○ Nursing Research: Dr. Cora A. Añonuevo ○ Nursing Administration: Dr. Annabelle R. Borromeo » Each specialty group was composed of UPCN faculty and members of partner institutions. This was done to facilitate further collaboration between the academe and practice setting in ensuring continuity of learning for the students and exchange of ideas to enhance the instructional design.</td>
<td>• Results. The mapping exercise showed that the 2012 NNCCS Responsibilities and Performance Indicators are well reflected in the different levels: Program Outcomes, Level Outcomes and Course Outcomes; and across specialty areas. • Workshop 2: Mapping of the 2012 NNCCS Responsibilities and Performance Indicators across specialties and practice settings (Appendix 4: for the Workshop Guide).</td>
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<td>INPUTS</td>
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<td>3</td>
<td>The group activities to complete the instructional designs continued. Each specialty group worked with their mentors to improve the instructional designs for specific courses</td>
<td></td>
<td>Presentation of outputs from the following specialties:  ○ Nursing Research  ○ Adult Health Nursing  ○ Maternal and Child Nursing  ○ Community Health Nursing  ○ Mental Health and Psychiatric Health Nursing.  • Common comments are: congruence with the program outcomes, consistency between the terminal and intermediate competencies and updating of the content. Teaching-learning strategies were also emphasized.</td>
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<td>4</td>
<td>Lecture on Developing Assessment Schemes in the context of OBE by Dr. Melfor Atienza of NTTC: Highlights were: use of the Performance Indicators as guide in ensuring that the responsibilities in the NNCCS are evaluated. The inputs were incorporated in the instructional designs of the specialty groups.</td>
<td>• Afternoon session: Focused on developing assessment tools based on the courses presented by each specialty group. Majority of the groups worked on existing tools and modified them to meet the OBE framework and the revised competencies. On the other hand, the Mental Health Psychiatric Nursing specialty developed an evaluation tool for assessing Process Recordings.</td>
<td>• Presentation of the Instructional Designs from the Adult Health Nursing specialty.  • Comments included ensuring the development of a separate Instructional Designs for the community health nursing component of the interventions courses to have specific terminal and intermediate competencies to reflect care for the family, community and population groups.</td>
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<td>5</td>
<td><strong>INPUTS</strong></td>
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<td>• Input focused on the future directions for the 2012 NNCCS embedding and spreading and collaboration between the UPCN and partner institutions. This was opened by Hon. Carmelita Divinagracia who highlighted the urgency to spread the NNCCS implementation in the academe and practice settings in response to needs of the nation and region.</td>
<td>• Each partner institution was asked about their plans to further strengthen the improvement and implementation of the UPCN curriculum in their own setting. They also expressed their need for assistance and partnership with the UPMCN on continuing professional development for their nurses.</td>
<td>• Presentation of evaluation tools: No complete evaluation tool was presented due to time constraints. The group expressed commitment to pursue the development of tools further during the OBE series of activities that will be conducted by the UPMCN Teaching Program in preparation for the curricular proposal.</td>
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<td>• Active exchange of commitment from the partners was facilitated by Dean Lourdes Marie S. Tejero.</td>
<td>• PGH Chief Nurse, Ms. Cecila G. Peña, expressed the continued commitment of the institution in embedding and spreading the 2012 NNCCS. This was echoed by the group through the sharing of learning experiences and commitment of participants per institution.</td>
<td>• The importance of the Functional Integration was reiterated. This emphasized the regular coordination between the academic institution and partner healthcare facility administration and personnel.</td>
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<td>• During this session, it was agreed upon that a semestral meeting be conducted for the purpose of curricular implementation and a regular orientation of preceptors be done.</td>
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**e. Role of Partners**

Partnership and collaboration between the academic institution and the partner agency was agreed upon by the group not only in the scheduling aspect but all throughout the planning for the course and actual implementation. Close coordination is done by meeting with the preceptors for orientation and course updates. Faculty members should also be oriented to the new policies of the institution.

Apart from these, partnership was sought by the agencies in the context of staff development through continuing professional development (CPD) and trainings. The Philippine General Hospital expressed their request in the orientation to the Nursing Intervention and Outcomes Classification, update on the new NANDA diagnoses and teaching-learning strategies. The National Center for Mental Health also expressed their request for CPDs.

**f. Integration of NNCCS in the Related Learning Experience Settings**

Representatives of partner institutions expressed the need to strengthen the integration efforts between and among the institutions.

This is highlighted in two aspects: (1) close coordination on the schedule, activities and needs to facilitate learning, and (2) ensure that the 2012 NNCCS Responsibilities and Performance Indicators are reflected in the standards of respective institutions, specifically in the Standards of Care and Policies, job descriptions, and tools to measure performance.
3. RESULTS

a. Outputs

The series of lectures and workshops were geared towards the completion of instructional designs that reflect the nurses’ responsibilities from the 2012 NNCCS and the OBE framework. Two sets of outputs were presented: exemplars from participants, which will be used by faculty members teaching the course of Implementation Facilitators (IFs) and instructional designs from the specialty mentors to be used by Master Trainers (MTs).

Two exemplars included in this report cover a pure classroom setting course (Nursing Research) and a clinical setting course (Nursing Interventions I). These, along with the instructional designs from the specialty mentors are reflected in Appendix 5 and 6 respectively.

b. Discussion Points.

The following themes were derived throughout the discussions during the plenary and workshop sessions:

- **Need of the practice setting**

  There was a common identified need to document the Standards of Care for the practice settings. Only PGH was able to present a developed Standards of Care for the institution. It was a clear realization by the participants representing partner agencies of the urgent need for a Standards of Care. It was noted that the basis for the standards are already stated in the job descriptions and tasks of the nurses in the setting. However, documenting the standards will ensure the quality of practice and will help the academe in ensuring that the students’ preparation is aligned with the practice setting. It was expressed that as partners, the UPCN and UP-PGH are requested to assist with the development of the Standards of Care of NCMH and MHD that reflects the 2012 NNCCS as well.

  Another expressed need of the practice setting is the enhanced partnership in conducting continuing professional development, training and development. This will enhance the nurse professionals and will ensure having practice models for the students during their RLE.

- **Role of the faculty in embedding the 2012 NNCCS and updating the curriculum**

  The need for congruence in the understanding of terminal and intermediate competencies was mentioned. However, the focus was on continuation of the updating of the curriculum under the Outcomes-Based Education approach and to ensure embedding of, not only the 2012 NNCCS, but also updates on specialties and topics.

  Enhanced teaching-learning strategies developed in partnership with preceptors was encouraged. In addition, valid evaluation tools need to be constructed as existing evaluation/assessment tools have been found to be lacking or not updated.

- **Active partnership and collaboration among preceptors, partner agencies and the UPMCN**

  The group agreed that close coordination be done not only in the conduct and scheduling of the RLE, rather in the preparation of the preceptors in supervision and evaluation of
students. Evaluation scheme for preceptors should be explored as a means to give feedback and assess the students.

Regular meetings under the Teaching Program, through the Integration Committee, and for each course should be done on a regular basis. And the formal Preceptorship Program be revived by UPCN for all the current and future preceptors in the partner institutions.

4. EVALUATION AND FEEDBACK

There was general agreement on the indicators of assessment in relation to the context, process and flow of the program. Majority of the evaluation and feedback came from nurses of the Philippine General Hospital Department of Nursing. They were functioning as preceptors to the BSN students of UPCN, and at the same time, were functioning as trainers for in-service and staff development program of PGH.

For the first timers to engage in knowing the NNCCS, they found the knowledge of NNCCS and its application as usable, useful and provides direction to their teaching and training functions (Appendix 9: An Assessment of the Program on Embedding and Spreading the 2012 NNCCS for the BSN Program).
Appendixes

Appendix 1. Program for Embedding and Spreading the 2012 NNCCS for the BSN Program
Appendix 2. List of Speakers and Participants
Appendix 3. Summary of Workshop I on Analysis of Standards of Nursing Care/Practice vis-à-vis 2012 NNCCS
Appendix 5. Exemplar: Nursing Research
Appendix 6A. Exemplar: Maternal and Child Nursing
Appendix 6B. Exemplar: Care of Children
Appendix 6C. Instructional Design: Prenatal Assessment
Appendix 7A. Exemplar: Training Program of MTs/Ifs on the Mainstreaming/Embedding of the 2012 NNCCS on the Topic of “Instructional Design for Faculty to Embed NNCCS For Responsibilities 2 and 5”. Adult Health Nursing
Appendix 7B. Exemplar: Adult Health Nursing: Holistic Care for Nursing Intervention Courses
Appendix 7C. Exemplar: Adult Health Nursing: Peri Operative Nursing Care
Appendix 8. Evaluation Tool
Appendix 9. Budget Estimate for the Training Program
Appendix 10. UPMCN Report
Appendix 1. UPMCN Program for Embedding and Spreading the 2012 National Nursing Core Competency Standards for the BSN Program.

Embedding and Spreading the 2012 National Nursing Core Competency Standards for the BSN Program.
An Academic Program Improvement Activity for University of the Philippines Manila College of Nursing, July 27-31, 2015

2012 National Core Competency Standards for the BSN Program

PROGRAM
Day 1 July 27 (Wednesday) – Dr. AO Balabanag – OIC
7:30 – 8:00 Registration
8:00 – 8:30 Opening Remarks
National Anthem
Moments of Ruth
Welcome Remarks
8:30 – 8:45 Present Status and Direction in Integrating the 2012 Nursing Core Competency Standards in the BSN Program
Hon. Carmencita M. Abaunin Chair, PRG, Board of Nursing
8:45 – 9:15 Overview of UP Manila College of Nursing’s Efforts in Integrating the 2012 Nursing Core Competency Standards in the BSN Program
Prof. Arnold B. Peralta, Head, Teaching Program
Context, Realities & Work Setting Scenarios
9:15 – 12:00 Workshop 1: Analysis of Standards of Nursing Care Practice via 5–5 Matrix
- Standards of Care (Hospital Settings):
  - Philips Interim Hospital
    - Ms. Melanie Saloy – PCH/DMET
  - Dr. Jose Fabella Memorial Hospital
    - Ms. Marie Theresia Pablo, Chief Nurse
  - Research Institute for Tropical Medicine
    - Ms. Lozada Olayvino, Chief Nurse
  - National Center for Mental Health
    - Ms. Lucie Espino, Chief Nurse
  - Standards of Care Public Health Settings:
    - Manila Health Department Training Office
      - Ms. Pita Maria Udalin
    - National Center for Mental Health
      - Ms. Neha Rajput, Nurse VI
5:00 – 6:00 Plenary Session 1: NCICS and Standards of Nursing Practice: Addressing Realities and Options
4:00 – 6:00 Synthesis

PROGRAM
Day 2 July 28 (Tuesday) – Prof. LBP Done – OIC
8:00 – 8:30 Recap
Addressing Gaps to Improve the Embedding and Spreading Initiatives of the NCICS
8:30 – 9:00 Presentation of UP College of Nursing Ongoing Curriculum Review
Prof. Arnold B. Peralta, Head, Teaching Program
- Mapping NCICS Responsibilities and Performance Indicators Across Specialties
- Mapping Performance Indicators per Course Across Setting
9:30 – 10:30 Selecting Teaching Learning Activities to Enhance the Embedding and Spreading Process of NCICS in Various Settings
Prof. Jennifer T. Puguo, Faculty, UPMCN
10:30 – 12:00 Workshop 2: Analysis of Instructional Designs Based on the NCICS: Addressing Options for Improvement
A. Care of Adults: Dr. Araceli O. Balabanag (prenatal, pediatric, adult, elderly)
B. Care of the Child & Adolescent: Prof. Arnold B. Peralta
C. Care of the Woman – Dr. Tereza I. Barcelo (pre-conception care and perinatal care)
D. Care of the Family and Community: Dr. Araceli O. Balabanag, Consultant, BCN
E. Care of the Population Group: Prof. Luz Ybarra, Done
F. Care of Clients with Maladaptive Responses: Ms. Betty P. Merito, Fellow, RCN, Member
G. Research – Dr. Core A. Añoveros
H. Leadership and Management: Dr. Annabelle Borromeo, Vice President, St. Luke’s Medical Center
## Appendix 2. List of Speakers and Participants

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<thead>
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<th>Speakers</th>
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<tr>
<td>1. Hon. Carmencita M. Abaquin</td>
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<td>2. Dr. Teresita I. Barcelo</td>
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<td>3. Dr. Araceli S. Maglaya</td>
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<td>4. Dr. Annabelle R. Borromeo</td>
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<td>5. Dr. Mellflor A. Atienza</td>
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<td>6. Dr. Carmelita C. Divinagracia</td>
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<tr>
<td>1. Dr. Cora A. Anonuevo - UPMCN</td>
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<td>2. Dr. Annebelle R. Borromeo - St Luke's Medical Center</td>
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<td>3. Ms. Marie Therese Pacabis - Jose Fabella Memorial Hospital</td>
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<td>4. Dr. Teresita I. Barcelo - Centro Escolar University</td>
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<td>5. Ms. Lucia Espinosa - National Center for Mental Health</td>
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<td>6. Ms. Betty F. Merritt</td>
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<td>7. Ms. Nelia A. Rafael - Manila Health Department</td>
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<td>1. Abad, Peter James</td>
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<td>2. Acop, Jocelyn G.</td>
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<td>3. Anonuevo, Cora A.</td>
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<td>4. Balabagno, Araceli O.</td>
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<td>5. Batalla, Mary Grace Anne P.</td>
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<td>6. Cariaso, Josephine E.</td>
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<td>7. Ceblano, Christine A.</td>
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<td>8. Dones, Luz Barbara P.</td>
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<td>9. Flores, Jo Lea</td>
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<td>10. Iellamo, Efreliz A.</td>
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<td>11. Leyva, Erwin William A.</td>
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<td>12. Mabale, Maria Angela A.</td>
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<td>13. Maderal, Vanessa M.</td>
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<td>14. Manahan, Lydia T.</td>
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<td>15. Mejico, Merle F.</td>
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<td>16. Ngaya-an, Floreliz</td>
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<td>17. Pagsibigan, Jesusa</td>
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<td>18. Paguio, Jenniffer T.</td>
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<td>19. Peralta, Arnold B.</td>
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<td>20. Ragotera, Ina G.</td>
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<td>21. Tejero, Lourdes Marie</td>
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<td>22. Valera, Mary Joan Therese C.</td>
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<td>23. Villarta, Bethel Buena P.</td>
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<th>Participants From Partner Institutions</th>
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<td><strong>UP-PGH</strong></td>
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<td>1. Andaya, Marites O.</td>
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<td>2. Asprec, Lourdes Teresa</td>
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<td>3. De Castro, Lydia B. (Preceptor)</td>
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<td>4. Ipapo, Leilani P.</td>
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<td>5. Navarro, Jeaneth(Preceptor)</td>
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<td>6. Navarro, Walter P.</td>
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<td>7. Oliver, Myra R.</td>
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<td>8. Pena, Cecile</td>
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<td>9. Punzalan, Maria Cecilia E.</td>
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<td>10. Salido, Melanie</td>
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<td>11. Sibulo, Maria Salve R.</td>
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<td>12. Villanueva, Marian T.(Preceptor)</td>
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<th>NATIONAL CENTER FOR MENTAL HEALTH</th>
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<td>1. Bajador, Jerico</td>
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<td>2. De Guzman, Jane P.</td>
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<td>3. Endrada, Wendy M.</td>
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<td>4. Pascua, Estelita G.</td>
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<td>1. Udtujan, Wenifreda</td>
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<th>ASSOCIATION OF DEANS OF PHILIPPINE COLLEGES OF NURSING</th>
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<td>1. So, Iris Chua - Chinese General Hospital College of Nursing</td>
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<td>1. Dumlao, Carfredda P.</td>
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Appendix 3. Summary of Workshop I on Analysis of Standards of Nursing Care/ Practice vis-à-vis 2012 NNCCS

1. Specialty: Adult Health Nursing and Nursing Administration

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<tr>
<th>Parameter</th>
<th>Special Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>Type of Clients: Individual/Group of clients (Categories: 1-4) Setting: Acute/Chronic, Emergency/Elective, Urgent/Emergent</td>
</tr>
<tr>
<td>Nursing Competencies</td>
<td><strong>Aligned</strong> Reflecting the Level I nurse (Entry competencies to the hospital of the New Nursing Graduate) Based on the Self-Competency Assessment Checklist for Newly-Hired Nurse (2012 NNCCS-based) Mirroring between the entry to PGH to the exit from UP Matching entry exam and skills evaluation to PGH</td>
</tr>
<tr>
<td>Learning and Development</td>
<td><strong>Aligned</strong> Training in UPCN matches the skills needed in PGH/other hospital Explore further skills development topics needed in PGH. Preparation be done in UPCN Exposure of students in the real life setting (schedule) Integration in the culture of the setting</td>
</tr>
<tr>
<td>Policies and Procedures</td>
<td>There are policies and procedures UPCN faculty needs to be oriented to ensure alignment Addressing concerns with Evidence Base Practice</td>
</tr>
<tr>
<td>Performance Appraisal</td>
<td>Tools for N1 are available that can be reviewed by UPCN to ensure alignment with student evaluation Refer to appraisal forms</td>
</tr>
<tr>
<td>Other Concerns</td>
<td>Communication Evaluation of preceptors Orientation and Feedback</td>
</tr>
</tbody>
</table>

2. Specialty: Community Health Nursing

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Special Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>Type of Clients: Individual, Family, Population Group and Community</td>
</tr>
<tr>
<td>Nursing Competencies</td>
<td>Not as specific as that of the competencies on NNCCS</td>
</tr>
<tr>
<td>Learning and Development</td>
<td>Categories on Learning and development for continuing education, in-service trainings, orientation have been presented</td>
</tr>
<tr>
<td>Policies and Procedures</td>
<td>Policies and procedures have been presented</td>
</tr>
<tr>
<td>Performance Appraisal</td>
<td>There are existing performance evaluation categories but the WS group was able to go over the information on specific competencies expected of the nurse only in MNCHN and TB DOTS</td>
</tr>
<tr>
<td>Other Concerns</td>
<td>Not stated</td>
</tr>
</tbody>
</table>
### 3. Specialty: Maternal and Child Health Nursing

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Special Consensus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Type of Clients: Individual - Perinatal, Newborn and Women</td>
</tr>
<tr>
<td></td>
<td>Setting:</td>
</tr>
<tr>
<td></td>
<td>NICU: 80-90 census per day (Intermediate, sepsis, high risk 1 (fully intubated, high risk 2 (step down before intermediate)</td>
</tr>
<tr>
<td></td>
<td>Fabella is recognized by WHO for perinatal practice</td>
</tr>
<tr>
<td></td>
<td>Fabella’s weakest point in terms of practice is women’s health</td>
</tr>
<tr>
<td><strong>Nursing Competencies</strong></td>
<td>Reproductive Health:</td>
</tr>
<tr>
<td></td>
<td>• male</td>
</tr>
<tr>
<td></td>
<td>• adolescent</td>
</tr>
<tr>
<td></td>
<td>Women’s Health:</td>
</tr>
<tr>
<td></td>
<td>• Reproductive health services</td>
</tr>
<tr>
<td></td>
<td>• Mental health of women</td>
</tr>
<tr>
<td></td>
<td>• Menopause care</td>
</tr>
<tr>
<td></td>
<td>• Oncology care (preparation and administration)</td>
</tr>
<tr>
<td></td>
<td>• STIs prevention and promotion</td>
</tr>
<tr>
<td></td>
<td>Perinatal Skills:</td>
</tr>
<tr>
<td></td>
<td>• Deliveries</td>
</tr>
<tr>
<td></td>
<td>• Suturing</td>
</tr>
<tr>
<td></td>
<td>• IE</td>
</tr>
<tr>
<td></td>
<td>• Partograph</td>
</tr>
<tr>
<td></td>
<td>Care of the preterm neonate</td>
</tr>
<tr>
<td></td>
<td>Pediatrics:</td>
</tr>
<tr>
<td></td>
<td>• Newborn Care</td>
</tr>
<tr>
<td><strong>Learning and Development</strong></td>
<td>TRAININGS:</td>
</tr>
<tr>
<td></td>
<td>• BLS</td>
</tr>
<tr>
<td></td>
<td>• Lactation management</td>
</tr>
<tr>
<td></td>
<td>• Rotation to each area: after 1-2 years, they will be assigned to area where they feel most comfortable</td>
</tr>
<tr>
<td></td>
<td>• NALS, PALS, STABLE</td>
</tr>
<tr>
<td></td>
<td>• BEMONC</td>
</tr>
<tr>
<td><strong>Policies and Procedures</strong></td>
<td>CERTIFICATION:</td>
</tr>
<tr>
<td></td>
<td>• Chemo - ANSAP</td>
</tr>
<tr>
<td></td>
<td>• IE and Suturing of Perineal Lacerations -MCNAP-ANSAP</td>
</tr>
<tr>
<td></td>
<td>• IVT - ANSAP</td>
</tr>
<tr>
<td><strong>Performance Appraisal</strong></td>
<td>Institutional Policies:</td>
</tr>
<tr>
<td></td>
<td>• suturing</td>
</tr>
<tr>
<td></td>
<td>• IE</td>
</tr>
<tr>
<td></td>
<td>• Partograph</td>
</tr>
<tr>
<td></td>
<td>• Women’s health</td>
</tr>
<tr>
<td></td>
<td>- PAP Smear</td>
</tr>
<tr>
<td></td>
<td>- Menopause</td>
</tr>
<tr>
<td></td>
<td>- STIs</td>
</tr>
<tr>
<td></td>
<td>- Abdominal uterine bleeding</td>
</tr>
<tr>
<td><strong>Other Concerns</strong></td>
<td>Functions and competencies based on those written above</td>
</tr>
<tr>
<td></td>
<td>Procedure/elements:</td>
</tr>
<tr>
<td></td>
<td>1. Mandated form by the Civil Service (2x a year)</td>
</tr>
<tr>
<td></td>
<td>2. Management of the unit</td>
</tr>
<tr>
<td></td>
<td>3. Actual client care (patient satisfaction form)</td>
</tr>
<tr>
<td></td>
<td>4. Trainings undertaken and how it was used</td>
</tr>
<tr>
<td></td>
<td>5. Professional conduct and ethics (appearance and grooming, communication, pharmaco-vigilance, social media)</td>
</tr>
<tr>
<td></td>
<td>6. Interpersonal skills, working with teams</td>
</tr>
<tr>
<td></td>
<td>7. Collaborative skills</td>
</tr>
<tr>
<td></td>
<td>What we practice does not completely synchronize with the content of what we teach: e.g. suturing, IEs</td>
</tr>
<tr>
<td></td>
<td>UP nurses should be distributed to key or specialized hospitals, where you need nurses to be at the forefront</td>
</tr>
</tbody>
</table>
## 4. Specialty: Mental Health and Psychiatric Nursing

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Special Consensus</th>
</tr>
</thead>
</table>
| Context            | National Center for Mental Health  
Clients: Psychiatric Patients  
Total Bed Capacity: 4,200 patients  
Implementing bed capacity: 3,100; Now: 3,155 patients  
Pavilion Wards: 27  
Sometimes a nurse needs to handle 2-3 wards and that can reach up to 100 patients  
Nurses: 414  
Challenge: How to address client needs based on the core competency standards given the number of patients vis a vis the number of nurses  
Specialty Areas: Dementia, Anxiety, Reproductive, Adolescence, Psychosocial Rehabilitation, Forensic |
| Nursing Competencies | There is a focus on individual client care  
Psychosocial Interventions are not consistently implemented in all settings  
There are special considerations for specific types of patients but there is a need to translate it into standards  
Practices are not yet translated into standards and not yet aligned with NNCCS |
| Learning and Development | There is a residency training for two years for entry-level nurses before acquiring the permanent position approved by the Civil Service and PRBON  
There is a nurse certification program from DOH and has level I to V: from Novice, to Advance Beginner, to Competent Practitioner, to Proficient Practitioner and Expert Practitioner on Mental Health |
| Policies and Procedures | Not yet aligned with NNCCS  
Standards are not yet on a policy level but still a work in progress |
| Performance Appraisal | Job description is based on SPMS (Strategic Performance Management System) by the Civil Service depending on the area of assignment |
| Other Concerns     | Not stated                                                                                                                                                                                                           |

<table>
<thead>
<tr>
<th>2012 NNCCS Responsibilities and Core Competencies and Performance Indicators</th>
<th>NURSING SPECIALTY (Community Health Nursing, Maternal and Child Health Nursing, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Classroom Setting (Lectures)</td>
</tr>
</tbody>
</table>
Appendix 5. Exemplar: Nursing Research

Course Title: Nursing Research (N-199.1, N199.2)

Outcome: Engages in Nursing or health related research with or under the supervision of an experienced researcher

Prepared By: Dr. Cora A. Anonuevo

RESPONSIBILITY: Develop a technically and ethically sound research proposal utilizing the research process.

<table>
<thead>
<tr>
<th>Learning Outcomes</th>
<th>Content</th>
<th>Learning Activities</th>
<th>Performance Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discuss key concepts in research and its relevance in the nursing profession</td>
<td>1. INTRODUCTION</td>
<td>Individual Seatwork: “How do you feel” activity</td>
<td>Participate actively in team activity</td>
</tr>
<tr>
<td>A. Definition, Purpose &amp; Rules of Research</td>
<td>Participants describe their feelings about research in one sentence by writing them on a piece of paper. Then they rate how positively or negatively they feel overall about nursing research.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Importance of research in evidence based practice and quality improvement in nursing</td>
<td>Participants share their individual responses. In the group, they will brainstorm using the guide questions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- What is research to you?</td>
<td>Facilitator synthesizes the responses and proceeds to conduct an introductory lecture.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Why is research important?</td>
<td>Facilitator uses vignettes to demonstrate the value of research in the following processes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Can you identify issues and topics in practice settings?</td>
<td>- evidence-based practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Types of Research</td>
<td>- quality improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Quantitative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Outcomes</td>
<td>Content</td>
<td>Learning Activities</td>
<td>Performance Indicators</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>---------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>2. Discuss the steps in preparing a research proposal complying with the ethical principles in nursing research.</td>
<td>Overview of the research process: A. Conceptualization B. Planning &amp; Designing C. Implementation D. Analytical Phase E. Writing the Report, Dissemination &amp; Utilization of results</td>
<td>Conduct Lecture-discussion</td>
<td>States the research problem, purpose of research or hypothesis based on the given scenarios Formulate a selected researchable problem that will contribute to knowledge base on the topic/problem Reviews literature to determine knowledge on the topic of interest and to identify context &amp; the need for the study. Submit a good &amp; critical review of literature Using the given scenarios, construct a framework of the proposed study showing the variables &amp; their logical relationships. Incorporate ethical principles in the research proposal</td>
</tr>
<tr>
<td></td>
<td>PLANNING &amp; PREPARING RESEARCH PROPOSAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. The Research Proposal: Purpose, Importance &amp; Parts</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Conceptualization Phase:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Problem Identification - How is a research idea or problem generated? - The fully developed research problem - Criteria for final selection of a research problem</td>
<td>Using given scenarios (e.g. Hypothetical or from published articles) in hospital and community settings, the participants: - state the research problem - formulate the research purpose - formulate the research questions Participants brainstorm to identify problems &amp; issues encountered in practice settings - community &amp; hospital that can be sources of research topics.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Literature Review - to identify the context, knowledge gaps, and justify the need for study - What is a good Literature Review? - Steps &amp; strategies for Searching for Literature - Guidelines to avoid Plagiarism in Literature Review &amp; Writing the Report</td>
<td>Direct participants to read Chap 5 of W.L. Newman’s Social Research Methods, 2003 The Literature Review and Ethical Concerns Provide them with sample of recent literature (theoretical &amp; empirical) Using guidelines for review, let them comment on the literature</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Study Framework: - Theoretical Framework - Conceptual Framework</td>
<td>Show examples of frameworks. Discuss the elements of a framework Identifies a theoretical framework or create a conceptual model to provide an organizing frame for the research study</td>
<td></td>
</tr>
</tbody>
</table>

N-199.2 Responsibility
1. Implement research proposal that is compliant to technical and ethical guidelines with supervision
2. Present research findings at a school or local forum
<table>
<thead>
<tr>
<th>Learning Outcomes</th>
<th>Content</th>
<th>Learning Activities</th>
<th>Performance Indicators</th>
</tr>
</thead>
</table>
| 1. Conduct research as a member of a research team | - Types of Data Collection Methods  
- Training the research team for data collection  
- Specify Methods for data analysis | Guided by the study framework & design, team members carry out their work plan, immerse themselves in the data collected, analyze data, hold reflection & feedback sessions | Participants in the following activities:  
- sampling procedure  
- data collection  
- data analysis  
- synthesizing data  
- deriving conclusions and implications |
| 1.1. Discuss data collection methods & procedures for collecting reliable data | Research Data Management On Record Keeping and Documentation  
- Data vs information  
- Definition of data management  
- Benefits of managing data  
- Research team members roles and responsibilities | Participants share their own understanding of the concepts (data, information, data management) Lecture - discussion | |
| 1.2. Discuss methods for data analysis | Data management principles in:  
Research data-materials covered I a data management plan  
Data planning - steps to take in beginning a research project  
Data management - the procedures in organizing & controlling research data  
Security - considerations for data access & long-term data stability  
Sharing - reasons & ways of sharing data | Lecture-discussion | Executes data processing & keep records of data in place |
| 2. Explain the importance of data management | Maintaining data integrity  
- Potential pitfalls that can invalidate data integrity | Case Vignettes | Participates satisfactorily in discussion |
| 3. Discuss the principles in data management | WRITING AND DISSEMINATING RESEARCH RESULTS/FINDINGS  
The IMRAD Format  
Guidelines in writing & communicating research reports  
- Oral Presentation  
- Poster Presentation | Team conducts write shop sessions | Completes research report using the IMRAD format  
Prepares an abstract consistent with specified guidelines  
Presents research results/findings in oral and/or poster forms |
Appendix 6A. Exemplar: Maternal and Child Nursing

Care for Woman During Labor and Delivery: Essential Intrapartum and Immediate Newborn Care

The sample concept for instructional design for maternal and child nursing is the care for women during labor and delivery particularly the Essential Intrapartum and Immediate Newborn Care (EINC). The instructional design prepares/helps the IFs to embed the 2012 NNCCS in teaching the sample concept. In this area, the variety of teaching learning activities can be and possibly used in the embedding but gives a lot of emphasis on certain the appropriateness and relevance of TL activities in the achievement of competencies. It also focuses on developing the IFs capacity to embed 2012 NNCCS in the concept of EINC.

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>TEACHING-LEARNING STRATEGIES</th>
<th>EVALUATION METHODS/TOOLS</th>
</tr>
</thead>
</table>
| 1. Assess the capacity of the “Implementing Facilitator” for embedding. | • Using the 2012 NNCCS, ask the IFs to identify the competencies present in their instructional design in teaching Essential Intrapartum and Immediate Newborn Care (EINC). (The IFs will review their own instructional designs used in their institutions)  
• Identify critical competencies in teaching EINC. From these competencies, ask the IFs should determine if the topics/content are enough to achieve the identified competencies. (The MT should explore more to determine if the IFs have difficulty in teaching EINC, if there are identified challenges particularly in topics/content wise, refer them to resources).  
• Show one significant competency as an example; use the competency relating to the skill in actual delivery. Demonstrate how this competency is best taught. Ask the consensus of the IFs regarding the teaching-learning activity. Ask the IFs if there are any challenges encountered in doing this e.g. video, mannequins, skills checklist. (The competencies can be achieved through appropriate and relevant teaching-learning activities).  
• Discuss the other competencies like the first one, let them identify those competencies and which among these sample TL activities should be used:  
  » Lecture/discussion  
  » Video presentation  
  » Use of skills checklist  
  » Demonstration-return demonstration  
• Emphasize the rationale in selecting the TL activities. The IFs should give adequate rationale for selecting the TL activities. | Instructional designs highlighting the 2012 NNCCS. |
<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>TEACHING-LEARNING STRATEGIES</th>
<th>EVALUATION METHODS/TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Assess the current TL scenarios based on IFs realities/ experiences related with NNCCS on care of the woman during labor and delivery.</td>
<td>For IFs working in the hospital and acts as preceptors, ask them if EINC is practiced in their hospital. (There should be consistency between the school and the affiliated hospital especially in this area). If there will be identified concerns, these should be discussed together with the IFs who are faculty. Present the laboratory requests expected for EINC, the materials and checklists needed, and the number of hours EINC should be discussed. Compare this with what they are doing, and ask them for feedback.</td>
<td></td>
</tr>
<tr>
<td>3. Specifies necessary processes, consequences, and outcomes related to the IFs TL needs on clinical supervision/ guided practicum on care of woman during labor and delivery.</td>
<td>Identify among those IFs who are teaching EINC. (If appropriate, ask those IFs if the faculty teaching EINC are trained or with certificate). Ask the IFs capacity to teach EINC (awareness is needed in order to help them identify what training they need). Ask also if those teaching EINC can supervise the students in the clinical area. If preceptors handle the students, ask them how they ensure that there is consistency in lecture and clinical area in performing EINC. In the context of EINC, ask the IFs for requirements expected for the students. Discuss this in a large group e.g. number of deliveries. In pairs, ask the IFs to identify the issues, difficulties, challenges regarding teaching EINC. Discuss their answers in whole group. Ask for their feedback on how to address these concerns.</td>
<td></td>
</tr>
<tr>
<td>4. Develop the instructional design/course design specifying:</td>
<td>Ask the IFs to bring out their own instructional designs on EINC. Give them time to revise/modify depending on previous discussions and activities. Share these to large group. From the 2012 NNCCS and the competencies in their updated/revised instructional designs, select the evaluation tools that will really assess students’ performance of competencies. From the 2012 NNCCS performance indicators related to EINC. (Evaluation tools should reflect achievement of competencies in the highest level of outcome possible) ask the IFs if these are reflected in their evaluation tools. Discuss how to use the evaluation tools for each competencies identified. Prepare unusual situations for discussions. Group them in pairs. Let them discuss the unusual situations and ask their suggestions on how to address the situations.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 6B. Exemplar: Care of Children

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>TEACHING-LEARNING STRATEGIES</th>
<th>EVALUATION METHODS/TOOLS</th>
</tr>
</thead>
</table>
| 1. Assess the capacity of the “Implementing Facilitator” for embedding. | Assign the participants in smaller groups. In the context of NNCCS focusing on pediatric assessment, ask the participants which major/significant competencies should be best taught through:  
- Lecture/discussion  
- Video Presentation  
- Provision of performance checklist  
- Demonstration - return demonstration (mannequin-actual pediatric client)  
If possible, provide setting for which the teaching-learning activity should take place.  
Show one significant competency as an example; use the competency relating to the skill in performing pediatric nursing history. Demonstrate how this competency is best taught. Ask the consensus of the IFs regarding the teaching-learning activity. Ask the IFs if there are any challenges encountered in doing this e.g. video, use actual client, skills checklist. (The competencies can be achieved through appropriate and relevant teaching-learning activities).  
Emphasize the rationale in selecting the TL activities. The IFs should give adequate rationale for selecting the TL activities. | Instructional designs highlighting the 2012 NNCCS. |
| 2. Assess the current TL scenarios based on IFs realities/ experiences related with NNCCS on pediatric care. | Ask them about any concerns in teaching pediatric assessment. Group the identified concerns into categories like:  
- Content  
- TL activities  
- Evaluation  
Use their pediatric assessment evaluation checklist to further identify the concerns.  
With the identified challenges, by groups, ask them how to address these concerns.  
Provide an actual scenario presented as a case of handling pediatric clients and doing assessment.  
Emphasize the advantage of the use of mannequin for pediatric assessment demonstration especially in providing patient safety and addressing ethical reasons.  
Present the laboratory expected for pediatric assessment, the materials and checklists needed, and the number of hours pediatric assessment should be discussed. Compare this with what they are doing, and ask them for feedback. | 
<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>TEACHING-LEARNING STRATEGIES</th>
<th>EVALUATION METHODS/ TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Specifies necessary processes, consequences, and outcomes related to the IFs TL needs on clinical supervision/guided practicum on pediatric care.</td>
<td>Identify among those IFs who are teaching pediatric nursing. (If appropriate, ask those IFs if the faculty teaching pediatric nursing for any qualifications). Ask the IFs regarding their capacity to teach pediatric nursing (awareness is needed in order to help them identify what training they need). Ask also if those teaching pediatric nursing supervise the students in the clinical area. If preceptors handle the students, ask them how they ensure that there is consistency in lecture and clinical area in pediatric assessment. In the context of pediatric assessment, ask the IFs for requirements expected from the students. Discuss this in a large group e.g. number of clients handled, areas for clinical exposure. In pairs, ask the IFs to identify the issues, difficulties, challenges regarding teaching pediatric assessment. Discuss their answers in large group. Ask for their feedback on how to address these concerns.</td>
<td></td>
</tr>
<tr>
<td>4. Develop the instructional design/course design specifying:</td>
<td>From the 2012 NNCCS and the competencies in their updated/revised instructional designs, select the evaluation tools that will really assess students' performance of competencies. From the 2012 NNCCS performance indicators related to EINC. (Evaluation tools should reflect achievement of competencies in the highest level of outcome possible) ask the IFs if these are reflected in their evaluation tools. Discuss how to use the evaluation tools for each competencies identified. Ask the faculty to bring their own performance evaluation checklist where pediatric assessment is included. As a large group, consolidate competencies relevant to pediatric assessment identified in the checklist (if their checklists are different from each other). Show the faculty a sample performance evaluation checklist. Compare this with their performance evaluation checklist. Include evidence-based nursing activities related to pediatric assessment. Ask the IFs to bring out their own instructional designs with pediatric assessment. Give them time to revise/modify depending on previous discussions and activities. Share these to large group. Prepare unusual situations for discussions. Group them in pairs. Let them discuss the unusual situations and ask their suggestions on how to address the situations.</td>
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</tr>
</tbody>
</table>
## Appendix 6C. Instructional Design: Prenatal Assessment

### INSTRUCTIONAL DESIGN for Implementation Facilitators

**SPECIALTY:** Maternal and Child Nursing  
**TOPIC:** Prenatal Assessment  
Prepared by: Maternal and Child Health Nursing Specialty Group: (TBarcelo-mentor, ABPeralta, EAlellamo, JNavarro)

<table>
<thead>
<tr>
<th>LEARNING OUTCOME</th>
<th>TOPIC</th>
<th>ACTIVITY</th>
<th>RESOURCES</th>
<th>EVALUATION</th>
</tr>
</thead>
</table>
| Specific competencies in the NNCS on performing prenatal assessment | • Prenatal Assessment:  
• Nursing History  
• Physical Assessment  
• Laboratory Exam | In the context of prenatal assessment, ask the participant which among the competencies should be taught through:  
• Lecture/discussion  
• Video Presentation  
• Provision of performance checklist  
• Demonstration-return demonstration (mannequin-actual pregnant client)  
| Apply nursing practice tools, guidelines and/or frameworks in prenatal assessment. | Performance Evaluation Checklist  
WHO guidelines relevant to prenatal assessment | • Ask the faculty to bring their own performance evaluation checklist.  
• As a large group, consolidate competencies relevant to prenatal assessment identified in the checklist (if their checklists are different from each other).  
• Show the faculty a standard performance evaluation checklist from CHED CMO. 14.  
• Compare this with their performance evaluation checklist.  
• Show the WHO guidelines relevant to prenatal assessment.  
• Include evidence-based nursing activities related to prenatal assessment. | CHED CMO. No. 14 checklist | Revised performance evaluation checklist. |
| Utilize nursing teaching learning strategies that will embed NNCCS in the prenatal assessment. | Home-based mothers record  
Mannequin for Leopold’s Maneuver Skills checklist for Leopold’s Maneuver | • Provide a sample case study that will show how to fill up the HBMR.  
• Prepare unusual situations for HBMR.  
• Emphasize that this is not only for documentation purposes only but also for providing health teaching.  
• Emphasize the advantage of the use of mannequin for Leopolds Maneuver demonstration especially in patient safety and ethical reasons.  
• Ask the participants to bring their Leopolds maneuver checklist. Ask the faculty to review the checklist in relation to NNCCS.  
• Highlight ethical issues, communication and patient safety and other significant NNCCS that needs to be emphasized.  
• Revise the skills checklist. | Home-Based Mothers Record  
Sample case study  
Unusual prenatal situations.  
Leopolds maneuver skills checklist. |
<table>
<thead>
<tr>
<th>LEARNING OUTCOME</th>
<th>TOPIC</th>
<th>ACTIVITY</th>
<th>RESOURCES</th>
<th>EVALUATION</th>
</tr>
</thead>
</table>
| Demonstrate how the achievement of specified competencies of the NNCCS in performing prenatal assessment. | Principles of using various evaluation tools for different competencies. | • Discuss how to use evaluation tools for each competencies identified.  
• Prepare unusual situations for discussion.  
• Group them in pairs.  
• Let them discuss the unusual situations and ask their suggestions on how to address the situations. | Evaluation tools for prenatal assessment | Revised skills checklist. |
| Utilize nursing teachinglearning strategies that will embed NNCCS in the pediatric assessment. | Pediatric assessment skills checklist. Pediatric performance evaluation checklist. | • Ask them about any concerns in teaching pediatric assessment.  
• Use their pediatric assessment evaluation checklist to identify the concerns.  
• With the identified challenges, by groups, ask them how to address these concerns.  
• Provide an actual scenario presented as a case of handling pediatric clients and doing assessment.  
| Demonstrate how the achievement of specified competencies of the NNCCS in performing pediatric assessment. | | • Discuss how to use evaluation tools for each competencies identified.  
• Prepare unusual situations for discussion.  
• Group them in pairs. Let them discuss the unusual situations and ask their suggestions on how to address the situations. | | |
Appendix 7A. Exemplar: Training Program of MTs/Ifs on the Mainstreaming/Embedding of the 2012 NNCCS on the Topic of “Instructional Design for Faculty to Embed NNCCS For Responsibilities 2 and 5”. Adult Health Nursing

[Resp. 2 Utilizes the nursing process in the interdisciplinary care of clients that empowers the client and promote safe quality care. Resp.5 Promotes professional and personal growth and development]

Expected Outcome 1: Developed Training Program for Education

ADULT HEALTH CARE
Assessing Adult Individual

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>TEACHING-LEARNING STRATEGIES</th>
<th>EVALUATION METHODS/TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assesses the capacity of the Implementing Facilitator (IF) for “embedding”.</td>
<td>A. On Assessment and Nursing Diagnoses:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Discusses ways to ensure working relationship with clients and his/her support system.</td>
<td>Completion of Functional Pattern of Assessment, given a client situation.</td>
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<tr>
<td></td>
<td>• Nurse-patient interaction</td>
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<tr>
<td></td>
<td>• Nursing History Guide</td>
<td>Checklists to differentiate assessment of individual clients: well, the chronically-ill and the acutely-ill.</td>
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<tr>
<td></td>
<td>• Gordon Functional Pattern of Assessment</td>
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<td></td>
<td>2. Differentiates assessment features for different clients: well, chronically-ill, acutely –ill, and on rehabilitation.</td>
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<td></td>
<td>• Assessment of the well client,.e.g. Risk Factors Assessment</td>
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<td></td>
<td>• Assessment of the chronically-ill</td>
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<td></td>
<td>• Assessment of the acutely-ill</td>
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<td>3. Clusters of relevant assessment cues appropriately, as bases for nursing diagnoses.</td>
<td>Given a clinical condition, development of a paradigm for explaining nursing diagnosis.</td>
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<td></td>
<td>• Paradigm development in explaining pathophysiologic reasoning of patient problems and selection of interventions.</td>
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<td></td>
<td>• Nursing Diagnosis (ND)</td>
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<tr>
<td></td>
<td>B. On Plan of Care and Nursing Interventions</td>
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<tr>
<td></td>
<td>1. Explains physiologic bases for selection of interventions.</td>
<td>Classifying nursing interventions for clients who are well, chronically-ill and acutely –ill.</td>
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<td>2. Decides on nursing interventions for clients requiring different levels of care: well, chronically-ill, acutely-ill, and on rehabilitation.</td>
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<td></td>
<td>• Nursing Interventions Outcomes (NIC)</td>
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<tr>
<td></td>
<td>• Nursing Outcomes Classification (NOC)</td>
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<tr>
<td></td>
<td>C. On Evidence-based practice and research implication</td>
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<tr>
<td></td>
<td>2. Guide for review of abstracts Resp. 2.1, 2.2, 2.3, 2.4.2</td>
<td></td>
</tr>
<tr>
<td>COMPETENCIES</td>
<td>TEACHING-LEARNING STRATEGIES</td>
<td>EVALUATION METHODS/ TOOLS</td>
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</tbody>
</table>
| 2. Assesses the current teaching- learning scenarios based on the FI’s realities/ experiences. | A. On Developing the Nursing Care Plan  
1. Sets goals and objectives of care; short-term and long-term care plans.  
• Plan of Care, given a client situation for well, chronically-ill and acutely-ill.  
• Patient discharge plan  
B. On Prioritization of Care  
1. Cites clinical nursing situations as bases for decisions on priority of care  
• Guide for prioritization of patient situation | Plan of care for the client who is well, chronically-ill and acutely-ill  
| 3. Specifies necessary processes, consequences, and outcomes related to the FI’s clinical supervision. | A. On Planning and Implementation of Related Clinical Learning Experiences  
1. Matches objectives of program/ or course with the scenarios/ or clinical situations in an identified setting.  
• Processes for morning circles  
• Bedside conferences  
• Post-conferences | Plan for morning circles, bedside conference, post conferences |
| 4. Develops the training/ instructional design/ course design specifying:     | A. On application of teaching-learning strategy in a clinical area, given a clinical setting for related learning experiences.  
1. Sets faculty/ or instructor- based centered-objectives (or MT/ IF centered-objectives).  
• Making a four-hour or eight-hour time and activity plan. | Faculty/instructor/preceptor objectives  
Time and activity plan for the clinical related experiences |
| 4.1. Appropriate nursing-practice based and desired work-setting –scenario generated teaching-learning strategies to enhance the FI’s competencies. | A. On developing assessment/ or evaluation tools for desired NNCCS outcomes (rubric).  
1. Discusses:  
• Clear statements of expected outcomes.  
• Indicators of performance  
• Developing scales to measure performance  
• Deciding on weights/ marks/ rating percentage to designated performance. | Rubric for evaluation of: Knowledge, skills  
And attitude- given patient situations for clients who are well, chronically-ill and acutely-ill. |
| 4.2. Evaluation methods and tools to determine achievement of the nursing core competency standards (NNCCS) based on performance indicators. | A. On creating linkages/ partnerships in the designated area of practice  
1. Describes the work environment: nursing delivery system and management; medical/ health team; collegiality and professionalism.  
• Enhancing capacity to interact with colleagues- in case conferences, management meetings.  
• Case reports/ discussion  
• Referrals | Making case reports.  
Making referrals – given a client situation |
EXPECTED OUTCOME 2: Translate 2012 NNCCS competencies to standards of care.

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>TEACHING-LEARNING STRATEGIES</th>
<th>EVALUATION METHODS/ TOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assesses the capacity of the Implementing Facilitator (IF) for &quot;embedding&quot;.</td>
<td>1. Application of NNCCS and existing standards of the practice area. • Patient Safety Standards • Hospital Infection Prevention and Control • Standards of Medication Administration</td>
<td>Use of performance indicators of standards</td>
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<tr>
<td></td>
<td>2. Studying and clarifying the NNCCS responsibilities and performance indicators</td>
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<td>3. Integrating knowledge of standards to the NNCCS performance indicators</td>
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<tr>
<td>2. Assesses the current teaching-learning scenarios based on the FI's realities/ experiences.</td>
<td>1. Cite actual scenarios that facilitate or serve as barriers to the application of standards</td>
<td>IFs to cite actual scenarios from their area of practice</td>
</tr>
<tr>
<td></td>
<td>2. Create nursing situations on importance of applicability of standards • Patient Safety Standards and its application</td>
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<tr>
<td>3. Specifies necessary processes, consequences, and outcomes related to the FI's clinical supervision.</td>
<td>1. Incorporates tasks in the teaching-learning strategy to be able to apply the requisites of the Standards on Patient Safety</td>
<td>Care Reports or case studies</td>
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<tr>
<td></td>
<td>2. Specifies which parts of the Patient Safety Standards will be applicable for the area of practice</td>
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<td>4. Develops the training/instructional design/course design specifying:</td>
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<tr>
<td></td>
<td>4.1. Appropriate nursing-practice based and desired work-setting—scenario generated teaching-learning strategies to enhance the FI's competencies.</td>
<td>Develop an instructional design for a component of the Patient Safety Standards • Prevention of Medication Errors and/or • Prevention of Hospital Acquired Infection</td>
</tr>
<tr>
<td></td>
<td>4.2. Evaluation methods and tools to determine achievement of the nursing core competency standards (NNCCS) based on performance indicators.</td>
<td>Develop an evaluation tool for the program on: • Prevention of Medication Errors and/or • Prevention of Hospital Acquired Infection</td>
</tr>
<tr>
<td></td>
<td>5. Creates linkages to install partnership and anchor FI teams in designated areas.</td>
<td>1. Coordinating the institution’s team on Patient Safety, and for Hospital Infection</td>
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<td></td>
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<td>2. Building capacity to interact effectively with Standards Committees team of the Institutions</td>
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</tbody>
</table>
Appendix 7B. Exemplar: Adult Health Nursing: Holistic Care for Nursing Intervention Courses

Adult Health Nursing (AHN) Analysis of Instructional Designs Based on the NNCCS: Addressing options for improvement

A. UPMCN: Concept & Approach in Structuring Nursing Intervention Courses in AHN. (UPCN 1980s’. Abaquin, Laurente)

B. APPROACH:

- CONCEPTUAL, USING HOLISTIC CARE AS UNIFYING FRAMEWORK
- COMPETENCY-BASED: building-up concepts, building-up competencies, accountability, faculty with mastery of the subject and with patience, honesty, humility, capacity to develop self.

C. ILLUSTRATION: KEY RESPONSIBILITY 2/ Competency 2.4.8. TO INTEGRATE THE CONCEPTS OF BODY, MIND, AND SPIRIT, AND COMPLEXITY OF CARE INTO NURSING PRACTICE. TO INCREASE THE AREA OF CONVERGENCE BY “KNOWING THE PATIENT” TOWARDS COMPETENCE IN HOLISTIC CARE”

14. Maintains holistic perspective and spiritual care [Related competencies]
10. Demonstrates caring and compassionate care, especially to vulnerable patients.
13. Uses complimentary, alternative and behavioural therapies appropriately
15. When end-of-life care is needed, ensures appropriate presence of significant others
16. Exercise
### ADULT HEALTH NURSING (AHN) HOLISTIC CARE_ Analysis of Instructional Designs for N105, N107, N109.1

<table>
<thead>
<tr>
<th>N 105 (LEVEL 1)</th>
<th>N 107; N 117 (LEVEL 2)</th>
<th>N109.1, N124 (LEVEL 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SETTING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital (General Ward, OR) Community</td>
<td>Hospital (General Ward, OR) Community</td>
<td>Critical Care Units</td>
</tr>
<tr>
<td><strong>TYPE OF CLIENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent to aging with beginning multiple disorders</td>
<td>Adolescent to aging with beginning multiple disorders</td>
<td>Adolescent to aging with Multiorgan failure</td>
</tr>
</tbody>
</table>

### OUTCOMES OF CARE: (See IOWA Model 1-5 Slide 18)

Functional: Energy Maintenance, Growth and Development, Mobility and Self-care  
Physiological: Cardiopulmonary, Elimination, Fluid And Electrolyte, Immune Response, Metabolic Regulation, Neurocognitive, Nutritional, Tissue Integrity, Sensory Function  
Psychosocial: Psychosocial Wellbeing, Psychosocial Adaptation, Self control, Social Interaction  
Health Knowledge and Behavior: Health Beliefs, Health Behavior, Health Knowledge, Risk Control and Safety  
Perspectives of Health: Health and Quality of Life (QOL), Symptom Status,

### ASSESSMENT:

<table>
<thead>
<tr>
<th>N 105 (LEVEL 1)</th>
<th>N 107; N 117 (LEVEL 2)</th>
<th>N109.1, N124 (LEVEL 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESSMENT:</strong></td>
<td></td>
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</tr>
<tr>
<td>Screening Focused</td>
<td>Screening Focused</td>
<td>Able To Identify Sudden Changes Physiologic Status</td>
</tr>
<tr>
<td>Risk Factor Assessment Support System</td>
<td>Spiritual Health Assessment Cultural Assessment Geriatric/Mobility</td>
<td>Focused Critical Care Assessment Spiritual Health Assessment State Anxiety Scale</td>
</tr>
<tr>
<td>Beginning Decision Making Skills</td>
<td>Beginning Decision Making Skills</td>
<td>Integration and Clinical Decision Making in order to Make the Best Clinical Judgment</td>
</tr>
</tbody>
</table>

Assessment of Health Promotion focused on Individual Clients (Pender 2002);
Functional health patterns, physical fitness, nutritional, health risk appraisal, spiritual health, social support, health beliefs, lifestyle assessment,

**NNCCS RESP. # 2 Competency # 2.4.8 Performance Indicator # 14, Maintains Holistic Perspective And Spiritual Care # 10 # 13, #15, #16**

2012 NNCCS EMBEDDING AHN IN NURSING INTERVENTIONS COURSES USING HOLISTIC CARE CONCEPTS. AOB. 2015 JULY
### PROBLEMS/NSG DX
- Beginning multiple disorders
- Sick role
- Poor Interaction

### PROBLEMS/NSG DX
- Beginning multiple disorders
- Powerlessness
- Hopelessness
- Spiritual Distress

### PROBLEMS/NSG DX
- Multi organ problems
- Fear and anxiety
- Isolation, sensory deprivation
- Sleeplessness

### INTERVENTIONS
- Health promotion: health promoting lifestyle - physical activity, nutrition
- Health Knowledge

### INTERVENTIONS
- Health promotion: stress management
- Instilling Hope
- Spiritual Care

### INTERVENTIONS
- Health promotion: exercise efficacy, cardiac rehabilitation
- Spiritual Growth
- Physical Presence

### OUTCOMES FOR HOLISTIC CARE
- Diagnostic/specific: physiologic measures' weight, BMI/WHR
- Holistic: Lifestyle change, functional status, perceptions, self-care, quality of life

### NNCCS: Responsibility #2. Competency #2.4.8. Performance Indicator
# 14 Maintains holistic perspective and spiritual care. #10 #13 #15 #16

### INTERVENTIONS
- Affective and behavioral expressions of health - aspects of wholeness (Pender, 2002 Health Promotion in Nursing Practice, 4th ed)
- Major Culture-free dimensions of health expressions
  1. Affect
  2. Attitude
  3. Activity
  4. Aspirations
  5. Accomplishments

### INTERVENTIONS
- Complementary Therapies
  - Hope - a feeling that provides comfort while enduring life threats and personal challenges - a feeling that what is wanted will happen - a desire that is accompanied by anticipation and expectation
  - Nurses unique opportunities: in healing
    - to help clients make connections of body-mind-spirit
    - being present to guide people in understanding meaning in their life through:
      - wellness instruction
      - acute situational crisis intervention
      - chronic illness management or
      - transition to death

### NNCCS: Responsibility #2. Competency #2.4.8 Performance Indicator #14

2012 NNCCS EMBEDDING AHN IN NURSING INTERVENTIONS COURSES USING HOLISTIC CARE CONCEPTS.
PROF. ARACELI O. BALABAGNO 2015 JULY
Course Title: **Nursing Interventions 1 (N-105)** Excerpt focused on Peri-Operative Nursing Care
Description: Nursing care of individuals of all ages and their family as they adapt to changes brought about by disturbances in oxygenation, fluid and electrolyte balance, reproduction and sexuality, in varied settings
Placement: Third Year, Second Semester

<table>
<thead>
<tr>
<th>PHASE OUTCOME</th>
<th>COURSE OUTCOME</th>
<th>TERMINAL COMPETENCIES</th>
<th>INTERMEDIATE COMPETENCIES</th>
<th>CONTENT</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide safe, quality, holistic and compassionate nursing care to Individuals, families with various physiologic alterations, chronic illness, and psychosocial needs; Population groups; High risk, vulnerable and marginalized groups utilizing the nursing process in the community and hospital setting.</td>
<td>Provides physiologic and psychosocial nursing interventions related to health promotion, disease prevention, early detection, therapeutic management, perioperative care and rehabilitation reflective of safe, quality, and compassionate care.</td>
<td>Given an <strong>actual</strong> high risk and sick newborn, pregnant women, children and adults with problems in oxygenation, fluid &amp; electrolyte balance, and reproduction, the student should be able to <strong>provide</strong> physiologic and psychosocial nursing interventions related to perioperative care reflective of safe, quality, and compassionate care.</td>
<td>Given a <strong>relevant</strong> questions, the student should be able to <strong>select the appropriate independent, dependent and collaborative therapeutic management (pharmacologic and non-pharmacologic)</strong> for clients with problems in oxygenation and fluid &amp; electrolyte balance during the peri-operative periods.</td>
<td><strong>Before the clinical rotation:</strong> Have the students accomplish a Self-Assessment on the OR Guided Observation Activity. <strong>In the clinical area:</strong> 1. During the first day of clinical rotation, orient students to the physical set-up of the unit and assign one student in an OR suite. Have students completely accomplish the OR Guided Observation Form by observing the unit and HCT. They may ask questions from HCT members if needed but must not perform/assist in any nursing tasks. 2. At the end of the day, discuss with the students their findings and synthesis. 3. Provide opportunity for the students to perform his/her role as scrub and circulating nurse by assign the student OR cases. 4. Ensure that complete OR forms (PRC-BON, UPCN OR Cases Logbook) are correctly accomplished. 5. Conduct a post conference to discuss actual case handled in terms of: a. Priority nursing diagnosis b. Nursing care</td>
<td><strong>Formative:</strong> - Accomplishment of the OR Guided Observation Activity - Participation in the pre and post conferences <strong>Summative:</strong> - Accomplished PRC-BON Performance Evaluation Checklist - Completion of a total of 15 cases handled (for both N105 and N107) - 5 for each role as circulating nurse, scrub nurse for Major operations and assisting in minor operations</td>
</tr>
</tbody>
</table>

*Prepared by: Adult Health Nursing Specialty Group (AOBalabagno, JTPaguio, JSPagsibigan, MGAPBatalla) and UP-PGH (MSalido, LBDeCastro, MAndaya) 08.30.2015*
September 4, 2015

Dear Nursing Colleagues,

The program on “Embedding and Spreading the 2012 NNCCS for the BSN Curriculum” was implemented last July 27-31, 2015 at the UPCN Sotejo Hall, Seminar Room.

Thank you for your active participation during this significant initiative to embed and spread the 2012 NNCCS. The program served to highlight the important role that each one of you may assume as master trainer and implementing facilitator to spread the use of the NNCCS.

We collectively aim to contribute to the development of nursing in our country through the efficient use of the national core competency standard. We also hope that this initiative will bridge the perceived gap between theory and practice, support the incoming nursing workforce, and engage expert nurses, such as you in sharing of knowledge and experiences towards a supportive working environment.

We enjoin you to please help us assess the program. We feel that based on the following attributes, you can best help in this assessment: (1) your involvement as experts in nursing practice of your respective fields; (2) your active participation during the workshops; (3) your reflections and intuitions in processing information, judgments, and (4) actions on nursing practice in real life situations.

May we refer you to the following questionnaire for the assessment. Please answer the questions accordingly. There is always caring and nurturing when nurses help each other.

Thank you,

Prof. Arnold B. Peralta
Head, Teaching Program, UPM CN

Prof. Araceli O. Balabagno
Chair, Program & Training Committee NNCCS

Prof. Luz Barbara P. Dones
Coordinator, API Activity for Embedding and Spreading the 2012 NNCCS for the BSN Program

Directions: There are three areas of assessment: Context, Process, and Flow of the Program. For each item description, please check one [ 0= not applicable, 1= somewhat applicable, 2= very applicable] and write your comments and remarks. We appreciate your comments and remarks to enrich the underpinnings of knowledge generation on the program. You may use the back pages for more space. Thank you.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>CONTEXT. This refers to the framework and general approach of the program.</td>
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<tr>
<td>1. The program framework reflected coherence with the general direction and knowledge of the standards of nursing practice.</td>
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<td>2. The program framework reflected a means in translating the standards to real-life nursing situations in practice.</td>
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<td>3. The program framework facilitated understanding ways of relating to nursing practice</td>
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<tr>
<td>4. The program framework will help carry-out the proposed implementation of the embedding and spreading of the NNCCS nationwide.</td>
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<tr>
<td>5. The NNCCS 2012 competency standards is consistent, in general with the practice settings, institution-based or community-based</td>
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<td>6. Other aspects that we might have missed.</td>
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<tr>
<td>PROCESS. This refers to the manner, the approach, and processes undertaken during the conduct of the program.</td>
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<td>7. The program objectives provided direction of the tasks to be carried out.</td>
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<tr>
<td>8. The teaching-learning approaches during the program enhanced understanding on the translation of the NNCCS for use of nurses.</td>
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<td>9. The workshops/small group meetings by specialties provided venue to discuss issues that were commonly experienced in the field.</td>
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<td>10. The small group meetings/workshops provided opportunities for planning as a specialty on performance standards.</td>
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<tr>
<td>11. The program provided bases for a. generating staff development/in service training for nurses, and b. generating job descriptions of nurses.</td>
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<tr>
<td>12. The plenary provided venue for discussion on matters of general concern in implementing the NNCCS.</td>
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<tr>
<td>13. Other aspects we might have missed.</td>
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<tr>
<td>DESCRIPTION</td>
<td>0</td>
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<td>2</td>
<td>COMMENTS</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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<tr>
<td><strong>FLOW.</strong> This refers to the concepts and content of the program.</td>
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<tr>
<td>14. The program provided understanding of the purpose and directions of the NNCCS for nursing development.</td>
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<td>15. The program provided understanding of the reasons for integrating outcomes based education.</td>
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<tr>
<td>16. The program session on mapping of performance indicators across specialties and practice settings provided understanding on where each one’s role can fit –in.</td>
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<tr>
<td>17. The program session on the following enhanced capability to use the NNCCS:</td>
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<tr>
<td>a. Teaching-learning activities to enhance embedding,</td>
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<tr>
<td>b. Developing assessment tools</td>
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<tr>
<td>18. The program session (small group) on “standards of care for hospital setting and community setting” provided understanding of application in real-life nursing situations.</td>
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<td></td>
<td></td>
<td>Please indicate session, encircle one: PGH, JFabellaMH, NCMentalH, ManilaHD.</td>
</tr>
<tr>
<td>19. The program session (small group) on “instructional designs (ID) addressing options for improvement” provided new insights, and better ways of working on the IDs.</td>
<td></td>
<td></td>
<td></td>
<td>Please indicate session, encircle one: AHN, Care of the Woman, Child an Adolescent, Community, Maladaptive Responses, Research, Leadership &amp; management.</td>
</tr>
<tr>
<td>20. The program session on “sustaining commitment to embed and spread NNCCS” reflected collaboration by nurses as fundamental.</td>
<td></td>
<td></td>
<td></td>
<td>PGH, JFMH, NCMH, MHD:</td>
</tr>
<tr>
<td>21. The program session on “creating linkages towards partnership in NNCCS embedding by UPCN” reflected commitment as a national university in pursuing a national development program in nursing.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>22. General comments, impressions. Please indicate also, if this is the first time you learned about the NNCCS 2012. Thank you.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name: _________________________________  Institution _________________________________
Appendix 9. Budget Estimate for the Training Program

The expenses for training covered the items reflected below. Indicated are the estimated cost for a total of fifty (50) participants, including speakers and facilitators, for a five-day workshop.

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>DESCRIPTION</th>
<th>ESTIMATED COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venue and AVP equipment</td>
<td>Able to accommodate 50 participants, with break-out spaces, and AVP equipment</td>
<td>PHP 4,000.00 / day At no cost if conducted within the university / college</td>
</tr>
<tr>
<td>Supplies and Handouts</td>
<td>School supplies for workshops Reproduction of worksheets USB for soft copy of references and other materials</td>
<td>PHP 400.00 / person</td>
</tr>
<tr>
<td>Honoraria</td>
<td>Speakers, Facilitators OICs, Project Assistant</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. INTRODUCTION

A. PROJECT BACKGROUND

The Professional Regulatory Board of Nursing (PRBON) embarked on an extensive and comprehensive review of the nursing core competency standard using a competency-based framework and creation paradigm which was conceptualized in 2009. The Core Competency Revisiting Project was undertaken as a collaborative activity of the PRBON with our nursing partners from the academe and service who were members of the various nursing professional organizations, UPM College of Nursing as WHO Collaborating Center for Nursing Development, among others.

The process of revisiting the nursing core competencies included work setting scenario analysis, benchmarking with nursing core competencies of other countries, field validation studies on the roles and responsibilities in the hospital and community settings, integrative review of outputs from validation strategies, presentation of validation analysis and core competency consensual validation.

From the lengthy process emerged the Revised Nursing Core Competency Standards emphasizing the three roles of the nurse: (1) Beginning Nurses’ Role on Client Care, (2) Beginning Nurses’ Role on Management and Leadership and (3) Beginning Nurses’ Role on Research.

The Program Design and Training for the Embedding of the NNCCS 2012 for nursing education was collaboratively undertaken with the UP Manila College of Nursing in its role as a WHO Collaborating Center (WHOCC) for Leadership in Nursing Development.

The program design and training for the embedding was carried out by the UP Manila College of Nursing through the UP Manila Academic Program Improvement (API) in coordination with the Continuing Education and Community Extension Services program.

B. TERMS OF REFERENCE FOR THE DEVELOPMENT OF MODELS FOR EMBEDDING OF 2012 NNCCS FOR NURSING EDUCATION AND NURSING SERVICE

TERMS OF REFERENCE OF THE UNIVERSITY OF THE PHILIPPINES MANILA COLLEGE OF NURSING

<table>
<thead>
<tr>
<th>PHASES</th>
<th>DELIVERABLES</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Development of a Model Program Design for the Embedding of 2012 NNCCS in Nursing Education</td>
<td>Model Program Design for the Embedding of 2012 NNCCS in Nursing Education developed</td>
<td>2nd Quarter 2015</td>
</tr>
<tr>
<td>2. Pilot test the Model Program Design of UPMCN with Philippine General Hospital, Department of Nursing and community partners to demonstrate the functional integration between nursing education and service.</td>
<td>Pilot tested Model Program Design of UPMCN with Philippine General Hospital, Department of Nursing and community partners demonstrating the functional integration between nursing education and service</td>
<td>3rd Quarter 2015</td>
</tr>
<tr>
<td>3. Submission of the Model Program Design for the Embedding of 2012 NNCCS in Nursing Education to the Professional Regulation Commission, Professional Regulatory Board of Nursing for incorporation in the 2012 NNCCS MONOGRAPH 2</td>
<td>Model Program Design for the Embedding of 2012 NNCCS in Nursing Education submitted to the Professional Regulation Commission, Professional Regulatory Board of Nursing for incorporation in the 2012 NNCCS MONOGRAPH 2</td>
<td>End of 3rd Quarter</td>
</tr>
</tbody>
</table>

C. MODELS FOR EMBEDDING ACROSS VARIED RECIPIENTS OF CARE

C.1 MODELS FOR THE FAMILY, POPULATION GROUP AND COMMUNITY AS CLIENT. Please refer to the Model developed by Araceli S. Maglaya, PhD, RN.

C.2 MODEL FOR INDIVIDUAL AS A CLIENT. Please refer to Module 5.8 Client Care on Care of Older Person (18 pages), ADPCN and ILO on NNCCS, 2015 developed by Araceli Ocampo Balabagno, PhD, RN.

D. MODEL PROGRAM DESIGN FOR THE EMBEDDING OF 2012 NNCCS IN NURSING EDUCATION

Please refer to the attached program titled: Embedding and Spreading the 2012 Nationa Nursing Core Competency Standards for the BSN Program. An Academic Program Improvement Activity for University of the Philippines Manila College of Nursing July 27-31, 2015 (Appendix 1).

GOAL

The 5-day activity for the “Embedding the NNCCS 2012 for the BSN Program” was conducted to integrate the 2012 National Nursing Core Competency Standards for Nursing Education. This training program was carried out by the UP Manila College of Nursing through the UP Manila Academic Program Improvement (API) in coordination with the Continuing Education and Community Extension Services program.

The activity’s main goal was to assist the UPCN faculty and partners, specifically the Philippine General Hospital Department of Nursing preceptors, in integrating the 2012 NNCCS into the curricular design.
Specifically, the expected outcomes are to:
1. develop training program for nursing education
2. translate NNCCS to standards of care on the 4 types of clients
3. create performance evaluation tools on the care of the 4 types of clients
4. develop job descriptions on the care of the 4 types of clients for nurses in the practice setting.

II. METHOD AND PROCESSES.

A. Preparation and Scheduling

Preparation for the conduct of the activity was initiated by the request from the Professional Regulatory Board of Nursing (PRBON) to the UP Manila College of Nursing to provide an exemplar on how to conduct a program on embedding the 2012 National Nursing Core Competency Standards. As an active partner of the PRBON and CHED Center of Excellence, the UPMCN accepted the task with the team consisting of faculty members who have been involved in the NNCCS trainings (coaches, mentors and Master Trainers). This was followed by a series of meetings to plan for the program of activities. This was done in close coordination with the PRBON and selected coaches, mentors and contributors to the Training Module, to ensure consistency in the flow of the content and alignment of the activities. Scheduling was done to ensure that the program was done prior to the start of the semester and availability of majority of the faculty members. However, despite planning, some senior faculty members were out of the country and junior faculty members were tasked to assist in the enrolment activities. This limited the available faculty attending each session. This concern was addressed by dividing the faculty according to specialty groups to ensure faculty involvement and partnering with members from the practice setting.

B. Materials and Handouts

Materials, including handouts, references and worksheets, were provided in soft copy during the week’s sessions. Reference materials were also made available such as the ILO-funded Training Modules on the 2012 NNCCS, CHED CMO 14 and 2012 NNCCS (Monograph1). Hard copy of the Training Modules were also given to each partner institution who attended the activity. It was explained that the ILO Training Modules is only a reference on the varied approaches on how to teach some concepts and responsibilities in the 2012 NNCCS since it was developed for the use of Master Trainers and should not be used as the main reference for Nursing courses, specially for the main course content.

C. Selection of Participants and Speakers

Based on the determined activities, the project team ensured that inputs were given by speakers and facilitators with mastery of the content and familiar with the NNCCS. This was done by inviting experts from the PRBON, CHED-TCNE, leaders of specialty groups in Nursing, nurse administrators from the practice setting, and experts in Health Professions Education from the UP Manila National Teacher Training Center for the Health Professions (NTTC-HP).

Participants in the activity included faculty members of the UPCN, preceptors from the different practice settings (UP-PGH, Jose Fabella Medical Center, Manila Health Department, Research Institute for Tropical Medicine, National Center for Mental Health), training and research department members of the UP-PGH, and members of the ADPCN, as participant/observers (Appendix 2, List of Speakers and Participants).
D. Program Flow and Discussions

Day 1

An overview of the events leading to the present activity was done to set the stage for the week’s program. This also provided adequate input for the participants who were not directly involved in the activities of the NNCCS development. The inputs for the first day was intended to provide the context of the practice settings and the curriculum.

Inputs: Status of the 2012 NNCCS delivered by Hon. Carmencita A. Abaquin of the PRC-BON. Model of integration as guiding framework for the embedding and spreading activity by Dr. Araceli S. Maglaya. UPCN curricular efforts in the context of Outcomes-Based Education by Prof. Arnold B. Peralta, Head of the Teaching program.

Workshop 1: Analysis of Standards of Nursing Care/Practice vis-à-vis NNCCS. The purpose of the workshop was to analyze the Standards of Nursing Care/Practice. This was done by grouping the participants into the different specialties (Adult Health Nursing, Maternal and Child Health Nursing, Mental health and Psychiatric Nursing, Nursing Administration, and Community Health Nursing). The decision to group the participants this way was based on the way the institution groups their faculty members. This enhances focus on the standards being presented and allows for application in the different courses. Speakers presented the Standards of Care of their institutions and the participants discussed whether the said standards reflected the 2012 NNCCS in terms of the setting and types of clients, nursing competencies, professional learning and development, policies and procedures, and performance appraisal measures applied in the institution.

Results of WS 1. The workshop revealed that majority of the practice settings did not have documentation of Standards of Care. Among those were the Manila Health Department and the National Center for Mental Health. However, specific administrative policies, job descriptions and tasks assigned to nurses in the practice setting are available. From these sources of information, the participants were able to answer the guide questions. Moreover, presenters from the different practice settings have established partnerships during the workshop to help in the development of their Standards of Care (Appendix 3, Summary of Workshop 1).

Day 2


Results. The mapping exercise showed that the 2012 NNCCS Responsibilities and Performance Indicators are well reflected in the different levels: Program Outcomes, Level Outcomes and Course Outcomes; and across specialty areas.

Inputs: A talk on Selecting Teaching –Learning (TL) Strategies in varied settings was given by Prof. Jenniffer T. Paguio, describing the use of the University’s Virtual Learning Environment (UVLe). Suggested activities were given based on examples from different institutions and references on health professions education, use of social media and web-based platforms, and modalities in line with OBE - the Flipped classroom. Suggestions from the participants were also discussed and the application to the practice settings for training and CPD of nurses were also explored. However, concerns were raised on the ethical guidelines on the use of social media in teaching. The participants were encouraged to consider the examples presented in formulating the TL strategies in their respective instructional designs.
Discussion with Specialty Mentors and Development of Instructional Designs

The intent of these discussions was to have experts in the different concepts and fields of Nursing practice highlight ways to teach their assigned topic in the context of the NNCCS Responsibilities and Performance Indicators and Outcomes-based Education. Content was not the focus as the participants were considered content experts themselves and resources are available. Rather, exemplars of concepts covered were given to show how these can be taught.

Role of the Nurse as a Beginning Researcher by Dr. Cora A. Añonuevo.

Role of the Nurse as a Beginning Leader/Manager by Dr. Annabelle R. Borromeo.

These topics were discussed in a plenary setting because the concepts of research, leadership and management applies to all other concepts of Nursing practice and would be very useful for the instructional design development of each specialty.

Break-out session: where Participants were divided into specialty groups and were assigned a mentor who gave inputs on how to teach the concept assigned to them.

Adult Health Nursing: Dr. Araceli O. Balabagno
Community Health Nursing: Dr. Araceli S. Maglaya and Prof. Luz Barbara P. Dones
Maternal and Child Health Nursing Dr. Teresita I. Barcelo and Prof. Arnold B. Peralta
Mental Health and Psychiatric Nursing: Hon. Betty F. Merritt
Nursing Research: Dr. Cora A. Añonuevo
Nursing Administration: Dr. Annabelle R. Borromeo

Each specialty group was composed of UPCN faculty and members of partner institutions. This was done to facilitate further collaboration between the academe and practice setting in ensuring continuity of learning for the students and exchange of ideas to enhance the instructional design.

Day 3

The group activities to complete the instructional designs continued. Each specialty group worked with their mentors to improve the instructional designs for specific courses. This was followed by the presentation of outputs from the following specialties: Nursing Research, Maternal and Child Nursing, Community Health Nursing and Mental Health and Psychiatric Health Nursing.

Among the common comments are the congruence with the program outcomes, consistency between the terminal and intermediate competencies and updating of the content. Teaching-learning strategies were also emphasized.

Day 4

Inputs. Lecture on Developing Assessment Schemes in the context of OBE by Dr. Melfor Atienza of NTTC, highlighting the use of the Performance Indicators as guide in ensuring that the responsibilities in the NNCCS are evaluated. The inputs were incorporated in the instructional designs of the specialty groups.
Presentation of the Instructional Designs from the Adult Health Nursing specialty. Comments included ensuring the development of a separate Instructional Designs for the community health nursing component of the interventions courses to have specific terminal and intermediate competencies to reflect care for the family, community and population groups. Afternoon session: Focused on developing assessment tools based on the courses presented by each specialty group. Majority of the groups worked on existing tools and modified them to meet the OBE framework and the revised competencies. On the other hand, the Mental Health Psychiatric Nursing specialty developed an evaluation tool for assessing Process Recordings.

Day 5

Focused on the future directions for the 2012 NNCCS embedding and spreading and collaboration between the UPCN and partner institutions. This was opened by Hon. Carmelita Divinagracia who highlighted the urgency to spread the NNCCS implementation in the academe and practice settings in response to needs of the nation and region. She enjoined the partners in supporting the efforts spearheaded by the PRBON.

Active exchange of commitment from the partners was facilitated by Dean Lourdes Marie S. Tejero. Each partner institution was asked about their plans to further strengthen the improvement and implementation of the UPCN curriculum in their own setting. At the same time, their need for assistance and partnership with the UPMCN on continuing professional development for their nurses were explored. During this session, it was agreed upon that a semestral meeting be conducted for the purpose of curricular implementation and a regular orientation of preceptors be done.

Presentation of evaluation tools: However, No complete evaluation tool was presented due to time constraints. The group expressed commitment to pursue the development of tools further during the OBE series of activities that will be conducted by the UPMCN Teaching Program in preparation for the curricular proposal.

PGH Chief Nurse, Ms. Cecila G. Peña, expressed the continued commitment of the institution in embedding and spreading the 2012 NNCCS. This was echoed by the group through the sharing of learning experiences and commitment of participants per institution.

Finally, the Functional Integration Model was reiterated. This emphasized the coordination between the academic institution and partner healthcare facility administration and personnel.

E. Role of Partners

Partnership and collaboration between the academic institution and the partner agency was agreed upon by the group not only in the scheduling aspect. Rather, the coordination should be throughout the planning for the course and actual implementation. Close coordination is done by meeting with the preceptors for orientation and course updates. Faculty members should also be oriented to the new policies of the institution.

Apart from these, partnership was sought by the agencies in the context of staff development through continuing professional development (CPD) and trainings. The Philippine General Hospital expressed their request in the orientation to the Nursing Intervention and Outcomes Classification, update on the new NANDA diagnoses and teaching-learning strategies. The National Center for Mental Health also expressed their request for CPDs.
6. Integration of NNCCS in the Related Learning Experience Settings

Representatives of partner institutions expressed the need to strengthen the integration efforts between and among the institutions. This is highlighted in two aspects: (1) close coordination on the schedule, activities and needs to facilitate learning, and (2) ensure that the 2012 NNCCS Responsibilities and Performance Indicators are reflected in the standards of respective institutions, specifically in the Standards of Care and Policies, job descriptions, and tools to measure performance.

III. RESULTS

A. Outputs

The series of lectures and workshops were geared towards the completion of instructional designs that reflects the nurses’ responsibilities from the 2012 NNCCS and the OBE framework. Two sets of outputs were presented: exemplars from participants, which will be used by faculty members teaching the course of Implementation Facilitators (IFs) and instructional designs from the specialty mentors to be used by Master Trainers (MTs).

Two exemplars included in this report cover a pure classroom setting course (Nursing Research) and a clinical setting course (Nursing Interventions I). These, along with the instructional designs from the specialty mentors are reflected in Appendix 5 and 6 respectively.

B. Discussion Points.

Some themes were evident throughout the discussions during the plenary and workshop sessions. Among these were on ensuring the closure of the gaps between the classroom and the practice settings, which includes the following:

a. NEED

There was a common identified need to document the Standards of Care for the practice settings. Only PGH was able to present a developed Standards of Care for the institution. It was a clear realization by the participants representing partner agencies of the urgent need for a Standards of Care. It was noted that the basis for the standards are already stated in the job descriptions and tasks of the nurses in the setting. However, documenting the standards will ensure the quality of practice and will help the academe in ensuring that the students’ preparation is aligned with the practice setting. It was expressed that as partners, the UPCN and UP-PGH are requested to assist with the development of the Standards of Care of NCMH and MHD that reflects the 2012 NNCCS as well.

Another expressed need of the practice setting is the enhanced partnership in conducting continuing professional development, training and development. This will enhance the nurse professionals and will ensure having practice models for the students during their RLE.

b. Role of the faculty in embedding the NNCCS and updating the curriculum

The need for congruence in the understanding of terminal and intermediate competencies was mentioned. However, the focus was on continuation of the updating of the curriculum under the Outcomes-Based Education approach and to ensure embedding of, not only the 2012 NNCCS, but also updates on specialties and topics.
Enhanced teaching-learning strategies developed in partnership with preceptors was encouraged. In addition, valid evaluation tools need to be constructed as existing evaluation/assessment tools have been found to be lacking or not updated.

c. Active partnership and collaboration among preceptors, partner agencies and the UPCN

The group agreed that close coordination be done not only in the conduct and scheduling of the RLE, rather in the preparation of the preceptors in supervision and evaluation of students. Evaluation scheme for preceptors should be explored as a means to give feedback and assess the students.

Regular meetings under the Teaching Program, through the Integration Committee, and for each course should be done on a regular basis. And the formal Preceptorship Program be revived by UPCN for all the current and future preceptors in the partner institutions.

IV. EVALUATION AND FEEDBACK

There was general agreement on the indicators of assessment in relation to the context, process and flow of the program. Majority of the evaluation and feedback came from nurses of the Philippine General Hospital Department of Nursing. They were functioning as preceptors to the BSN students of UPCN, and at the same time, were functioning as trainers for inservice and staff development program of PGH.

For the first timers to engage in knowing the NNCCS, they found the knowledge of NNCCS and its application as usable, useful and provides direction to their teaching and training functions (Appendix 9: An Assessment of the Program on Embedding and Spreading the 2012 NNCCS for the BSN Program).

V. SUMMARY

The report covers the method and processes of the program implementation/ pilot testing of the Training for the Embedding of the 2012 NNCCS for Nursing Education. The highlights of the activities included demonstrating the process of implementation of the 2012 for different client groups – the individual, family, population group and community, and the functional integration between nursing education and service can be. Model instructional designs were developed.

Prepared by:
Prof. Arnold D Peralta
Prof. Jenniffer T Paguio
Prof. Luz Barbara P. Dones
Dr. Araceli O. Balabagno
The purpose of this paper is to present the experience of St. Luke’s Medical Center in embedding the new National Nursing Core Competency Standards (NNCCS). The goal is to provide an exemplar of how an institution can hardwire the standards in institutional job descriptions, performance evaluation and curriculum design for orientation/onboarding and continuing education.

The framework for the chosen embedding process is adapted from Maglaya (2013) and is illustrated in the following Figure:

![Figure 1. OSIME (Organizational Self-Assessment Implementation Monitoring Evaluation) Model for Embedding the New National Nursing Core Competency Standards in the Hospital Setting](image)

Hardwiring or embedding is a process of institutionalizing systems and processes in an organization's DNA so that it becomes a part of the day-to-day operations. The implication is that there is consistent and continuous application of the standards enterprise-wide.

This paper proposes a two-step process for achieving hardwiring of the NNCCS embodied in the OSIME Model: 1) organizational self-assessment (OS) and 2) Implementation, Monitoring, and
Evaluation (IME). The OSIME Model suggests that hardwiring the NNCCS is a disciplined process and not a random occurrence. Organizational self-assessment (OS) requires humility and an openness to the idea that not everything that occurs in an institution is perfect. The Implementation, Monitoring, and Evaluation (IME) phase requires purpose and perseverance. In the case of NNCCS, SLMC used the OSIME Model as a sustainability framework for embedding the new requirements in its daily workflow and culture.

1. Definition of Terms

It might be instructive, at this point to define the terms used in the NNCCS:

<table>
<thead>
<tr>
<th>TERMS</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competence</td>
<td>Integration of knowledge, skills, attitudes and values that underpin effective performance</td>
</tr>
<tr>
<td>Key Area of Responsibility</td>
<td>Shortened in the NNCCS as Responsibility</td>
</tr>
<tr>
<td></td>
<td>A defined area or domain of skilled performance</td>
</tr>
<tr>
<td>Core Competency</td>
<td>Element(s) of competency that contribute to and/or contribute to a key area of responsibility</td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>Shortened in the NNCCS as Indicator</td>
</tr>
<tr>
<td></td>
<td>A descriptive statement which can be assessed and which reflect the intent of a competency in terms of performance, behavior and circumstance</td>
</tr>
</tbody>
</table>

2. Organizational Self-Assessment

*Brief Description of the Medical Center*

St. Luke’s Medical Center (SLMC) is a health care system comprised of two hospitals, both located in Metro Manila. Both private hospitals have a bed capacity of 650-beds each and are both Level 3 facilities. Level 3 facilities are medical centers, with teaching and training programs, specializing in the care of complex patients (DOH, A.O. 2012 – 0012).

The hospitals that comprise the St. Luke’s Medical Center System are both Joint Commission International-accredited (JCIA) facilities. Facilities which have achieved JCIA accreditation have achieved the Gold Seal of Approval as a JCI-accredited entity. To successfully achieve initial accreditation and to maintain accreditation, institutions must substantially comply with over 300 standards and elements of performance. Preparing for JCIA is a challenging process. At a minimum, hospital staff must be familiar with current standards and ensure that the hospital’s systems and processes are compliant with the standards and have put in place systems to ensure high-quality and safe care.

*Mission and Vision*

The mission of the hospital is to provide state-of-the-art healthcare because our patients come first. Cutting edge technologies such as linear accelerator, high dose rate brachytherapy, stereotactic radiotherapy, 3D conformal radiation therapy, intensity modulated radiation therapy and third-generation robotics are some of the state-of-the-art technology that are available to patients. In addition there are minimally invasive therapies, cutting edge therapies like the transcatheter aortic valve replacement, radiofrequency ablation, liver dialysis, extracorporeal membrane oxygenation, and other technologies. Nurses therefore, are required to have the competencies to safely care for patients undergoing these procedures.
The vision of the St. Luke’s Medical Center is to attain international recognition as an academic medical center by 2020. Academic Medical Centers (also known as Teaching Hospitals) are academic healthcare environments that merge the clinical, academic, and research missions. They are widely reputed to provide high-quality care because their mission is to provide cutting edge care through the latest technology, systems, and processes. Teaching hospitals serve a unique role. They serve as training ground for health care professionals. Additionally, while many hospitals offer comprehensive care, teaching hospitals have additional capabilities to deliver sophisticated diagnostic and treatment services. Teaching hospitals also serve as centers of research and innovation, helping to develop new treatment and cures.

On an emotional level, the vision of SLMC is about bringing hope: the hope of new cures through research and innovation, the hope that things will be better through a great patient experience that is felt in a sustained way throughout the patient journey.

It has become increasingly clear in the literature that organizations that have found ways to ensure alignment of their strategies to their organizational missions/visions are most successful (Crotts, Dickson & Ford, 2015). Alignment is important to preserve the organization’s core values, to reinforce its purpose, and to stimulate continued progress towards its aspirations. The latter is what is reinforced when alignments in job descriptions, performance evaluation, and continuing education are made with the mission and vision.

**Patient Demographics Characteristics**

Describe pertinent characteristics of the patient population that is being served which may translate directly to competencies. For example, the patient mix may be 70% local and 30% foreign patients which may translate to the need for competencies in culture care.

**Professional Practice Model**

Swanson’s Theory of Caring (1991) is the basis for professional nursing practice at SLMC. In this theory, the caring role is defined by 5 competencies:

1. knowing (striving to understand an event as it has meaning in the life of the other, seeking true understanding and empathy),
2. being with (being emotionally present to the patient, conveying continuing availability so patient knows that “I’m here to listen.”),
3. doing for (doing for the patient what he/she would do for self if it were at all possible, preserving dignity without embarrassment and anticipating all needs),
4. enabling (facilitating the patient’s passage through life transitions and unfamiliar events through timely education, information, support, explanation with the end goal of maximizing self-care), and
5. maintaining belief (sustaining faith in the other’s capacity to get through an event or transition and face a future with meaning, sustaining hope that the patient will make it through).

While the nursing process is foundational to the NNCCS, Swanson’s processes are also critical to successful nursing practice at SLMC. The process of assessment is intuitively translated into Swanson’s “knowing,” but in a deeper and more holistic sense than is required in the medically-rooted assessment. Implementation is translated into “being with,” “doing for,” “enabling,” and “maintaining belief” in the performance of necessary interventions. Evaluation is what is missing in the Swanson model.
Because of its primary aspirations for safe and quality care, nurses, as well as other health care professionals working at the St. Luke’s Medical Center, must have competencies that are required for the medical center to achieve its strategic goals. High quality care and safety are requirements of health care practice that are dependent on competency. Following are the competencies that employees must possess to ensure that the Medical Center’s goals are achieved:

<table>
<thead>
<tr>
<th>No.</th>
<th>SLMC COMPETENCIES</th>
<th>DEFINITIONS</th>
</tr>
</thead>
</table>
| 1   | Communication (CO)                 | Interacts effectively with patients, families, and colleagues, fostering mutual respect and shared decision-making, to enhance patient satisfaction and health outcomes. Breakdowns in communication are responsible for errors, excessive costs, and unsafe patient care. (Judd, 2013)  
*Note: self-awareness, assertiveness* |
| 2   | Critical Thinking (CT)             | Engages in the disciplined process of actively and skillfully conceptualizing, applying, analyzing, and/or evaluating information gathered from, or generated by observation, experience, reflection, reasoning leading to conclusions, implications, and consequences, objectives from alternative viewpoints, and frame of reference (Scriven & Paul, 2015).  
*Note: critical thinking is self-directed, self-monitored, and self-corrective thinking.* |
| 3   | Evidence-based Practice (EP)       | Integrates the best evidence available using nursing expertise and the values and preferences of individuals, families, and communities who are served by health care                                                                                                                                 |
| 4   | Informatics and Technology (IT)    | Uses information and technology to communicate, manage knowledge, mitigate error, and support decision-making (QSEN, 2007)                                                                                                                                                 |
| 5   | Leadership (LD)                    | Transforms and influences behaviors of individuals and groups to promote, establish, and achieve shared goals; collaborate to participate in inter-professional efforts; and implement change.  
*Note: leadership is action, not a position. Every nurse must be a leader and advocate for patient care.* |
| 6   | Patient-Centered Care (PC)         | Provides holistic care that recognizes an individual’s preferences, values, and needs and respects the patient/family as a full partner in providing compassionate, coordinated, age and culturally appropriate, safe, and effective care                                                                                                                                 |
| 7   | Professionalism (PF)               | Demonstrates accountability for the delivery of standards-based nursing care that is consistent with moral, altruistic, legal, ethical, regulatory, and humanistic principles                                                                                                                                 |
| 8   | Quality Improvement (QI)           | Uses data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of the hospital’s systems  
*Note: nurse-sensitive indicators, improvement in delivery, quality, efficiency and outcomes of patient care, use of data for decision-making, evaluation and improvement activities and patient outcomes* |

Table 1. Matrix of Required SLMC Competencies and Definitions, Based on Practice Context
<table>
<thead>
<tr>
<th>No.</th>
<th>SLMC COMPETENCIES</th>
<th>DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Safety (SA)</td>
<td>Minimizes risk of harm to patients and providers through both system effectiveness and individual performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Note: maintain a culture of safety</td>
</tr>
<tr>
<td>10</td>
<td>Service Excellence (SE)</td>
<td>Consistently meets and manages patient expectations through outstanding professional/clinical excellence with outstanding personal service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Note: Four key elements: delivering the promise of quality health care, providing a personal touch, doing more than an adequate job, and resolving problems well (Johnston, 2004)</td>
</tr>
<tr>
<td>11</td>
<td>Systems-Based Practice (SB)</td>
<td>Demonstrates an awareness of and responsiveness to the larger context of the health care system and calls on microsystem resources to provide care that is of optimal quality and value; an antidote to reductionism or “silo thinking”</td>
</tr>
<tr>
<td></td>
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<td>*Note: Cost containment, resource allocation, collaborative practice, mechanisms for respectful interdisciplinary approaches to patient care issues</td>
</tr>
<tr>
<td>12</td>
<td>Teamwork and Collaboration (TC)</td>
<td>Functions effectively within nursing and interdisciplinary teams, fostering open communication, mutual respect, shared decision making, team learning and development</td>
</tr>
</tbody>
</table>

*Adapted from: MA Action Committee, 2014*

**Mapping and Reconciliation**

Mapping and reconciliation is an activity for determining gaps and overlaps between the identified institutional competencies and the NNCC standards. In addition, a determination of alignments is also imperative.
Table 2. Mapping SLMC Organizational Competency Requirements with New National Nurse Competency Standards

### Role on Client Care

<table>
<thead>
<tr>
<th>Organizational Competencies</th>
<th>Responsibility 1</th>
<th>Responsibility 2</th>
<th>Responsibility 3</th>
<th>Responsibility 4</th>
<th>Responsibility 5</th>
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### Role on Client Care

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<thead>
<tr>
<th>Organizational Competencies</th>
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<th>Responsibility 3</th>
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### Role on Management and Leadership

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<thead>
<tr>
<th>Organizational Competences</th>
<th>Responsibility 1</th>
<th>Responsibility 2</th>
<th>Responsibility 3</th>
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### Role on Research

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</table>
3. Analysis of Mapping

A cross-validation analysis of the organizational competencies vis-à-vis the NNCCS reveals that the most number of occurrences or “hits” is found in 2.4.1 which requires the nurse to implement appropriate psychosocial/therapeutic interventions to render holistic care in any setting. This finding is validation of the most “high value” competency that is required for the practice of nursing because it brings to bear most of the competencies that a registered nurse must possess in order to be accomplished. Other important competencies are the provision of evidence-based practices to deliver care standards in a participatory or patient-centered approach, communication that is effective and focused on meeting the patient’s needs through collaboration, priority-setting, and quality improvement. Table 3 shows the competencies and performance indicators in detail.

<table>
<thead>
<tr>
<th>Number of Hits</th>
<th>Code</th>
<th>Competency</th>
<th>Performance Indicator</th>
</tr>
</thead>
</table>
| 8              | 2.4.1  | Implements appropriate psychosocial/therapeutic interventions to render holistic nursing care in any setting | 1. Addresses with respect, trust, and concern for safety, client’s needs, issues or problems, related with psychosocial adaptation using appropriate communication/interpersonal techniques/strategies  
2. Utilizes therapeutic interventions appropriate to psychosocial phenomenon/ maladaptive behavior patterns/problems identified  
2.1. Utilizes therapeutic use of self (e.g., uses self-awareness techniques/strategies, determines appropriate strategies to achieve the goals of the nurse-patient relationship, seeks consensual validation with client).  
2.2. Implements psychosocial/therapeutic interventions (e.g., nurse-client relationship therapy, relaxation exercise/therapy, behavioural/cognition therapy, coping assistance, mental health counselling/education, environmental structuring/milieu therapy, psycho-spiritual care, and crisis intervention/psychological stress de-briefing)  
2.3. Carries out biophysical interventions (e.g., nutritional intervention, detoxification, pharmacotherapeutics)  
3. Collaborates with client support system and the multidisciplinary team in developing, implementing, and evaluating the plan of care |
| 7              | 2.4.2  | Provides appropriate evidence-based nursing care using a participatory approach based on: a. Variety of theories and standards relevant to health and healing  
b. research  
c. clinical practice  
d. clinical preferences  
e. client and staff safety  
f. customer care standards | 1. Develops competence of the client to participate in using appropriate evidence-based nursing care  
2. Refers to appropriate authority client’s situations not within his/her capabilities  
3. Decides on appropriate interventions to address client’s specific concerns  
4. Performs autonomously a wide range of nursing interventions (action, treatments, and techniques) in accordance with nursing standards which include health promotion, disease or injury prevention, health maintenance and restoration, rehabilitation promotion, and provision of palliation |
<table>
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<tbody>
<tr>
<td>7</td>
<td>2.4.2</td>
<td>Provides appropriate evidence-based nursing care using a participatory approach based on: a. Variety of theories and standards relevant to health and healing b. research c. clinical practice d. clinical preferences e. client and staff safety f. customer care standards</td>
<td>1. Develops competence of the client to participate in using appropriate evidence-based nursing care 2. Refers to appropriate authority client’s situations not within his/her capabilities 3. Decides on appropriate interventions to address client’s specific concerns 4. Performs autonomously a wide range of nursing interventions (action, treatments, and techniques) in accordance with nursing standards which include health promotion, disease or injury prevention, health maintenance and restoration, rehabilitation promotion, and provision of palliation</td>
</tr>
<tr>
<td>7</td>
<td>3.1.3</td>
<td>Implements with the team the developed action plan for the identified variance to improve the system or process</td>
<td>1. Selects an appropriate model that would be appropriate to change and improve the system or process (e.g., Plan-Do-Check-Act or PDCA) 2. Develops an action plan with the goal of changing the system or process 3. Carries out the change on a small scale (i.e., pilot study) 4. Checks the effects of the change by collecting data and information utilizing appropriate methods and tools 5. Implements change in the system or process based on the result so the pilot study</td>
</tr>
<tr>
<td>7</td>
<td>3.1.4</td>
<td>Communicates, both in oral and written form, the results of the quality improvement project in partnership with the quality improvement team/ quality assurance/ nursing audit team</td>
<td>1. Plans for the presentation of the results of the quality improvement project 2. Includes in the report, conclusions, recommendations, actions, and follow up, specifying the appropriate individuals and groups to whom the report will be submitted</td>
</tr>
<tr>
<td>6</td>
<td>2.3</td>
<td>Formulates with the client a plan of care to address the health conditions, needs, problems, and issues based on priorities</td>
<td>1. Selects priorities among a list of conditions or problems 2. Specifies goals, objectives, and expected outcomes of care, maximizing client’s competencies 3. Selects appropriate interventions/ strategies enhancing opportunities for health promotion, wellness response, prevention of problems/ complications, and eliminating gaps/ deficiencies 4. Uses methods/ tools to maximize client/ family participation in planning appropriate interventions/ strategies 5. Develops, with the client, an evaluation plan specifying criteria/ indicators, methods and tools 6. Collaborates with the client and the inter-professional health care team in developing the plan of care 7. Modifies plan of care according to one’s judgment, skills or knowledge as client’s needs change</td>
</tr>
<tr>
<td>Number of Hits</td>
<td>Code</td>
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</table>
| 6             | 2.4.3| Applies safety principles, evidence-based practice, infection control measures and appropriate protective devices consistently, when providing nursing care and preventing injury to clients, self, and other health care workers, and the public | 1. Performs evidence-based nursing procedures safely and effectively  
2. Uses appropriate technology to perform safe and efficient nursing interventions  
3. Applies consistently principles of infection control in practice  
4. Uses appropriate personal protective equipment  
5. Ensures that the members of the health care team and visitors perform infection control measures accordingly  
6. Requests change in assignment when his/her competence level does not meet the client’s care needs |
| 6             | 3.1.1| Prepares a data collection and analysis plan as a member of the quality improvement/ quality assurance/ nursing audit team | 1. Identifies opportunities for improvement of systems or processes in the delivery of health care services  
2. Reviews related literature procedures, and other documents to clarify current knowledge regarding the problem  
3. Prioritizes identified opportunities for continuous quality improvement taking into consideration those which occur frequently and affect a large number of patients, high risk problems, and aspects of care that produce problems to patients and staff  
4. Selects appropriate methodology in collecting and analyzing data  
5. Undergoes training as necessary regarding utilization of appropriate data collection and analysis methods/ tools |

4. **Job Description and Performance Evaluation**

Following is the new clinical nurse job description incorporating the results of the organizational assessment, mapping and reconciliation analysis. The job description also features the performance indicators and the evaluation methodology for both self and supervisory assessments:

**Position:** Clinical Nurse  
**Reports to:** Nurse Unit Manager

**Purpose:** The staff nurse practices at a high level of autonomy and accountability in collaboration with the interprofessional team to provide a continuum of patient care that is safe, high-quality, patient-centered, evidence-based, and cost-efficient, with a focus on continuously improving systems and processes so that patients are consistently satisfied with the experience of care.
## Duties and Responsibilities:

<table>
<thead>
<tr>
<th>Key Area</th>
<th>Core Competency</th>
<th>Performance Indicator</th>
<th>As Evidenced By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Comprehensive Care</td>
<td>Applies an integration of theory, research, experience, and practical knowledge in providing safe, holistic care for patients and their families within maximum scope of practice through protocols, practice guidelines, care paths, and medical directives.</td>
<td>1. Conducts a thorough health assessment of the patient's physical, psychosocial, cultural, and spiritual needs as part of “knowing” the patient</td>
<td>1. Completing a patient history and physical examination</td>
</tr>
</tbody>
</table>
|                     |                                                                                 | 2. Formulates and implements a holistic plan of care that is communicated and clarified with the patient/family | 1. Completing an appropriate care plan in a timely manner  
2. Making appropriate entries in the patient communication board  
3. Validation with patient and family through nursing leadership rounds |
|                     |                                                                                 | 3. Interprets and organizes sequencing of diagnostic tests and procedures as required using nursing judgement and expertise | 1. No incidents of missed tests, delayed tests, critical test results not relayed to MD                |
|                     |                                                                                 | 4. Questions doctor’s orders                                                                                                                 | 1. Through direct observation  
2. Validation with MDs                                                                                      |
|                     |                                                                                 | 5. Administers medications correctly and in a timely manner                                                                                  | 1. Through direct observation, peer evaluation  
2. No. of medication errors                                                                                 |
|                     |                                                                                 | 6. Protects the patient from infection                                                                                                       | 1. Hand hygiene compliance with direct observation  
2. Participates in safety huddles                                                                          |
<p>|                     |                                                                                 | 7. Prioritizes care                                                                                                                          | 1. No incidents                                                                                     |</p>
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<tr>
<th>Key Area</th>
<th>Core Competency</th>
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<th>As Evidenced By</th>
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</table>
| Supportive Care and      | Provides holistic nursing care to meet the emotional, psychological, informational, spiritual, and practical needs of patients throughout the spectrum of care | 1. Establishes a caring and therapeutic relationship with patients demonstrating trust, respect, and honesty  
2. Develops a collaborative partnership with the patient/family that is respectful of their needs, wishes, knowledge, experience, values, and beliefs  
3. Demonstrates excellent communication skills during all phases of the therapeutic relationship  
4. Creates an environment of support by listening attentively and offering support and confidentiality  
5. Demonstrates the ability of "being there" for or "being with" the patient throughout the illness experience by acknowledging the patient's reality and encouraging hope  
6. Identifies gaps in service and addresses them | 1. Validation with patient and family through nursing leadership rounds  
1. Through direct observation  
2. Patient's/family's verbal and written commendations  
2. Validation with patient and family through nursing leadership rounds  
1. Through direct observation  
2. Feedback from patient experience peers  
3. Validation with patient and family through nursing leadership rounds |
<p>| Service Excellence       |                                                                                   |                                                                                                                                                                                                                        |                                                                                                |</p>
<table>
<thead>
<tr>
<th>Key Area</th>
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</table>
| Navigating the System | Helps the patient and family to navigate our system of care by expediting access to services and resources and improving continuity and coordination of care throughout the care continuum | 1. Organizes the interdisciplinary plan of care with other services and team members as required to facilitate the seamless movement of the patient through the health care system  
  2. Demonstrates knowledge about the SLMC routines and protocols by using SLMC resources like The Source, etc.  
  3. Follows the process of patient education/ health counselling which consists of need assessment, statement of learning need, development of learning objectives with the patient, implementation of teaching, and evaluation of learning  
  4. Applies evidence-based practice in the development of teaching tools/programs  
  5. Advocates for the patient/family by mobilizing appropriate resources tailored to the individual patient's care in a timely fashion  
  6. Translates medical knowledge and procedures for the patient/family using language that is appropriate for the patient | 1. The interdisciplinary plan of care is complete and addresses the most current patient problems  
  1. Through direct observation  
  1. Through direct observation  
  2. Chart Review: completion of the Patient Family Education (PFE) form with appropriate entries  
  1. Evaluation of tool  
  1. No. of commendation and complaints  
  1. Direct observation |
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</thead>
<tbody>
<tr>
<td>Professional Practice</td>
<td>Is accountable for his/her own decision-making and actions, and maintaining competence to facilitate the best possible outcomes for patients</td>
<td>1. Participates in professional and specialty nursing organizations</td>
<td>1. Verification</td>
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<td>2. Supports development of and participates in clinically relevant research, committee, and project work</td>
<td>1. Verification</td>
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<td>3. Advocates for and supports the development, implementation, and evaluation of quality improvement initiatives (policy and procedure changes, standards, protocols, clinical pathways, etc.)</td>
<td>1. Verification</td>
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<tr>
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<td>4. Engages in self-appraisal by being proactive and innovative in meeting own learning needs based on served population needs and changes in practice</td>
<td>1. Request for continuing education attendance 2. Attendance in mandatory inservice</td>
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<td>5. Performs reflective practice which includes the required capacities for self-awareness, self-knowledge, empathy, awareness of boundaries and capabilities, and maximum scope of the professional role</td>
<td>1. Identifies own limitations 2. Asks for help or assistance</td>
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<td>6. Role models for nursing through the demonstration of expertise at level of experience</td>
<td>1. Direct observation 2. Peer evaluation</td>
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<td>7. Acts as a preceptor or mentor to staff/students, providing written or verbal feedback, as necessary</td>
<td>1. Peer evaluation</td>
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<td>8. Recognizes ethical dilemmas and works through them using resources and the St. Luke’s Ethical Framework</td>
<td>1. Direct observation</td>
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<td>9. Demonstrates ethical behavior (i.e., honesty, comes to work on time, uses work time for work, no social media during work time, etc.)</td>
<td>1. Attendance record 2. Direct observation</td>
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<td>10. Recognizes when own values and beliefs conflict with the patient’s and is able to demonstrate conflict resolution skills</td>
<td>1. Direct observation</td>
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<tr>
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<tr>
<td>Collaborative Practice</td>
<td>Shares in the holistic care of patients, together with members of the intradisciplinary team, through a complementary relationship which is based on shared decision-making and joint problem solving</td>
<td>1. Demonstrates an understanding of the scope of practice as a nurse to ensure role clarity, authority, and accountability</td>
<td>1. Direct observation</td>
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<td>2. Utilizes strong communication and interpersonal skills to facilitate mutual agreement and acceptance of responsibilities within scope of practice, about shared care and distribution of activities</td>
<td>1. Direct observation</td>
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<td>3. Facilitates cost-effective care through complementary but non-duplicating roles in collaborative practice</td>
<td>1. Direct observation</td>
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<td>4. Demonstrates strong communication skills to work in partnership with the MDs to provide a trusting and respectful professional relationship</td>
<td>1. Direct observation</td>
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<td>5. Demonstrates strong communication skills to work in partnership with other health care team members (i.e., ancillary personnel, nursing assistants, patient experience staff, pharmacists, housekeeping staff, dietary staff, etc.)</td>
<td>1. Direct observation 2. NA evaluation 3. Ancillary personnel feedback</td>
</tr>
</tbody>
</table>

Qualifications:
- Current registration through PRC
- At least BSN
- Computer skills required
- Current BLS certificate
- Additional competencies in specialized areas are required

5. Onboarding/Orientation, and Continuing Education

Identifying Concepts Embedded in NNCCS

The NNCC Standards were examined for concepts pertinent to the successful acquisition of the specified competencies. The approach recommended is to identify key words or concepts that resonate with the realities and contexts of the organization.

Cross Validating with Modules Already in Use

This exercise is done for determining if the concepts in the NNCCS are adequately addressed in the existing modules. Adjustment in module design, strategies, and assessment tools are then performed.

The activities for identification of concepts embedded in NNCCS and cross-validating current module content is seen in Table 4.
<table>
<thead>
<tr>
<th>Number</th>
<th>Responsibility</th>
<th>Concept</th>
<th>Included In</th>
</tr>
</thead>
</table>
| 1      | Practices in accordance with legal principles and the Code of Ethics in making personal and professional judgment | • Ethico-legal framework of nursing practice  
• Code of Ethics  
• Scope and standards of nursing practice  
• Terms of contract of employment  
• Mission/vision/values of hospital  
• Patient rights and responsibilities  
• Informed consent  
• Questioning unclear orders, decisions, or actions | Onboarding/Orientation Module  
Speaking Up/Assertiveness Module |
| 2      | Utilizes the nursing process in the interdisciplinary care of clients that empowers the clients and promotes safe quality care | • Working relationship with client  
• Holistic, patient-centered care  
• Data gathering tools for assessment of the working relationship  
  - Nursing history taking  
  - Physical/developmental/psychosocial assessment  
  - Lab and diagnostic results  
• Data analysis with norm comparison  
• Nursing diagnosis  
• Interdisciplinary care planning  
  - Psychosocial/therapeutic  
  - Physical/physiologic  
  - Pharmacological  
  - Basic, advanced, rehabilitative  
  - Spiritual  
  - Complementary/alternative/non-traditional  
  - Participatory and empowerment strategies for client and family  
  - Health education  
• Age-appropriate care  
• Population-based care (i.e., adult, pregnant)  
• Vulnerable populations (i.e., pediatric, elderly, end-of-life, immunocompromised, HIV, marginalized/subsidized care)  
• Evidence-based care  
• Prioritization of interventions  
• Infection control  
• Personal protective equipment  
• Fall Management  
• Medication management and use  
• Adverse drug reaction reporting  
• Pain Management  
• Monitoring, Surveillance, Evaluation, Vigilance  
• Outcomes of care  
• Communicating results of care to the physician and other health team members  
• Primary/Preventive Care in the hospital setting  
• Disaster Management  
• Recognizing limitations and asking for assistance from more senior members of the health care team | Onboarding/ Orientation Module  
MIAD Module  
Care Planning Module  
Infection Control Module  
Fall Management Module  
Medication Administration Module  
Competency Module  
Pain Management Module  
Communicating with Physicians Module  
Disaster Management Module  
Code Rainbow Module |
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| 3      | Maintains complete and up-to-date recording and reporting system               | • Documentation of care  
• Security and confidentiality of information  
• Use of informatics                                                                 | Documentation Module  
Onboarding/orientation Module                                                                 |
| 4      | Establishes collaborative relationship with colleagues and other members of the team to enhance nursing and other health care services | • Clear scope of nursing functions  
• Respecting the role of other team members  
• Coordination/liaison function of nursing                                                                 | Onboarding/orientation Module                                                                 |
| 5      | Promotes professional and personal growth and development                      | • Identification of own learning needs  
• Obtaining feedback  
• Personal learning plan  
• Developing a career plan  
• Participating in professional activities  
• Working with senior members of the health care team: addressing the authority gradient  
• Conflict resolution strategies  
• Modelling professional behavior                                                                 | Transformational Leadership Module                                                                 |

**Nurse’s Role on Management and Leadership**

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<tr>
<th>Number</th>
<th>Responsibility</th>
<th>Concept</th>
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</table>
| 1      | Demonstrates management and leadership skills to provide safe and quality care | • Recognizing rapidly deteriorating patient status  
• Rapid Response Teams  
• Code Blue  
• Proper use of human, material, financial, and other resources  
• Cost-effectiveness  
• Active listening  
• Closed-loop communication  
• 2-challenge rule  
• CUS technique  
• DESC technique  
• Use of the e-Library  
• Use of Lippincott’s Evidence-Based reference                                                                 | Rapid Response Teams Module  
Stewardship Module  
Closed Loop Communication Module  
Teamwork Module  
Onboarding/Orientation Module                                                                 |
| 2      | Demonstrates accountability for safe nursing practice                          | • Policy development  
• Self-scheduling  
• Time management                                                                 | Shared Leadership Module  
Self-Scheduling Module  
Managing Your Workload Module  
Chart Audit Module                                                                 |
### Responsibility Concept

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<th>Number</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>3</td>
<td>Demonstrates management and leadership skills to deliver health services effectively to specific client groups in the community</td>
<td>• Early discharge planning</td>
<td>Early Discharge Planning Module</td>
</tr>
<tr>
<td>4</td>
<td>Manages a component of nursing service</td>
<td>• Charge nurse functions&lt;br&gt;• Electronic logbooks&lt;br&gt;• Ordering supplies&lt;br&gt;• Use of Omnicell&lt;br&gt;• Linen issues&lt;br&gt;• Working with Food and Nutrition&lt;br&gt;• Working with Housekeeping&lt;br&gt;• Positive Practice Environment</td>
<td>Charge Nurse Module Orientation/Onboarding</td>
</tr>
<tr>
<td>5</td>
<td>Demonstrates ability to lead and supervise nursing support staff</td>
<td>• Delegation&lt;br&gt;• Handling conflict&lt;br&gt;• Lateral violence&lt;br&gt;• Coaching/Mentoring&lt;br&gt;• Progressive Disciplinary process&lt;br&gt;• Providing feedback&lt;br&gt;• Above the line, on the line, below the line conversations</td>
<td>Delegation Module&lt;br&gt;Conflict Resolution Module&lt;br&gt;Teamwork Module&lt;br&gt;Leadership Evaluation Module</td>
</tr>
<tr>
<td>6</td>
<td>Utilizes appropriate mechanics for networking, linkage building and referrals</td>
<td>• Advocacy strategies&lt;br&gt;• Networking</td>
<td>Advocacy Module (not yet available)</td>
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### Nurses' Role on Research

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<th>Responsibility</th>
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<tbody>
<tr>
<td>1</td>
<td>Engages in nursing or health-related research with or under the supervision of an experienced researcher</td>
<td>• Nurse as consumer of research&lt;br&gt;• Evidence-based practice&lt;br&gt;• QI tools&lt;br&gt;• Oral presentation&lt;br&gt;• Poster presentation</td>
<td>Research Primer Module&lt;br&gt;EBP Module&lt;br&gt;Quality and Safety Module</td>
</tr>
<tr>
<td>2</td>
<td>Evaluates research study/report utilizing guidelines in the conduct of a written research critique</td>
<td>• Critiquing research</td>
<td>Research Primer Module</td>
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<tr>
<td>3</td>
<td>Applies the research process in improving client care in partnership with a quality improvement/quality assurance/nursing audit team</td>
<td>• Small test of change&lt;br&gt;• Conducting a pilot&lt;br&gt;• Use of SLMC research and EBP resources</td>
<td>Safety Officer Module</td>
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6. Summary

Embedding the new National Nursing Core Competency Standards in an organization requires a deep understanding not only of the contents of the standards but also of how these standards can be hardwired or integrated in both the essential and quotidian aspects of the organization. Resources available to the organization are also important considerations on how to plan for the rollout.

References


Appendix 1

EMBEDDING THE NEW NATIONAL NURSE CORE COMPETENCY STANDARDS IN HOSPITAL FACILITIES

ORGANIZATIONAL SELF-ASSESSMENT (PART 1)

What is the mission of the hospital?

What are the competencies to the members of the nursing staff need to possess to successfully carry out the mission?

What is the vision of the hospital?

What competencies do the members of the Nursing staff need to possess to successfully carry out the vision?

Based on your customer/patient base and their characteristics/demographics, what competencies should members of the nursing staff need to possess?

Based on the resources (i.e., human, infrastructure, equipment, educational material, etc.), what competencies should members of the nursing staff need to possess?

Shorten the above list to not more than 12 competencies:
Shorten the above list to not more than 12 competencies:

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<tr>
<th>No.</th>
<th>Competency</th>
<th>Remarks / Notes</th>
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EMBEDDING THE NEW NATIONAL NURSE CORE COMPETENCY STANDARDS
IN HOSPITAL FACILITIES

ORGANIZATIONAL SELF-ASSESSMENT (PART 2)

The first step in embedding the new National Nurse Core Competency Standards is to conduct an organization-wide Self-Assessment. The Self-Assessment must be deliberate and honest, open to the possibility that the current conditions may not be perfect, if it is to serve its purpose. This process requires an organization to compare itself against the standards to assess the organization’s current state and establish baseline.

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<th>Y</th>
<th>N</th>
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<tr>
<td>1. Is the organization clear as to its mission and the competencies required from its nursing staff to successfully complete the mission?</td>
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<td>2. Is the organization clear as to its vision and the competencies required from its nursing staff to successfully attain the vision?</td>
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<td>3. Is the information about the organization’s customers/patients, their demographics, preferences, and health/disease patterns available?</td>
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<tr>
<td>4. Based on the information about the organization’s customers/patients, are the competencies required from its nursing staff to meet the demands of patients/families based on their demographics, preferences, and health/disease patterns clear?</td>
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<td>5. Are the organization’s unique value proposition (i.e., one that will help this organization stand out from the rest of the competition) and the competencies required to support this clear?</td>
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<td>6. Is the organization clear as to its human resource limitations, if any, that may indicate the need for staff competencies required to overcome these limitations or to still succeed in despite these limitations?</td>
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<tr>
<td>7. Is the organization clear as to its infrastructure limitations, if any, that may indicate the need for staff competencies required to overcome these limitations or to still succeed despite these limitations?</td>
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<tr>
<td>8. Is the organization clear as to its budgetary limitations, if any, that may indicate the need for staff competencies required to overcome these limitations or to still succeed despite these limitations?</td>
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<tr>
<td>9. Is the organization clear as to its supply/equipment limitations, if any, that may indicate the need for staff competencies required to overcome these limitations or to still succeed despite these limitations?</td>
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Functional Integration between nursing education and service is one of the initiatives identified by the PRBON and their nursing partners in the Professional Nursing Roadmap Towards Good Governance. Through the implementation of this initiative improved nursing education and nursing service delivery is envisioned.

For the pilot testing of the Embedding and Spreading of 2012 NNCCS selected academic institutions with their base hospitals and affiliation hospitals were invited to participate using the functional integration between nursing education and service mechanism. UPMCN agreed to participate in the Embedding and Spreading of 2012 NNCCS using the Functional Integration between nursing education and service mechanism.

A. Historical Brief:

**Purpose.** The institutionalization of functional integration of the two nursing units of the University of the Philippines Manila aims to bring about a more effective and efficient nursing service delivery and quality nursing education. Functional integration refers to a process of achieving unity through joint efforts and sharing of resources of the UPM College of Nursing and the PGH Department of Nursing in attaining their desired goal, which is the improvement of nursing in terms of practice, education, research and other defined areas common to both.

It is hoped that through the collaborative type of integration, the following will be achieved:
1. Efficient, effective, and dynamic system through:
   1.1. Communication at all levels in the structure
   1.2. Decision making activities in joint programs/ projects at the interface level.
2. Strengthen the three aspects of administration: operation, human resources, and clinical practice.
3. Other activities: Higher and relevant research output, facilitation of academic programs, professional advancement.

This was conceptualized in 1976, and was implemented informally since then. The proposal development was headed by Cecilia M. Laurente of the PGH Department of Nursing Service. The following were parts of the joint proposal: career ladder system for clinical advancement, the Nurse Residency Training Program towards clinical specialization; establishment of clinics, such as triage nursing, wellness clinic; preceptorship program; programs and projects in clinical nursing; continuing education; nursing research and development; giving of dual appointments to qualified nursing personnel and faculty members. Through the years, joint activities were undertaken. Some of the succeeding programs included Training in Problem Oriented Recording, Training in Psychiatric Nursing, Continuing Education programs, and preceptorship program. In terms of teaching, Nursing Service personnel who were academically qualified were given appointment by UP Manila as lecturers at the College of Nursing.
In January 10, 1977, the UP Executive Vice President approved the recommendation of PGH Director Gabriel Carreon on “Preceptors”: “Appointment of PGH Nursing Service personnel who are academically qualified as “preceptors” of nursing students on clinical practice without honorarium. The preceptors should be responsible to the College of Nursing for the quality of instruction and to the Chairman of the clinical department for the quality of patient nursing care”.

In 1984, Dean Aurora Yapchiongco worked with PGH Department of Nursing Service Chief Nurse P. Nicolas, Deogracia Valderrama, Erlinda Ortin, Cecilia M. Laurente to strengthen the integration between the two units. The Preceptorship Program was highlighted. In 1986, both units worked together for the creation of the Task Force ADN (Assistant Director for Nursing) which acted as a pressure group and became instrumental in the appointment of Mrs. Anesia B. Dionisio as ADN. In 1986, approval was granted for preceptors to have honorarium for services rendered outside of duty hours.

The succeeding joint programs included Seminar Workshops in Nursing Diagnosis, Continuing Preceptorship Program, Strengthening Clinical Teaching Competencies of Nurse Preceptors, and regular related continuing education activities.

The functional integration was formally institutionalized on October 29, 1993 with the approval of UP Manila Chancellor Ernesto O. Domingo upon the request of Dean Thelma F. Corcega of the College of Nursing, Anesia B. Dionisio, Director II, Department of Nursing, and Felipe A. Estrella, Jr., MD, Director IV Philippine General Hospital.

ORGANIZATION. To achieve integration of the collaborative type is to have a core of staff to serve as “linking pins” between the two units. The core staff, also known as the functional liaison, will use the process of democratic participation and group decision-making to achieve a stronger linkage between the PGH Nursing Service and the UPM College of Nursing.

Horizontally, this core staff serves as the coordinating body in planning, implementing, evaluating, joint programs/ projects at the interface level. Vertically, the Assistant for Clinical Nursing (UPMCN)* and the Assistant Director for Nursing Service serve as the “linking pins” between their own levels below and above the organizational structure of each unit. (* This can be the Head of the Teaching Program, or as designated by the Dean).
CONTINUING WORK

• In 1995, the core group was composed of Prof. Carmencita M. Abaquin (Presiding) Head of the Teaching Program; Prof. Araceli O. Balabagno, Head of CECSP; Dr. Letty G. Kuan, Head RCWP; Mrs. Deogracia Valderrama, ADN and Chief DNRD; Ms. Imelda Mangaser, Chief DNET. The activities that were highlighted then included the Skills Manual, Nursing Documentation, Standardization of Nurses Station, Creation of Emergency Care Project and Child Abuse Unit. For research activities, studies were done on nurses’ documentation revision of flow sheets. Funding sources included the UP College of Nursing Foundation. [Reference: Minutes of meetings of the Integration Committee]

• PGH Assistant Directors for Nursing Services, Mrs. Deogracia M. Valderrama and Rita V. Tamse had appointment as part-time faculty and lecturers at the College of Nursing graduate program on Nursing Administration. Joint activities of continuing education on Critical Care Nursing have been undertaken, as well as support of CN lecturers for IV Therapy Programs, clinical nursing areas, cardiac rehabilitation. The CN faculty served as lecturers of DNET and DNRD on research areas.

• In 2005, the College of Nursing offered the Seminar Workshop on Evidence-Based Nursing for the nurse coordinators of PGH. Faculty members were part of some research activities of the Department of nursing.
• In 2011 jointly with Ms. Rita V Tamse, ADN, PGH, Dean Araceli O. Balabagno, worked collaboratively with WHO WPRO coordinators to have the WHO Patient Safety Curriculum introduced to UPM nursing. Gradually both units had representatives participate in training programs on patient safety. This was eventually integrated in the curriculum, as well as in clinical areas on patient safety standards.

• The program for advance nursing practice was jointly undertaken by both units in 2013. This led to the Department of Nursing, ADN, Ms. Imelda Mangaser, defining a core group who will undergo academic and clinical training on areas of specialization. This project had support from the PGH Director Jose C. Gonzales.

2015 FUNCTIONAL INTEGRATION ACTIVITY OF UPMCN, PGHDN AND WITH OTHER PARTNER HEALTH INSTITUTIONS

In 2015, the College of Nursing and PGH Department of Nursing participants from DNET and DNRD and other partner Health Institutions worked together to understand the implementation of the National Nursing Core Competency Standards (NNCCS, 2012) as promulgated by the Professional Regulation Board of Nursing.

This was carried out through University of the Philippines Manila, College of Nursing (Academic Program Improvement 2015 July 27-31) on “Embedding & Spreading the 2012 NNCCS for the BSN Curriculum”.

Description. This is a five-day activity aimed at developing competencies of UPCN faculty and preceptors in embedding and spreading the 2012 National Nursing Core Competency Standards in the BSN Program. This program will be the model for the nationwide implementation of NNCCS “embedding and spreading” in coordination with the Professional Regulatory Board of Nursing.

Participants. All faculty of UP College of Nursing, clinical preceptors and partners from hospitals of affiliation in the Philippine General Hospital, Dr. Jose Fabella Memorial Hospital, Research Institute of Tropical Medicine, Manila Health Department and National Center for Mental Health.


Program Outcome. Develop the competencies of the faculty and preceptors in embedding and spreading the NNCCS to the BSN Program curricular design.

After the series of discussions throughout the 5-day activity, it was expressed by representatives of partner institutions where related learning experiences are conducted and the UPCN faculty that there is a need to strengthen the integration efforts between and among the institutions. This is highlighted in two aspects:

1. close coordination on the schedule, activities and needs to facilitate learning and
2. ensure that the 2012 NNCCS Responsibilities and Performance Indicators are reflected in the respective institutions, specifically, in the Standards of Care and Practice, policies, job descriptions, and tools to measure performance.
B. Results

a. Outputs

The series of lectures and workshops were geared towards the completion of instructional designs that reflect the responsibilities from the 2012 NNCCS and the OBE framework.

Two sets of outputs were presented:
1. Exemplars from participants, which will be used by faculty members teaching the course and instructional designs from the specialty mentors to be used by Implementation Facilitators (IFs).
2. Two exemplars included in this report cover a pure classroom setting course (Nursing Research) and a clinical setting course (Nursing Interventions I). These, along with the instructional designs from the specialty mentors are reflected in Appendix E and F respectively.

b. Discussion Points

Some themes were evident throughout the discussions during the plenary and workshop sessions. Among these were on ensuring the closure of the gaps between the classroom and the practice settings, which includes the following:

1. Need of the practice setting

There was a common identified need to document the Standards of Care for the practice settings. Only PGH was able to present a developed Standards of Care for the institution. It was a clear realization by the participants representing partner agencies of the urgent need for a Standards of Care. It was noted that the basis for the standards are already stated in the job descriptions and task of the nurses in the setting. However, documenting the standards will ensure the quality of practice and will help the academe in ensuring that the students’ preparation is aligned with the practice setting. It was expressed that as partners, the UPCN and UP-PGH are requested to assist with the development of the Standards of Care of NCMH and MHD that reflects the 2012 NNCCS as well. Another expressed need of the practice setting is the enhanced partnership in conducting continuing professions education, training and development. This will enhance the nurse professionals and will ensure having practice models for the students during their RLE. Finally, the participants from the partner agencies

2. Role of the faculty in embedding the NNCCS and updating the curriculum

The need for congruence in the understanding of terminal and intermediate competencies was mentioned. However, the focus was on continuation of the updating of the curriculum under the Outcomes- Based Education approach and to ensure embedding of, not only the 2012 NNCCS, but also updates on specialties and topics.

Enhanced teaching-learning strategies developed in partnership with preceptors was encouraged. In addition, valid evaluation tools need to be constructed as existing evaluation/assessment tools have been found to be lacking or not updated.
3. **Active partnership and collaboration among preceptors, partner agencies and the UPCN.** The group agreed that close coordination be done not only in the conduct and scheduling of the RLE, rather in the preparation of the preceptors in supervision and evaluation of students. Evaluation scheme for preceptors should be explored as a means to give feedback and assess the students.

The functional integration between the UPMCN, PGHDN and the other Partner Institutions brings a common goal to contribute to nation building through quality nursing education and quality client care, and in support of the quest for excellence of the University of the Philippines. Likewise, the various institutions were involved in the program design development and in reviewing and updating their nursing standards. This activities are crucial to the embedding of the 2012 NNCCS in their workplace.

The Appendixes submitted for the report are the same as the Appendixes in the UPMCN Model.
V. OVERALL SUMMARY AND FUTURE PLANS

A. OVERALL SUMMARY

Monograph 2 was envisioned to serve as a guide to ensure proper embedding and spreading of the 2012 National Nursing Core Competency Standards (NNCCS) in both nursing education and nursing service (hospital-based and community-based) nationwide.

In the introductory section, the legal bases was presented: Article III, Sec. 9 (c) of Republic Act No. 9173 known as the “Philippine Nursing Act of 2002.” Thus the PRBON is empowered to take the lead in the improvement and effective implementation of the core competency standards of nursing practice in the Philippines to ensure safe and quality nursing care, and maintain integrity of the nursing profession.

To be able to have the proper perspective, the development of 2012 National Nursing Core Competency Standards (NNCCS) including the various phases involved in the process of revisiting the nursing core competency standards were presented. From these processes the three roles of the nurse were derived: (1) Beginning Nurses’ Role on Client Care, (2) Beginning Nurses’ Role on Management and Leadership and (3) Beginning Nurses’ Role on Research. Likewise, the various responsibilities, competencies and performance indicators were spelled out. Four types of clients of the nurse were also identified: (1) individuals with varying age group, gender and health-illness status, (2) healthy and at-risk family, (3) population groups and (4) community. All these were accomplished through the collaboration of our nursing partners.


Then printing of 2012 NNCCS - as Monograph I was undertaken by the PRBON and copies were distributed to our nursing partners, the various nursing professional organizations, academic institutions and hospitals.

The core group planned to develop training modules to be used during the training of trainers (TOT) to ensure proper implementation of the 2012 NNCCS nationwide. Likewise a framework for implementation was conceptualized. The International Labour Organization, through its DWAB project, partnered with the CHED and PRC to implement the subproject entitled “Nursing Core Competencies Training for Master Trainers in Nursing Education and Practice.” CHED obtained a grant from the ILO which was funded by the European Union. The training modules were prepared by nursing experts from the academe, service and community to ensure that examples, case studies and scenarios in the workplace were realistic and relevant and to ensure compliance with the NNCCS. The master trainer’s are envisioned to: (1) train implementation facilitators who will implement the NNCCS in their unit, department, or organization; (2) perform site assessments and determine performance gaps; (3) prepare, train, and provide process consultation to the unit, department, or organization implementing the NNCCS.

The significance of the 2012 NNCCS gave emphasis on the three important features of the Philippine Qualifications Framework (PQF) and the ASEAN Qualifications Reference Framework.
(AQRF) namely: shift to outcomes-based education and use of learning outcomes, implementation of quality assurance mechanisms and ensuring international alignment of qualifications. The various responsibilities of nurses as they assume the three roles identified in the 2012 NNCCS served as the basis for the development of the eleven program outcomes that is being utilized in the development of the Outcome-based Basic Nursing Education Program, Standards of the Professional Nursing Practice in various settings in the Philippines, Continuing Professional Development in Nursing; Modification of job descriptions in nursing practice, Draft of the Outcome-based Test Framework which serves as the basis for the development of the Course Syllabi, Table Of Specifications (TOS) and test questions for the “entry level” nursing practice in the Philippine Nursing Licensure Examination, National Nursing Career Progression Program (NNCCP) for nursing practice in the Philippines and other related evaluation tools in various practice settings in the Philippines.

The PRBON created eight (8) committees to ensure proper implementation of the 2012 NNCCS. Responsibilities and functions were spelled out and chairpersons and members of the committees were identified. The committees included: Oversight and Steering; Selection; Program, Design and Training; Resource Generation; Logistics; Information, Communication and Media Relations; Continuous Quality Improvement and Research. Several meetings were held to develop specific guidelines and desired instructional designs.

In Section II, Instructional design templates for embedding and spreading 2012 NNCCS for the four types of clients in the home and community setting were presented. The first module was developed as an instructional design template model for the embedding and spreading of 2012 NNCCS by the Master Trainer/Implementation Facilitators for 2012 NNCCS considering the family as client in the home, the school, health center/clinic in the rural villages, urban areas/settlements and industrial/ occupational settings. And the second module is an instructional design template model for the embedding of the 2012 NNCCS by the Master Trainer/ Implementation Facilitators considering the population group and community as clients in the home, the school, health center/ clinic in the rural villages, urban areas/settlements and industrial/ occupational settings.

The Objectives of the first module are to: describe the NNCCS on the family as client based on the performance indicators; specify what and how an instructional activity will be carried out to guide students or nurse-trainees on how to apply the knowledge component/topic or concept to carry out the NNCCS on care of the family as client; Identify appropriate nursing practice tools, guidelines and/or frameworks on the care of the family as client; describe teaching-learning strategies/ activities to guide students and/or nurse-trainee through critical thinking in inquiry-based nursing practice; illustrate evaluation methods and tools to determine achievement of specific sets of NNCCS on the family as client and specify decisions, policies, and actions necessary to facilitate implementation of NNCCS in appropriate work-settings (e.g. nursing education, service, policy institutions, and organizations).

On the other hand, the second module’s objective are to: use the NNCCS on care of the population group and the community as bases for developing course/instructional designs, guided by appropriate nursing practice framework/s, methods, tools, and/or guidelines; illustrate an inquiry-based nursing practice framework in using the NNCCS as bases for enhancing standards of practice, job description/s, performance evaluation methods and tools, and training designs and develop a sample training design to guide master trainer-cum-implementation facilitators in embedding the NNCCS in Nursing Education and Nursing Service.

Included in the modules were specific tables and references to serve as guide in the use of the NNCCS considering the family, population group and community as client partners in various community settings.
It is hoped that these modules together with the training modules developed through the ILO DWAB project will be used by the Master Trainers and Implementation Facilitators during the nationwide embedding and spreading of NNCCS.

In Section III, two models for embedding and spreading of 2012 NNCCS in Nursing Education and Service were presented. The first model was developed by the UPMCN for embedding and spreading of 2012 NNCCS in Nursing Education and the second model was developed for St. Luke’s Medical Center as an exemplar for embedding NNCCS in a Private, JCIA Accredited, Level 3 Academic Medical Center.

The UPMCN model gave emphasis on the method and processes of the program implementation/pilot testing of the Training for the Embedding of the 2012 NNCCS for Nursing Education (BSN Program) done through the UP Manila Academic Program Improvement (API) in coordination with its Continuing Education and Community Extension Services Program on July 27-31, 2015. The activity’s main goal was to assist the UPMCN faculty and partners, specifically the Philippine General Hospital Department of Nursing preceptors and preceptors from health facilities utilized by UPMCN in integrating the 2012 NNCCS into the curricular design. The expected outcomes included the: development of training program for nursing education; translation of NNCCS to standards of care on the 4 types of clients; creation of performance evaluation tools on the care of the 4 types of clients; and development job descriptions on the care of the 4 types of clients for nurses in the practice setting. The following methods and processes were highlighted: Preparation and Scheduling; Materials and Handouts; Selection of Participants and Speakers; Program Flow and Discussions; Role of Partners and Integration of NNCCS in the Related Learning Experience.

Based on the planned activities, the project team ensured that inputs were given by speakers and facilitators with mastery of the content and familiarity with the NNCCS. This was done by inviting experts from the PRBON, CHED-TCNE, leaders of specialty groups in Nursing, nurse administrators from the practice setting, and experts in Health Professions Education from the UP Manila National Teacher Training Center for the Health Professions (NTTC-HP).

Participants in the activity included faculty members of the UPMCN, preceptors from the different practice settings (UP-PGH, Jose Fabella Memorial Hospital, Manila Health Department, Research Institute for Tropical Medicine, National Center for Mental Health), Training and Research Department members of the UP-PGH, and members of the ADPCN, as participant/observers.

Detailed daily program flow and discussions specifically inputs and workshop activities, outputs, results and discussion points were presented. First day workshop focused on: Analysis of Standards of Nursing Care/Practice vis-à-vis NNCCS; Day 2 WS on: Mapping of the 2012 NNCCS Responsibilities and Performance Indicators across specialties and practice settings; Day 3 each specialty group work on the completion of their instructional designs, Day 4 focused on the presentation of the Instructional Designs from the Adult Health Nursing, Maternal and Child Nursing, Mental Health and Psychiatry and Community Health Nursing Specialty groups. Day 5 focused to future directions for the embedding and spreading of the 2012 NNCCS and collaboration between the UPCN and partner institutions. The development of evaluation tools was not completed on the 5th day but commitment to finish the evaluation tools during the Outcome based BSN program activities planned by the Teaching Program was verbalized. Themes and lessons learned were also presented. To guide future MTs and IFs various appendices were included. Functional integration of UPMCN and PGH Department of Nursing Services was reviewed and more structured activities are planned to help both Institutions.
The second model in Section III presented the experience of St. Luke’s Medical Center in embedding the new National Nursing Core Competency Standards (NNCCS). Its goal was to provide an exemplar of how an institution can hardwire the standards in institutional job descriptions, performance evaluation and curriculum design for orientation/on boarding and continuing education. The framework for the chosen embedding process was adapted from Maglaya (2013) which was presented during the NNCCS implementation planning. The SLMC model utilized the OSIME (Organizational Self-Assessment Implementation Monitoring Evaluation) Model for Embedding the New National Nursing Core Competency Standards in the Hospital Setting. The Author defined hardwiring or embedding as a process of institutionalizing systems and processes in an organization’s DNA so that it becomes a part of the day-to-day operations thus there is consistent and continuous application of the standards enterprise-wide. A two-step process for achieving hardwiring of the NNCCS embodied in the OSIME Model was presented: 1) organizational self-assessment (OS) and 2) Implementation, Monitoring, and Evaluation (IME). The implications emphasized were: the OSIME Model suggests that hardwiring the NNCCS is a disciplined process and not a random occurrence; that organizational self-assessment (OS) requires humility and an openness to the idea that not everything that occurs in an institution is perfect; and that the Implementation, Monitoring, and Evaluation (IME) phase requires purpose and perseverance. In the case of NNCCS, SLMC used the OSIME Model as a sustainability framework for embedding the new requirements in its daily workflow and culture. The Organizational self-assessment (OS) presented a brief description of the medical center; its vision and mission statement; the patient demographics characteristics; the professional practice model using Swanson’s Theory of Caring; a mapping and reconciliation process using the SLMC Competencies [Communication (CO), Critical Thinking (CT), Evidence-based Practice (EP), Informatics and Technology (IT), Leadership (LD), Patient-Centered Care (PC), Professionalism (PF), Quality Improvement (QI), Safety (SA), Service Excellence (SE), Systems-Based Practice (SB), Teamwork and Collaboration (TC)] with the New National Nurse Competency Standards (NNCCS). These was followed by a discussion of the cross-validation analysis of the organizational competencies vis-à-vis the NNCCS.

The new clinical nurse job description incorporating the result of the mapping and reconciliation analysis was presented. The job description presented also featured the performance indicators and the evaluation methodology for both self and supervisory assessments. For the Onboarding/Orientation, and Continuing Education, 2 processes were presented: Identification of Concepts Embedded in NNCCS and Cross Validation with Continuing Education Modules Already in Use. Adjustment in module design, strategies, and assessment tools were then performed. The activities for identification of concepts embedded in NNCCS and cross-validating current module content are illustrated in table form. Embedding the new National Nursing Core Competency Standards in an organization requires a deep understanding not only of the contents of the standards but also of how these standards can be hardwired or integrated in both the essential and quotidian aspects of the organization. Resources available to the organization are also important considerations on how to plan for the rollout. The Appendix featured the Parts I and II of the Organizational Self-Assessment for embedding the new NNCCS in hospital facilities.

All the above features, processes and methods presented in Section III can provide the Master Trainers and Implementation Facilitators concrete exemplars for the nationwide implementation of NNCCS.

SECTION IV featured the functional integration of the University of the Philippines Manila College Of Nursing and the Philippine General Hospital Department of Nursing as a model for functional integration between nursing education and nursing service. A historical brief was presented where the purpose, organization and the various collaborative activities were presented. The 2015 Functional Integration Activity of UPMCN, PGHDN and With Other Partner Health Institutions worked together to study and learn the implementation of the National Nursing Core Competency
Standards (NNCCS, 2012) as promulgated by the Professional Regulation Board of Nursing. This was carried out through University of the Philippines Manila Academic Program Improvement 2015 July 27-31 on “Embedding & Spreading the 2012 NNCCS for the BSN Curriculum”. A detailed presentation on the output of this activity can be seen in Section III.

The functional integration between the UPMCN, PGHDN and the other Partner Institutions brings a common goal to contribute to nation building through quality nursing education and quality client care, and in support of the quest for excellence of the University of the Philippines. Likewise, the various institutions were involved in the program design development and in reviewing and updating their nursing standards. These activities are crucial to the embedding of the 2012 NNCCS in their workplace.

B. FUTURE PLANS

The PRBON in partnership with our nursing leaders from the academe, nursing service and nursing organizations have agreed to undertake regional workshops for the embedding and spreading of NNCCS, using the modules for the Master Trainers and Implementation Facilitators and the various features, methods and processes underscored in the models for embedding and spreading NNCCS in nursing education and service. The Master Trainers from Luzon, Visayas and Mindanao who were trained will be invited for the regional and nationwide implementation. We likewise recognize the need to train more Master Trainers and Implementation Facilitators from both the academe and service. The PRBON will be inviting interested and committed nursing partners to participate in the nationwide NNCCS implementation. The Mentors and Coaches involved in the previous TOT will also be invited for the nationwide NNCCS Implementation.

The PRBON under the new leadership is thus enjoined to undertake the regional and nationwide NNCCS embedding and spreading. The Association of Deans of Philippine Colleges of Nursing (ADPCN) and the Association of Nursing Service Administrators of the Philippines (ANSAP) have likewise agreed to undertake collaborative activities to embed and spread NNCCS as well as to show case functional integration between nursing service and education. They have formed working committees for this purpose. The Philippine Nurses Association (PNA), who is the PRC Accredited Professional Organizations, the National League of Philippine Government Nurses (NLPGN), the Occupational Health Nurses Association of the Philippines (OHNAP), the Critical Care Nurses Association of the Philippines Inc. (CCNAPI), the Philippine Nursing Informatics Association (PNIA) and the other professional nursing organizations have also verbalized their commitment to support regional embedding and spreading of NNCCS.

With pride, I would like to commend the commitment of our nursing leaders from the academe, service and organizations, in undertaking these trailblazing projects that the PRBON has initiated, for without them we could not push through its completion. All these are jointly undertaken to uplift our beloved nursing profession and to achieve our vision of “providing professional nursing care that is BEST for the Filipino and the CHOICE of the World”.

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