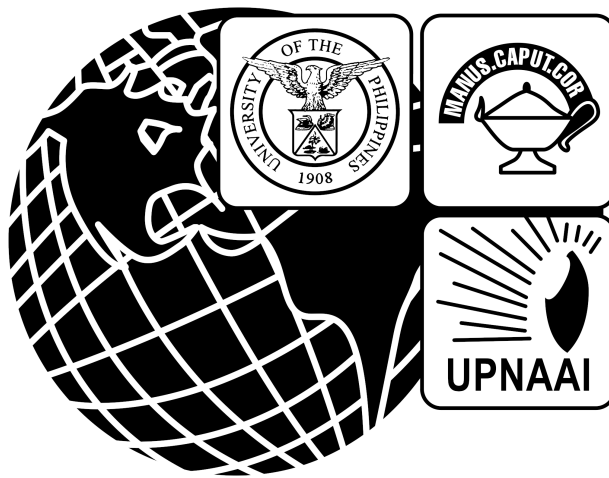




39th Annual UPNAAI CONVENTION AND EDUCATION CONFERENCE

August 3 and 4, 2018

Treasure Island, Las Vegas, Nevada



CONFERENCE PROCEEDINGS

CONFRONTING THE MODERN-DAY CHALLENGE OF BIOETHICAL And OTHER CRITICAL HEALTHCARE ISSUES

August 3, 2018

Treasure Island

3300 S Las Vegas Blvd, Las Vegas, NV 89109

CEU Accreditation

This program is approved for 5.6 contact hours of continuing education by the California Board of Nursing (CA BON), provider number CEP6961. This activity was planned in accordance with the CA BON Accreditation Standards and Policies.

How to Evaluate and Claim Education Credit

Every attendee must provide an email address upon registration. The attendee will receive an email notification on August 10, 2018 with instructions on how to complete the online podium and poster evaluations. The attendee will be able to print the CEU certificate upon completion of both evaluation forms. *The deadline to complete the online evaluation and obtain a certificate is September 10, 2018.*

Disclosure and Conflict of Interest Resolution Policy

UPNAAI Education Committee staff requires all podium and poster presenters to disclose relevant personal financial relationship with commercial interests prior to contributing to the activity. The staff assess disclosed relationships and follow a defined process to resolve real or implied conflicts to ensure to the best of our ability that all educational content is free of commercial bias.

Overall Conference Objectives

- Discuss the laws and regulations about advance directives, end of life decisions, and hospice care
- Assess proficiency in formulating safe, effective, and ethical clinical decisions by reconciling nursing jurisprudence, moral values, and ethics in various healthcare settings
- Appraise the nursing role and responsibilities in managing the care and meeting the needs of the patient, the family and significant others in palliative, end-of life care and post traumatic event

Education Conference and Poster Presentation

Friday, August 3, 2018

Moderator: Wilhelmina Aguilar Ungco, BSN'79, RN, CCRN

1ST VP and Chair, UPNAAI Education and Research Committee 2017-2019

7:00 AM Registration, Breakfast, Poster Presentation

8:00 AM Welcome Remarks

Wilhelmina Ungco, BSN'79, RN, CCRN

UPNAAI 1st Vice-President 2017-2019

8:05 AM Opening Prayer

Rev. Fr. Joseph Walter M. Villamiel, BSN'92, MA'98, STB, STL-MA

8:15 AM Presentation of the 2018 JVS Award Recipient

Peregrine Francisco, GN'69, BSN'71, MSA, RN

Chair, Awards and Citation Committee 2017-2019

8:25 AM Keynote Address: *The Current Challenges of Bioethics & Other Critical Health Care Issues In Hospice Palliative Care: A Philippine Perspective*
Carmencita M. Abaquin, PhD, RN
2018 Distinguished Julita V Sotejo Medallion of Honor Recipient

8:55 AM Break into Concurrent Sessions

CONCURRENT SESSION A

Host: Celine Marie Pico, BSN'80, RN, CAPA
Co-Chair, Poster Sub-Committee, UPNAAI PRO 2017-2019

9:05 AM *Applications of Biblical and Moral Bases of Christian Ethics to Nursing and Health Care*
Rev. Fr. Joseph Walter M. Villamiel, BSN'92, MA'98, STB, STL-MA

9:45 AM *Why Hospice? Why Now?*
Finnette Castaneda, BSN'92, RN, PHN

10:25 AM *Legal Implications of Healthcare Decisions and Documenting One's Final Wishes*
Atty. Gary Fales, Esq

CONCURRENT SESSION B

Host: Rina D. Gangozo, BSN'92, RN, CCM, CMCN
Co-Chair, Poster Sub-Committee

9:05 AM *End of Life Option Act and Other Ethical Issues*
Maidaflor Rana Maybir, BSN'89, MSN, RN, CCRN

9:45 AM *How Nurses Can Uphold the Dignity of Life*
Rev. William J.M. Kenny

10:25 AM *Trauma and Resilience Among Filipino American Women: Challenges and Ethical Issues*
Dr. Andrew Thomas Reyes, PhD, RN

10:55 AM BREAK: RECONVENE IN TREASURE ISLAND-A for GENERAL ASSEMBLY

11:05 AM Summary of the Two Concurrent Sessions
Dr. Carmencita Abaquin, PhD, RN
2018 Distinguished Julita V Sotejo Medallion of Honor Awardee

11:20 AM Q&A

11:45 AM Closing Remarks & Awarding of Certificates to Speakers and Poster Presenters
Deborah-Anne Y. Butuyan, BSN'89, RN
UPNAAI President 2017-2019

12:00 PM Poster Presentations

The Current Challenges of Bioethics and Other Critical Health Care Issues In Hospice Palliative Care: A Philippine Perspective

Dr. Carmencita Abaquin, PhD, RN

2018 Distinguished Julita V. Sotejo Medallion of Honor Recipient

Objectives:

At the end of the session, the participant will be able to:

- Discuss the developments and challenges of hospice and palliative care in the Philippines
- Describe how human dignity is maintained at the end of life

HOSPICE AND PALLIATIVE CARE

Historical Perspective

- Hospice palliative movement in the Philippines began in the 1980s.
- In 1991 the Philippine Cancer Society founded its first home care program and offered support to other interested groups.
- In 2008, 34 hospice palliative care organizations and 108 hospice/palliative services provided end of life care to the needy members of our population.

Hospice Care Activity – includes: *Referrals, Out Patient Department, Home visits, Counselling and Psychosocial activities*

Education Training Programs for Hospice and Palliative Care: formal, conventions/ updates; informal, nonformal.

Focus of Basic Training Program include: *Principles & practice of palliative care; Symptom control; Pain; Ethics; How to start your hospice visit; Preparation of the dying patient & family; Grief and bereavement (Classroom and practicum)*

A feature of Filipino Culture is its strong religious tradition.

Challenges and Issues in Hospice Palliative Care – are categorized into: Palliative Care and Society; The Health Care Community; Government; and Service Provision.

Bioethical and Health Care Challenges in Hospice Palliative Care needed to be addressed. Principles of Bioethics – serve as basis for decision making of practitioners.

Ethical issues surrounding end of life care are not only medical or science but social, legal, religious, and cultural.

Ethics Board – formed to ensure sound decisions. Take note – The SHPM DOES NOT advocate Euthanasia. Its advocacy is congruent with those of major religious and ethics groups in the country.

DYING WITH DIGNITY

Basis for the meaning of Dignified Dying – Man is created in the image of God, Core Value, Universal Declaration of Human Rights, Dignity – a duty and a right in professional codes and human right framework

Several studies were undertaken to serve as bases for the nursing interventions:

- FGD was conducted to determine “How human dignity is maintained”
 - Perceptions of Dying and Death Among Adult Filipino Patients With Terminal Cancer: *Implications for Nursing Management*
 - How A Nurse Provide Spiritual Care
 - Support For The Family – During Wake and Bereavement Time
 - Supporting Dignified Dying in the Philippines by A. Doorenbos, C. Abaquin, et al
 - A, B, C, & D of Dignity of Conserving Care by Dr. Chocchinov (20)
- This work focused on: A – Attitude of care providers; B – Behaviors associated with care; C – Compassion; D – Dialogue

Applications of Biblical and Moral Bases of Christian Ethics to Nursing and Healthcare

Fr. Joseph Walter M. Villamiel, BSN’92, MA’98, STB, STL-MA
Resident Chaplain and Formator
Notre Dame de Vie (NDV) Center of Solitude for Asia

Learning Objectives:

At the end of the session, the participants will be able to

- Identify the scriptural or biblical foundational references of some well-known principles of bioethics
- Explain the connection between common bioethical principles and the basic tenets of Christian Ethics and/or Catholic moral teaching
- Recognize the application of the principles of Christian/Catholic morality to contemporary bioethical issues (*confronting nurse-practitioners today*)

Abstract:

The *genesis* of professional nursing is historically inseparable from Christianity. The medieval nurses were religious women dedicated to the application of the corporal works of mercy taught in the Scriptures (Matthew 25:35-40) by Jesus, the Divine Healer. For believers, this Jesus, “*the Way, the Truth and the Life*,” (John 14:6) fulfills the Old and the New Testament, embodying both the Ten Commandments and the Beatitudes leading to eternal life. Thus, any “life ethics” essentially traces its roots in the Bible. From the creation accounts (Genesis) and the divine law (*Exodus and Deuteronomy*), to the prayers in the *Psalms* and the oracles of the Prophets, to the Gospel narratives and St. Paul’s letters, we find the building blocks of fundamental bioethical principles relevant to nursing *praxis*: **beneficence, nonmaleficence, justice, autonomy, (free and) informed consent, “double effect”, legitimate cooperation...**

In our rapidly evolving digital society - - driven by materialism, relativism and individualism - - a nurse practitioner confronted with issues such as **patients’ rights, “reproductive technologies,” researches involving human subjects, “end-of-life” care**, etc., can still make bioethically-sound decisions, by finding an ever-dependable guide in Catholic moral doctrine on **conscience, natural law, dignity of person, sanctity/inviolability of human life, totality/holism, stewardship, solidarity, subsidiarity, common good**.

WHY HOSPICE? WHY NOW?

Finnette Castaneda, BSN, RN, PHN
Home Health, Hospice and Palliative Care Nurse
Kaiser Permanente, Panorama City Medical Center, CA

Learning Objectives:

- The participant will identify the different requirements for patients to qualify for hospice care in their disease spectrum.
- The participant will be able to identify eligibility and payment, hospice goals of care, levels of care, benefit period, and the practical benefits of the hospice program.

Abstract:

Hospice is a Medicare funded program offered to Medicare patients with Part A benefits. It is also covered by most health insurance companies, also known as HMOs (Health Maintenance Organizations).

A person is deemed hospice appropriate if their physician documents their Certification of Terminal Illness with a prognosis of 6 months or less if the disease runs its normal course. Most common diseases are:

1. Terminal cancer that is not cured by regular treatment (chemotherapy, radiation, and surgery) with Palliative Performance Scale of less than 70%
2. Congestive Heart Failure with Ejection Fraction of 20% or less, symptomatic despite optimal treatment
3. End Stage Renal Disease discontinuing or not starting dialysis
4. End Stage Liver Disease
5. Stroke and/or Coma with poor nutritional support
6. Progressive ALS with life threatening complications
7. Symptomatic Respiratory Failure with decreased functional capacity
8. Alzheimer's; Lewy Body Dementia – FAST 7 (Functional Assessment Staging for Dementia)
9. End Stage AIDS – not seen in the past 15 years

Common misconceptions of hospice encountered through the years:

1. "Oh, no! I don't want to go to a hospice!" It is NOT necessarily a PLACE where people die --- although some hospice agencies provide a hospice home for their clients.
2. "Grandma is 95 years old. She needs to be on hospice!" It is NOT just because of old age. We had a patient from 104 to 107 years old off and on hospice.
3. "We have had your insurance since 1950!" Health insurance is not an investment plan.
4. "My mom needs a caregiver so she needs hospice." Hospice benefits do not cover caregivers but some agencies provide caregiver relief.

The benefit period covers an initial 90 days, a subsequent 90 day period (totaling 6 months), then a face to face physician encounter is needed for every subsequent 60 day period which is indefinite but needs very meticulous documentation of decline.

Covered benefits include: free medicines related to the terminal illness even delivered to the home, most dme are free, home visits of team members including but not limited to the physician, nurse, social worker, spiritual counselor if desired, as the interdisciplinary team plus home health aide (as the most popular team member), volunteer services, physical therapy, occupational therapy and dietary consult.

The goal of hospice care must be aligned to the patient and family's goal of comfort care instead of curative care which includes management of symptoms such as pain, constipation, shortness of breath, nausea and vomiting, home safety, and emotional and spiritual distress. This care is provided in the patient's home, assisted living facility, board and care, or skilled nursing facility within the service area of the hospice agency. It means that calling 911 for emergency services related to the primary diagnosis may mean revoking hospice benefits for the duration of the benefit period. The hospice agency is available for the patient 24 hours per day for triage calls and even visits at night as needed for symptom management issues or pronouncement visits.

There are different levels of care available for the hospice patient:

1. Routine home care – care and visits are provided in their place of residence
2. Respite – short term inpatient care when necessary to give families and caregivers a break/respite (in our agency, up to 5 days in a contracted skilled nursing facility including transportation and medications)
3. Inpatient Care – short term symptom management outside of the patient's home either in the hospital but most of the time in a contracted skilled nursing facility to stabilize acute or chronic symptoms out of control
3. Continuous care – symptom management in the patient's place of residence for periods of 8 to 24 hours a day during a crisis period – not just because the patient needs a caregiver. This care consists mostly of nursing care but may also include aide services and other disciplines.

POLST (Physician Orders for Life-Sustaining Treatment) is discussed with the patient and family during the course of visits to ensure that the patient's desires are respected. Patient does not have to have a DNR but education is key for complete understanding of what full code entails.

Rights and responsibilities: Patients have a right to choose their hospice doctor, including the hospice agency that is Medicare certified, that will provide their care. They may also decide to change agencies once during each benefit period. They have the right to revoke hospice should they desire curative treatment or change their minds. They may also be discharged if they are no longer terminally ill by showing signs of improvement or stabilization of disease.

The patient is the driver of his own care plan, our favorite homework back in nursing school. The team adjusts the care plan accordingly as he progresses towards set goals, as problems are resolved, and barriers to learning are overcome.

LEGAL IMPLICATIONS OF HEALTHCARE DECISIONS and DOCUMENTING ONE'S FINAL WISHES

Gary L. Fales, Esq.
The Law Offices of Gary L. Fales and Associates
Las Vegas, Nevada

Learning objective: Proper use of Advance Directives and communicating with incapacitated patients

End of Life Option Act

Maidaflor Rana-Maybir, BSN, MSN, RN, CCRN
St. Francis Medical Center, Lynwood, CA

Learning Objectives:

- Participants will have a broader understanding of EOLO Act from its description and mandated legal requirements
- Through a brief historical background, learners will discern similarities and differences between state enacted laws

Abstract:

According to Benjamin Franklin, nothing in this world is certain except death and taxes. One cannot get away from both of these in one's lifetime. Americans value their freedom of choice in almost all aspects of their lives. They savor options ranging from a simple decision such as where or what to eat to a more complicated dilemma of dealing with death. Progressive technological advancements with immediate gratification leaves very little room for anguish, hardship, or discomfort. Pain cannot be tolerated and afflictions from serious illnesses are unheard of. Discomfort from all these suffering brought about the End of Life Option Act (EOLOA) or SB 128 movement. This act is also known as Death with Dignity, Coalition for Compassionate Care or Physician Assisted Suicide. Important facts and a brief history will be presented about this bill and its cohorts. As a mindboggling treat, some discussions of bioethical considerations and position statements will be included.

How Nurses Can Uphold The Dignity of Life

Rev. William J.M. Kenny
Founding Pastor
Holy Spirit Catholic Church, Las Vegas

Learning Objectives:

At the end of the session the participants will:

- Gain knowledge and understanding of the sanctity of life from conception to natural death
- Incorporate this knowledge in providing care to the critically ill and the dying

Outline

1. Catholic Teaching on Pro-Life and Medical Issues
 - a. Papal Pronouncements
 - b. United States Conference of Catholic Bishops (USCCB) Documents
2. Specific Topics
 - a. Birth Control
 - i. Artificial Contraception
 - ii. Natural Family Planning (NFP)
 - b. In Vitro Fertilization
 - c. Surrogate Motherhood
 - d. Sperm Bank
 - e. Life of mother vs. Life of child
 - f. Abortion
 - g. Euthanasia
 - h. Death with Dignity
3. Questions

Trauma and Resilience Among Filipino American Women: Challenges and Ethical Issues

Andrew Thomas Reyes, PhD, MSN, RN
Associate Professor
UNLV School of Nursing

Learning Objectives:

- To discuss the results and implications of a study about resilience and posttraumatic stress among Filipino American women.
- To explore the challenges and ethical issues related to conducting research about trauma and resilience among Filipino American women

Abstract:

This presentation is about a study on the resilience and posttraumatic stress among Filipino American women (FAW). This study aimed to determine the potential mediating effect of resilience on the relationship between type of traumatic exposure and posttraumatic stress disorder (PTSD) symptoms of FAW. The study had a total of 188 participants residing within the Las Vegas, Nevada area. Participants completed a paper-and-pencil survey of the following: PTSD Checklist for DSM-5, Connor-Davidson Resilience Scale, and the Brief Betrayal Trauma Survey. Participants reported high levels of resilience and low levels of PTSD symptom severity. Non-interpersonal trauma (as opposed to traumas caused by perpetrators with whom the victims had close relationships with) occurring after the age of 18 years was the most common form of traumatic exposure. We did not find a direct relationship between type of trauma and resilience in any of the models, but we did find consistently significant, negative relationships between resilience and PTSD, and positive relationships between type of trauma and PTSD symptoms. Findings imply that resilience is an important factor when examining traumatic exposures and posttraumatic stress responses among FAWs. Challenges and ethical issues about conducting research on the psychological trauma of FAW will be discussed.

**CONFRONTING THE MODERN DAY CHALLENGE OF BIOETHICS AND
OTHER CRITICAL HEALTH CARE ISSUES”**

August 3, 2018

Treasure Island, 3300 S Las Vegas Blvd., 89109 Vegas, NV

*The Current Challenges Of Bioethics & Other
Critical Health Care Issues In Hospice Palliative
Care: A Philippine Perspective”*



CARMENCITA M. ABAQUIN, RN, PhD

OBJECTIVES

At the end of the session, you will be able to:

- Discuss the developments and challenges of hospice and palliative care in the Philippines
- Describe how is human dignity maintained at the end of life?

I. Developments Of Hospice & Palliative Care In The Philippines

1. Historical Development of Hospice Palliative Care

Date	Event
1989	Supportive, Palliative and Hospice Care initiative: UP-PGH
1991	Phil. Cancer Society opens first home care programme
1994	Phil. Cancer Society initiates training in association with Dr. Jo Magno
	Madre de Amor Hospice Foundation established
	Ayala Alabang Hospice Care Foundation established
	Hospice Program opens in Makati Medical Centre
	Phil Children's Centre begins Hospice Programme
1995	First Palliative Care Symposium held by PCS and DOH: Dr. Jo Magno Speaker
	Manual published in English and Filipino by PCS
1997	Central Luzon Pain Management & Hospice Care Centre opens, Olongapo
	Hospice Care Programme established at UST
	Hospice & Family Care Foundation of the Phil. Established, Iloilo
	Munting Paraiso opens: UP-PGH
	Hospice Care Programme established: Western Visayas Medical Centre
	Palliative Care Service begins in the Eduardo I. Aboitz Cancer Centre, RAEI

I. Developments Of Hospice & Palliative Care In The Philippines

Historical Development of Hospice Palliative Care

Date	Event
1999	Cannossian Sisters of Charity include Hospice Care in Community Programmes: Mindanao
	Buena Vista Verde Caring Centre opens: Perpetual Socorro Hospital, Cebu City
2001	Quezon-Lucena Cancer Society HHP opens
	Starfish Programme opens: San Lazaro Hospital, Manila
2002	Palcare Volunteer Group formed
	NHPCCP launched, late re-named Hospice Philippines
2007	Hospice Halfway House opened in Bulacan by PALCARE in partnership with JIREH
	Palliative Care service opens at FEU-NRMF
	Palliative Care service opens at The Medical City, Pasig
	MoH proposed free standing hospice facility in Davao at a cost of half a billion pesos
2008	Hospice Philippine forms 5 subgroups

108 hospice and palliative care services
34 organizations

I. Developments Of Hospice & Palliative Care In The Philippines

Hospice Palliative Care Development

2. Hospice care activity

- | | |
|--------------------------|---------------------------|
| ➤ Referrals | ➤ Counselling |
| ➤ Out Patient Department | ➤ Psychosocial activities |
| ➤ Home visits | |

3. Perception of 'hospice' and 'palliative care' in the Philippines

- *'Palliative care' has a sharp focus on pain control – reflecting its historical links with the Pain Society of the Philippines*
- *'Hospice care' has a strong association with dying and support for the bereaved*

4. National & Professional Associations:

- *Hospice Philippines (formerly known as National Hospice & Palliative Care Council of the Philippine (NHPCCP) - launched 2004; with 16 founding organizations & 81 individual members; Oct. 2007 – 24 organizations*
- *Pain Society of the Philippines – organized mid 1980s.*
- *Asia Pacific Hospice Palliative Care Network (APHN) –*

I. Developments Of Hospice & Palliative Care In The Philippines

Hospice Palliative Care Development

5. Education Training programs for hospice' and 'palliative care':

- 1st Congress of the Association of Southeast Pain Societies (ASEAPS) in Manila Nov. 29-Dec 2, 2006, hosted by Pain Society of the Philippines
- 7th Asia Pacific Hospice Conference (APHN) Sept. 2007 hosted by Hospice Philippines
- APHN Diploma in Palliative Care/Graduate Certificate in Health (Palliative Care) Flinders University, Adelaide –
- Medical School curricula – hospice approach intro. to the Phil. 1989 incorp. into family medicine at UP-PGH; 2000 offered fellowship in hospice palliative care
- FEU-NRMF – 2007 hospice palliative care added top curriculum
- Hospital based training program – the Starfish project – San Lázaro Hospital for infectious Diseases 2002. 2005. PCS with Dr Jo Magno
- Nursing Curriculum – BSN – Concepts – Roles & responsibilities of the Nurse, Hospice Palliative Care, End of Life Care, Dying with Dignity, Communication. Comfort, Safety and Privacy Needs. etc

I. Developments Of Hospice & Palliative Care In The Philippines

Hospice Palliative Care Development

6. A feature of Filipino Culture is its strong religious tradition. 90% of the population claim to be Christians – mostly Roman Catholic – and this perspective is integrated into the country's public life, social networks and personal spiritualities.

- *Meetings begin with prayer*
- *Festivals demonstrate the tenets of faith*
- *Ceremonies, rituals, novenas, and devotions point to a distinct relationship between the secular and the divine.*

7. Focus of Basic Training Program

- | | |
|---|--|
| ➤ <i>Principles & practice of palliative care</i> | ➤ <i>How to start your hospice visit</i> |
| ➤ <i>Symptom control</i> | ➤ <i>Preparation of the dying patient & family</i> |
| ➤ <i>Pain</i> | ➤ <i>Grief and bereavement</i> |
| ➤ <i>Ethics</i> | |

I. Developments Of Hospice & Palliative Care In The Philippines

B. Challenges/Issues in Hospice Palliative Care

1. Palliative Care and Society

- | | |
|--|---|
| ➤ <i>The RP - a resource constrained country</i> | ➤ <i>Provision is problematic in remote areas & patchy throughout the archipelago</i> |
| ➤ <i>Lack of Public Awareness</i> | |

2. The Health Care Community

- | | |
|--|---|
| ➤ <i>Lack of Training of medical & nursing staff</i> | ➤ <i>Low number of doctors with S2 licences (essential to prescribe morphine)</i> |
| ➤ <i>Low credibility / interest in palliative care</i> | ➤ <i>Unwillingness of doctors to refer patients</i> |

3. Government

- | | |
|--|---|
| <i>Lack of political will to support palliative care</i> | <i>No government stream for hospice funding</i> |
|--|---|

4. Service Provision

- | | |
|---|---|
| ➤ <i>Maintaining a pool of trained & available volunteers</i> | ➤ <i>Procuring drugs, equipment & materials</i> |
| ➤ <i>Securing administrative support</i> | ➤ <i>Training</i> |
| ➤ <i>Funding</i> | ➤ <i>Becoming over attached to patients particularly children</i> |

I. Developments Of Hospice & Palliative Care In The Philippines

II. Bioethical & Critical Health Care Challenges In Hospice & Palliative Care Dev. In The Philippines

- Importance of Bioethics in medical decision making and research
- Principles of Bioethics

- “Respect For Autonomy” ,
- Beneficence (Doing Good For The Patient),
- Nonmaleficence (Not Harming)
- Justice.

Questions: Which of these principles takes precedence?

- What are some of these ethical issues surrounding end of life care?

- withholding and withdrawing of treatment (life support),
- terminal sedation,
- determination of death,
- DNR (“do not resuscitate”) orders,

- artificial nutrition and hydration (“ feeding tubes”),
- euthanasia,
- assisted suicide,
- the availability & opportunities associated with palliative & hospice care.

I. Developments Of Hospice & Palliative Care In The Philippines

II. Bioethical & Critical Health Care Challenges In Hospice & Palliative Care Development In The Philippines

- Ethical issues / dilemmas in end of life care are not only medical or science but social, legal, religious and cultural.
- **Example:** *When cultural or religious beliefs conflict with recommended care – what will you do as a nurse? You or your patient are distressed over decisions made. Families are uncertain about who should make decisions if the patient is unable to do so?*
- **Guide:** Family member should put aside their self-interest and judge the situation and come to a decision in the patient's best interest
- Advance Directives and Surrogate decision making (Recommendations on how the surrogate decision maker should proceed)
 - Follow /base the decision on strongly consider - patient's recorded preferences (**advance directives**)
 - If no directives are available – apply the patient's own preferences and values (**substituted judgments**)
 - If patient's preferences and values are not known – choose the most reasonable choice which is in accord with the patient's best interest (**best interest standard**)

I. Developments Of Hospice & Palliative Care In The Philippines

II. Bioethical & Critical Health Care Challenges In Hospice & Palliative Care Dev. In The Philippines

- Importance of Bioethics in medical decision making and research
- Principles of Bioethics

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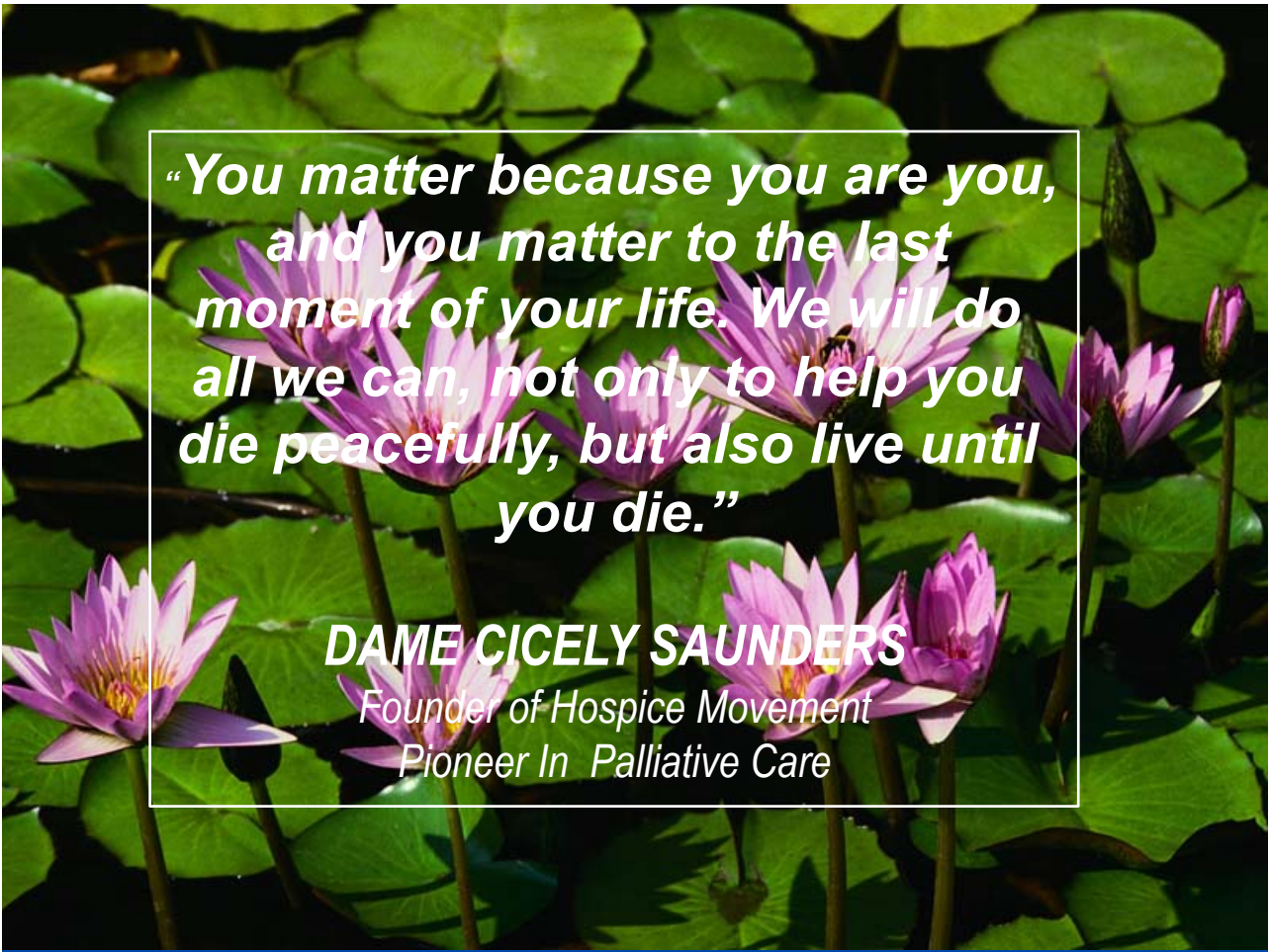
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- assisted suicide,
- the availability & opportunities associated with palliative & hospice care.

I. Developments Of Hospice & Palliative Care In The Philippines

II. Bioethical & Critical Health Care Challenges In Hospice & Palliative Care Development In The Philippines

- **DISCLAIMER** – The SHPM DOES NOT advocate Euthanasia. Its advocacy is congruent with those of major religious and ethic groups in the country.
- Everyone has the right to request and receive appropriate palliative care interventions to relieve suffering. But Euthanasia is not palliative care,
- **TERMINAL PAIN AND THE PRINCIPLE OF DOUBLE EFFECT**
- An act having both foreseen good and bad (harmful) effects is justifiable if... Intention... Means to achieve the good effect



***“You matter because you are you,
and you matter to the last
moment of your life. We will do
all we can, not only to help you
die peacefully, but also live until
you die.”***

DAME CICELY SAUNDERS

Founder of Hospice Movement

Pioneer In Palliative Care

III. Basis For Meaning Of Dignified Dying

- Man is created in the image of God
- Core Value – Respect for the dignity of each person regardless of color, race, creed, gender, religious and political affiliation, type and stage of illness.
- Universal Declaration of Human Rights – states that all human beings are born free and equal in dignity and rights
- Dignity appears as a duty and a right in professional codes and human right framework

III. How Human Dignity Is Maintained - FGD Results

- Human dignity is maintained when patient:
 - *is comfortable and clean*
 - *physical, psychological and spiritual needs are met*
 - *participates in making significant decisions regarding management of illness*
 - *can focus on his/her unfinished business*
 - *love ones are around attending to his/her needs*
 - *has open communication to express his concerns/ plans/wishes*
 - *has good and healthy family relationships*
 - *is at peace with God*

III. How Nurse Provide Spiritual Care – FGD Result

- Call the priest/ minister who will administer the following:
 - > sacrament of reconciliation; > sacrament of communion or
 - > sacrament of the sick > rituals for the dying
- Facilitate pastoral care services.
- Praying & singing religious songs with patient & family
- Being with the patient – presence to provide support is many times enough to instill hope
- Therapeutic touch may also be used
- Therapeutic use of self – encourage the patient to express his/her unfinished business. This involves skills such as listening, empathy, humility, and commitment.

Abaquin, Carmencita M. and Balabagno, Araceli O. "Focus Group Discussion on the Role of the Nurse in Promoting Dignity of Dying" 2007

III. Perceptions of Dying and Death Among Adult Filipino Patients With Terminal Cancer: *Implications for Nursing Management*

- Explored the phenomenon of dying and death as experienced by cancer patients, their caregivers and nurses.
- It aimed to arrive at a more responsive nursing approach towards helping patients have peaceful death and quality care.
- **Findings :**
 - Nurses perceived terminal cancer as a state of helplessness and powerlessness of patients.
 - Patients and caregivers described two (2) important aspects towards acceptance of peaceful death:
 - *the presence of family support & acceptance that the family feels the burden of the patient,*
 - *relates to their belief in GOD, and dying as a time to surrender self.*

III. Perceptions Of Dying & Death Among Adult Filipino Patients With Terminal Cancer: Implications For Nursing Management Cont.

■ Findings Cont:

Nurses have similarity in their perception with that of patients and family as derived from the cues given on acceptance of death.

Nurses observed the following cues of the patients' acceptance of death:

- *having their children and family at the bedside in near-death situation,*
- *expressions of freedom from pain, reunion with their deceased loved-ones, and being able to entrust their soul to God.*

III. Support For The Family – During Wake & Bereavement Time FGD Result

- Expressed availability of nurse when needed
- Presence – use of active listening, therapeutic communication, appropriate use of touch
- Condoling with the bereaved family during the wake,
- Joining family in prayer for the 9 days novena after the death and on the 40th day after death; necrological service
- Offer masses & prayers for the eternal repose of the soul of the dead
- Call or visit during bereavement phase
- Symbolic practices during bereavement camps :
 - Releasing of balloons during the burial
 - Writing wishes for dead relative and attaching them to a paper boat and together these are released in the river or body of water

Abaquin, Carmencita M. and Balabagno, Araceli O. "Focus Group Discussion on the Role of the Nurse in Promoting Dignity of Dying" 2007

III. Supporting Dignified Dying in the Philippines

by A. Doorenbos, C. Abaquin, M. Perrin, L. Eaton, A. Balabagno, T. Rue, R. Ramos

- **Purpose:** This study aimed to assess appropriateness of the International Classification for Nursing Practice (ICNP) catalogue *Palliative Care for Dignified Dying* for nursing interventions in the Philippines
- **Methods:** The study recruited 230 nurses to complete the ICNP Dignified Dying survey. Participants rated ICNP nursing interventions items and identified additional interventions for promoting dignified dying.
- **Results:** All of the Interventions were scored on average as being at least “slightly important. The three top-ranked nursing interventions categories were providing **social support, maintaining privacy boundaries and relieving psychological distress.**
- The Nursing Interventions utilized in the Philippines were in accord with the Dignity-Conserving Care Model, representing each of the three major categories of the model: **illness-related concerns, dignity conserving repertoire and social dignity inventory**

III. A, B, C, & D of Dignity Conserving Care

Dr. Chochinov

- **A – is for ATTITUDE** of care providers & their need to examine their assumptions towards patients, the aged, the homeless, those with addictions etc. This can influence how one is assessed and cared for.
- **B – looks at BEHAVIOURS** associated with care especially in light of these attitudes. Actions must always be based on kindness and respect.
- **C – explores the notion of COMPASSION** and encourages providers to be in touch with their own feelings. Compassion refers to a deep awareness of the suffering of another, coupled with the wish to relieve it.
- **D – refers to DIALOGUE:** getting to know the person & who they are, acknowledging the dignity and uniqueness of the person beyond the illness itself, and recognizing the emotional impact that accompanies their illness.





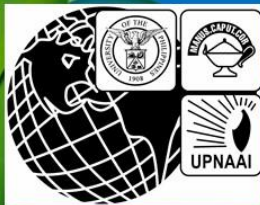
“ I say to people who care for people who are dying: “ If you really love that person and want to help them, be with them when their end comes. You don’t have to do anything, but really be there with them.”

**ELIZABETH KUBLER-ROSS
ON DEATH AND DYING**

THANK YOU FOR LISTENING

Applications of Biblical and Moral Bases of Christian Ethics to Nursing and Healthcare

"Confronting the Modern-day Challenge of Bioethical and other Critical Health Care Issues"



39th UPNAAI Convention
03 August 2018, Las Vegas NV

Rev. Fr. Joseph Walter M. VILLAMIEL
BSN'92, MA'98, STB, STL-MA (c)
Institut Notre-Dame de Vie



Matthew 25:31-46 (works of mercy)



...He will place the **sheep on his right** and the goats on his left. Then the king will say to those on his right, 'Come, **you who are blessed by my Father**. Inherit the kingdom prepared for you from the foundation of the world.

For I was hungry and you gave me food, I was thirsty and you gave me drink, a stranger and you welcomed me, naked and you clothed me, ILL and you CARED for me, in prison and you visited me.'

Then the righteous will answer him and say, 'Lord, when did we see you hungry and feed you, or thirsty and give you drink? When did we see you a stranger and welcome you, or naked and clothe you? When did we see you ill or in prison, and visit you?

'And the king will say to them in reply, **'AMEN, I SAY TO YOU, WHATEVER YOU DID FOR ONE OF THESE LEAST BROTHERS OF MINE, YOU DID FOR ME.'**

In the beginning...

Genesis 1

(HUMAN DIGNITY, stewardship, complementarity, fecundity, EXCELLENCE)

1...when God created the heavens and the earth...

25 God saw how good it was...

26 Then God said: "**Let US make man in OUR image, after OUR likeness. Let them have DOMINION** over the fish of the sea, the birds of the air...over all the creatures ..."

27 God created man in his image; in the divine image he created him; **male and female** he created them.

28 God BLESSED them, saying: "**Be FERTILE and multiply**; fill the earth and subdue it. **Have DOMINION** over the fish of the sea, the birds of the air, and all the living things ...

31 God looked at everything he had made, and **he found it VERY GOOD.**

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3



Judeo-
Christian
account

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Five Main Natural Inclinations/Needs of Human Beings (NATURAL LAW*):

1. To **DO GOOD** and to **AVOID EVIL** (first principles of **practical reason**, fundamental in moral life, inseparable from the **desire for happiness**: **beneficence, nonmaleficence** / "do no harm")
2. To **PRESERVE one's LIFE /BEING** and to avoid death (fundamental **existence**)
3. To **PROCREATE**: sexual union between male and female, and the rearing of offspring (power to **transmit life** by the exercise of one's sexuality)
4. To **KNOW THE TRUTH** about God and the world (the yearning for **truth as the proper object of the intellect**)
5. To **LIVE IN SOCIETY** to satisfy the necessities of life (from our awareness of the other and of the good, engendering the **desire for communication and relationships**)



St. Thomas Aquinas
(*Summa Theologiae*
I-II, 94, 2; II-II, 141, 6)

* "NATURAL" *not because it's automatic in nature (biologism or physicalism) but because the REASON which reflects on nature is natural to man (VS 42-43) ... Yet it's not always recognized by everyone!*⁴

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« May the God of peace Himself make you perfectly holy and may you entirely, **spirit** (*pneuma*), **soul** (*psuché*), and **body** (*soma*), be preserved blameless for the coming of our Lord Jesus Christ. » (1 Thessalonians 5:23)



Judeo-Christian Anthropology:

TRIPARTITE STRUCTURAL UNITY of the “**THREE LIVES**” of the human person :

- physical/animal
- psychical/psychological
- spiritual

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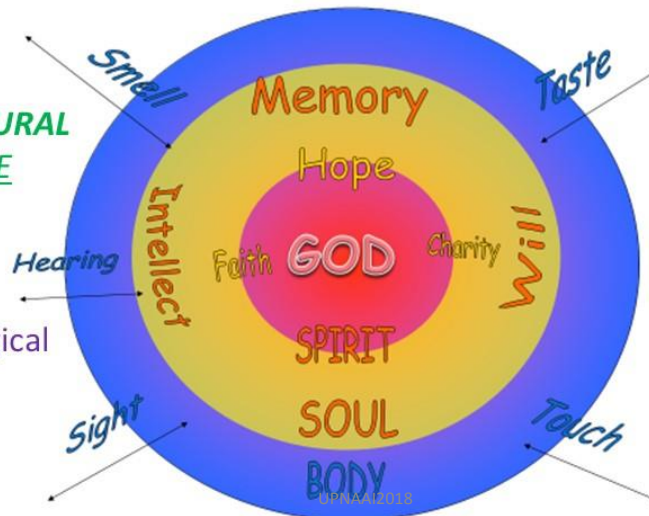
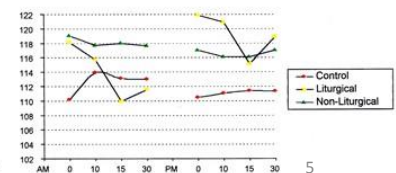
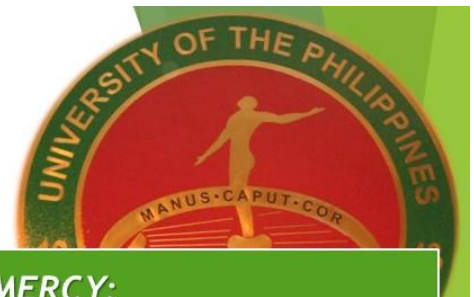


Figure 15.
MEAN SBP PATTERN OF SUBJECTS (in mmHg)



Later diverse expressions
(cultural, religious, scientific) of this
STRUCTURAL UNITY of the HUMAN PERSON
(Principle of Integrity, Totality, Holism)



3 Dimensions of the Filipino experience of MERCY:
“AWA” (**compassion**), “unAWA” (**understanding**), “gAWA” (**action**)

“This is the challenge that life offers you: to **LEARN HOW TO LOVE**. Not just to accumulate information For this the GOSPEL offers us a serene way forward: using the **three languages of the MIND, HEART AND HANDS** - and to use them in harmony...” (Pope Francis, Manila 2015)

Fundamental affirmation in the health sciences:
“Man or the human person is a **BIO-PSYCHOSOCIO-SPIRITUAL** being.”
“Holistic competence in the areas of **SKILLS, KNOWLEDGE, ATTITUDE.**”

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6



What is CONSCIENCE?



In the **depths of his heart**, man **detects a LAW** which he **does not impose upon himself**, but which **holds him to obedience**.

Always summoning him to **LOVE GOOD** and **AVOID EVIL**, the voice of conscience when necessary speaks to his heart: **do this, shun that**.

For man has **in his heart a law written by God**; to obey it is the very **DIGNITY of man**; according to it he will be judged.

Conscience is the **most SECRET CORE** and **SANCTUARY** of a man.

There he is alone with **God**, whose voice echoes in his depths...

(Gaudium et Spes no. 16, Vatican II)



“CONSCIENCE is a **judgment of REASON** whereby the human person **recognizes the moral quality of a concrete act** that he is going to perform, is in the process of performing, or has already **completed**.”

(Catechism of the Catholic Church 1778)



What are the **sources** of the morality of human acts?

the **OBJECT** chosen

- either a true or apparent good

the **INTENTION** of the subject who acts

- the purpose for which the subject performs the act

the **CIRCUMSTANCES** of the act

- include its consequences

- ✓ An ACT is **morally good** when it assumes **simultaneously** the goodness of the object, of the end, and of the circumstances.
- ✓ A **chosen object** can by itself vitiate an act in its entirety, even if the intention is good.
- ✓ **Circumstances** can increase or diminish the responsibility of the one who is acting but they cannot change the moral quality of the acts themselves. They never make good an act which is in itself evil.



The *DECALOGUE* (“Ten Words”) of Life



Exodus 20:2-17 (“Divinely revealed Law”)	Deuteronomy 5:6-21	CHARTER OF HUMAN RIGHTS AND FREEDOM
I am the LORD your God, who brought you out of the land of Egypt, out of the house of bondage. YOU SHALL HAVE NO OTHER GODS BEFORE ME. You shall not make for yourself a graven image, or any likeness of anything that is in heaven above, or that is in the earth beneath, or that is in the water under the earth; you shall not bow down to them or serve them; for I the LORD your God am a jealous God, visiting the iniquity of the fathers upon the children to the third and the fourth generation of those who hate me, but showing steadfast love to thousands of those who love me and keep my commandments. YOU SHALL NOT TAKE THE NAME OF THE LORD YOUR GOD IN VAIN; for the LORD will not hold him guiltless who takes his name in vain.	I am the LORD your God, who brought you out of the land of Egypt, out of the house of bondage. You shall have no other gods before me... You shall not take the name of the LORD your God in vain:...	1. the right to a religious rapport with God (FREEDOM OF RELIGION) 2. right to the RESPECT FOR BELIEFS and religious symbols.
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The *DECALOGUE* (“Ten Words”) of Life



Exodus 20:2-17	Deuteronomy 5:6-21	“CHARTER” OF HUMAN RIGHTS AND FREEDOM
REMEMBER THE SABBATH DAY, TO KEEP IT HOLY. Six days you shall labor, and do all your work; but the seventh day is a sabbath to the LORD your God... for in six days the LORD made heaven and earth, the sea, and all that is in them, and rested the seventh day; therefore the LORD blessed the sabbath day and hallowed it.	Observe the sabbath day, to keep it holy...	3. the right to FREEDOM OF WORSHIP and secondly to leisure, to free time and to quality of life.
HONOR YOUR FATHER AND YOUR MOTHER, that your days may be long in the land which the LORD your God gives you.	Honor your father and your mother...	4. the RIGHT OF FAMILIES to just and protective policies, of children to support from their parents and to education and training in work and social values, the right of elderly parents to respect and to support from their children
YOU SHALL NOT KILL.	You shall not kill.	5. the RIGHT TO LIFE (to be born), to respect for life (to live and die a natural death)
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The *DECALOGUE* ("Ten Words") of Life



Exodus 20:2-17	Deuteronomy 5:6-21	"CHARTER" OF HUMAN RIGHTS AND FREEDOM
YOU SHALL NOT COMMIT ADULTERY.	Neither shall you commit adultery.	6. the RIGHT OF PERSONS to free choice of a spouse, the right of the couple to respect, encouragement and support from the state and from society at large, the right of children to stability (emotional, affective, financial) from their parents
YOU SHALL NOT STEAL.	Neither shall you steal.	7. the right to civil liberties (physical integrity, choice of life and career, FREEDOM OF MOVEMENT AND OF EXPRESSION)
YOU SHALL NOT BEAR FALSE WITNESS against your neighbor.	Neither shall you bear false witness against your neighbor.	8. the right to a good reputation, and secondly to RESPECT FOR PRIVATE LIFE AND UNBIASED (true) INFORMATION
YOU SHALL NOT COVET your neighbor's house; you shall not covet YOUR NEIGHBOR'S WIFE... or maidservant	Neither shall you covet your neighbor's wife...	9. the RIGHT TO domestic and professional SECURITY and tranquility, and further to freedom of activity
or his ox, or his ass, or ANYTHING THAT IS YOUR NEIGHBOR'S.	You shall not desire... anything that is UPNAAI2018	10. the RIGHT TO PRIVATE PROPERTY , including the certainty of civil protection of material goods. 11



This "**GOSPEL OF LIFE**" affirms at its core: relationship with the living God; **life as a gift of God**; life's **sacredness and inviolability**; the absolute unacceptability of abortion and euthanasia; the duty to protect life with loving concern; the true significance of sexuality and procreation as expressions of that giving and receiving of love which give life meaning. (*Evangelium Vitae* no. 81)



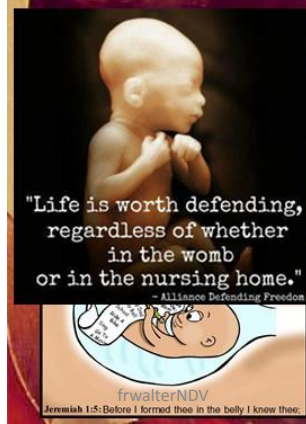
PSALM 130,1-2.13-15 "LORD...you know me: you know when I sit and stand; ... **You formed my inmost being; YOU KNIT ME IN MY MOTHER'S WOMB.** I praise you, so wonderfully you made me; ... **My very self you knew; my bones were not hidden from you, When I was being made in secret...**"



ISAIAH 49, 1-5: "Hear me, O coastlands, listen, O distant peoples. **THE LORD CALLED ME FROM BIRTH, FROM MY MOTHER'S WOMB HE GAVE ME MY NAME.** He made of me a sharp-edged sword and concealed me in the shadow of his arm. He made me a polished arrow, in his quiver he hid me. .."



JEREMIAH 1,4-8: "**BEFORE I FORMED YOU IN THE WOMB. I KNEW YOU**, before you were born I DEDICATED you, a PROPHET to the nations I APPOINTED you. ..Have no fear before them, because I AM WITH YOU to deliver you, says the LORD.



Beyond the Letters of the Law... the **SPIRIT OF LOVE!**

- 17 As he was setting out on a journey, a man ran up, knelt down before him, and asked him, **"GOOD TEACHER, WHAT MUST I DO TO INHERIT ETERNAL LIFE?"**
- 18 Jesus answered him, **"Why do you call me good? No one is good but God alone."**
- 19 You know **THE COMMANDMENTS**: ***'You shall not kill; you shall not commit adultery; you shall not steal; you shall not bear false witness; you shall not defraud; honor your father and your mother.'***
- 20 He replied and said to him, ***"Teacher, all of these I have observed from my youth."***
- 21 Jesus, **LOOKing at him, LOVED him** and said to him, **"You are lacking in one thing. Go, sell what you have, and GIVE TO THE POOR and you will have treasure in heaven; then COME, FOLLOW ME."**
- 22 At that statement his face fell, and he went away SAD, for he had many possessions.

(Mark 10:17-22 or Matthew 19:16-22)



LOVE = "gift of self"
+ **DETACHMENT**
(self-dispossession)
+ **CHARITY**
+ **DISCIPLESHIP**



What **NORMS** must **CONSCIENCE** always follow?

There are **three (3)** general norms:

- 1) one may **NEVER DO EVIL** so that good may result from it (cf. **Romans 3:8**); ***"The end does not justify the means."***
- 2) the so-called **GOLDEN RULE**: ***"Do to others whatever you would have them do to you. This is the Law and the Prophets."*** (Matthew 7:12);
- 3) **CHARITY** always proceeds by way of **respect for one's neighbor and his conscience**, even though this *does not mean accepting as good something that is objectively evil* (eg. blasphemy, homicide, adultery...)

"Knowledge inflates with pride, but love builds up." (1 Cor 8:1)

"It is good not to do anything that causes your brother to stumble."

(Rom 14:21)

(CSDC 375, CCC 1789)





Mark 8:22-26 (JESUS THE DIVINE HEALER)



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22 When they arrived at **Bethsaida**, they brought to him a **blind man** and **begged him to touch him**.

23 He **took the blind man by the hand** and **led him outside the village**. **Putting spittle on his eyes** he laid his hands on him and asked, *"Do you see anything?"*

24 Looking up he replied, *"I see people looking like trees and walking."*

25 Then he **laid hands on his eyes a second time** and he saw clearly; his sight was restored and he could see everything distinctly.

26 Then he sent him home and said, *"Do not even go into the village."*

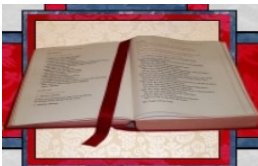
22 **THERAPEUTIC TOUCH**

23 **-SUPPORTIVE CARE**
-PRIVACY
-INCULTURATION
-VERIFICATION

24-25 **GRADUALITY**
in the
HEALING PROCESS

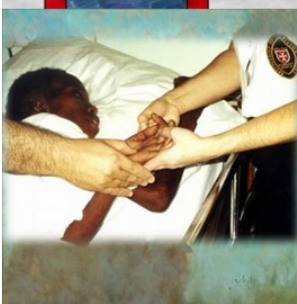
26 **-DISCHARGE INSTRUCTION**

15



Luke 18:35-43

(AUTONOMY, CONSENT, TRUST, ROLE-MODELLING)



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35 Now as he approached **Jericho** a **blind man** was **sitting by the roadside begging**,

36 and hearing a crowd going by, he inquired what was happening.

37 They told him, "Jesus of Nazareth is passing by."

38 He shouted, *"Jesus, Son of David, have pity on me!"*

39 The **people walking in front rebuked him, telling him to be silent**, but he kept calling out all the more, *"Son of David, have pity on me!"*

40 Then Jesus stopped and ordered that he be brought to him; and when he came near, Jesus asked him,

41 *"WHAT DO YOU WANT ME TO DO FOR YOU?"* He replied, *"Lord, please let me see."*

42 Jesus told him, *"Have sight; your FAITH has saved you."*

43 He immediately received his sight and followed him, giving glory to God. **When they saw this, all the people gave praise to God.**

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16



Fundamental Principles of Catholic SOCIAL Moral TEACHING



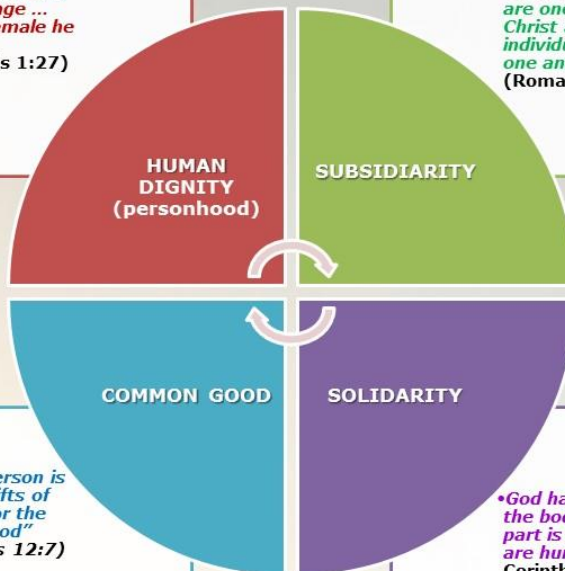
"Subhuman living conditions, arbitrary imprisonment, deportation, slavery, prostitution, trafficking, disgraceful working conditions, **where people are treated as mere tools for profit, these are infamies indeed.**" (GS 27)

• "God created us in his own image ... male and female he created us." (Genesis 1:27)



It means achieving the conditions that **make it possible for ALL** to come to their full potential as persons and to become all that God intends them to be. Simply stated, it means **"all for one, one for all"**.

• "To each person is given the gifts of the Spirit for the common good" (Corinthians 12:7)



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• "...we though many, are one body in Christ and individually parts of one another." (Romans 12: 4-5)



Every person or group in society must have the freedom and the means to do what it can best do for itself without being taken over by a higher body. **"Don't take over what others can do for themselves".**

To live in union with one another, supporting one another, committed to the good of all and each individual, **"all responsible for all."** (John Paul II: Social Concerns of the Church 38.4) **We are all our brothers and sisters' keepers as one family.**

"IMAGO DEI" = love, mercy, charity, service above self

"IMAGO DEI" = communion, compassion, care, self-oblation

"The DIVINE IMAGE is present in every man. It shines forth in the **COMMUNION OF PERSONS**, in the likeness of the **UNITY** of the divine persons among themselves." (Catechism of the Catholic Church no. 1702)

« God created man in his own image and likeness: calling him to **existence through love**, he called him at the same time **for love... LOVE** is therefore the **FUNDAMENTAL AND INNATE VOCATION** of every human being....As an **incarnate spirit**, that is a soul which expresses itself in a body and a body informed by an immortal spirit, **man is CALLED TO LOVE in his unified TOTALITY** ... the **BODY** is made a sharer in **SPIRITUAL LOVE**. » (Familiaris Consortio no. 11)

"What does it matter if I am washing-up, cleaning the stairs or philosophizing? Only one thing matters: CHARITY." – Bl. Fr. Marie-Eugene





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Contemporary CHALLENGES to BIOETHICS and HEALTH CARE VOCATION



1.



"CULTURE OF DEATH"



2.



"TYRANNY OF RELATIVISM"

3.



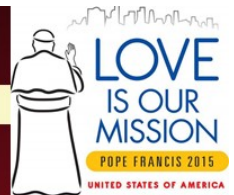
"GLOBALIZATION OF INDIFFERENCE"

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BIOETHICS: UNIVERSAL CALL TO SANCTITY



"BE MERCIFUL, just as also your Father is merciful."

Luke 6:36



"...BE PERFECT, just as your heavenly Father is perfect."

Matthew 5:48



"BE HOLY, for I, the LORD your God, am holy."

Leviticus 19:2b/20:7/11:44.45

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20

WHY HOSPICE? WHY NOW?

By: Finnette Castaneda, RN, BSN, PHN
RN Case Manager

***MAKE EVERYDAY A BONUS DAY...
It is a blessing from God!***

This is a change in perspective:
instead of waiting for “THE day,”
it is: LIVE UNTIL “THE day!”



Learning Objectives:

- ▶ The participant will identify the different requirements for patients to qualify for hospice care in their disease spectrum.
- ▶ The participant will be able to identify eligibility and payment, hospice goals of care, levels of care, benefit period, and the practical benefits of the hospice program.



What is HOSPICE?

Hospice is a PROGRAM... not a PLACE.

Most *common* diseases are:

- ▶ Terminal cancer that is not cured by regular treatment (chemotherapy, radiation and surgery) with Palliative Performance Scale of less than 70%
- ▶ Congestive Heart Failure with Ejection Fraction of 20% or less, symptomatic despite optimal treatment
- ▶ End Stage Renal Disease discontinuing or not starting dialysis
- ▶ End Stage Liver Disease
- ▶ Stroke and/or Coma with poor nutritional support
- ▶ Progressive ALS with life threatening complications
- ▶ Symptomatic Respiratory Failure with decreased functional capacity
- ▶ Alzheimer's; Lewy Body Dementia - FAST 7 (Functional Assessment Staging for Dementia)
- ▶ End Stage AIDS



Hospice Eligibility Guidelines:

GENERAL (NON-SPECIFIC) TERMINAL ILLNESS:

- ▶ Terminal illness with expected prognosis of 6 months or less.
- ▶ Documented clinical progression of disease = may have multiple admissions to ED, inpt. Hospitalizations, or Home Health visits; decline in s/sx and test results
- ▶ Palliative Performance Scale (**PPS**) score is **<60%**, cancer patients may have a higher performance score.
- ▶ Involuntary **weight loss >10%** and/or Albumin <2.5 (helpful)
- ▶ Patient is receiving supportive care. Treatments are palliative or comfort oriented = may receive IVs, NGTs, TPN, transfusions or radiotherapy if required for comfort or improve functional level.
- ▶ **Patient** accepts hospice care.



CANCER - done w/ surgery, chemo, radiation (for other agencies)

Patient meets ALL of the following:

1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing sx, lab values and/or evidence of metastatic disease

2. Palliative performance Scale (PPS) $\leq$ 70%

Supporting documentation includes:

Hypercalcemia $>$ 12

Cachexia or weight loss of 5% in past 3 months

Recurrent disease after surgery/radiation/chemotherapy

Signs and sx of advanced disease (e.g. nausea, requirement for transfusions, malignant ascites or pleural effusion, etc.)

ADULT FAILURE TO THRIVE - old age?

- ▶ Patient meets ALL of the following:
- ▶ Palliative performance Scale $\leq$ 40%
- ▶ BMI $<$ 22
- ▶ Pt refusing enteral or parenteral nutrition support or has not responded to such nutritional support, despite adequate caloric intake

RENAL FAILURE - stopping or not starting dialysis
The patient has 1, 2, and 3.

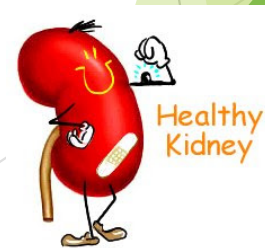
1. The pat is **not seeking dialysis** or renal transplant
AND

2. Creatinine clearance* is $<$ 10 cc/min ($<$ 15 for diabetics)
AND

3. **Serum creatinine $>$ 8.0 mg/dl** ($>$ 6.0 mg/dl for diabetics)

Supporting documentation for chronic renal failure includes: Uremia, Oliguria (urine output $<$ 400 cc in 24 hours), Intractable hyperkalemia ($>$ 7.0), Uremic pericarditis, Hepatorenal syndrome, Intractable fluid overload.

Supporting documentation for acute renal failure includes: Mechanical ventilation, Malignancy (other organ system), Chronic lung disease, Advanced cardiac disease, Advanced liver disease



DEMENTIA - walking, talking, eating?

The patient has both 1 and 2:

1. Stage 7C or beyond according to the FAST Scale

AND (FAST 7)

2. One or more of the following conditions in the 12 months:

Aspiration pneumonia

Pyelonephritis

Functional Assessment Scale (FAST):

- 1 No difficulty either subjectively or objectively.
- 2 Complains of forgetting location of objects. Subjective work difficulties.
- 3 Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
- 4 Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances, such as forgetting to pay bills, etc.)
- 5 Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised. *
- 6 Occasionally or more frequently over the past weeks. * for the following
 - A) Improperly putting on clothes without assistance or cueing .
 - B) Unable to bathe properly (not able to choose proper water temp)
 - C) Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue)
 - D) Urinary incontinence
 - E) Fecal incontinence

Septicemia

Multiple **pressure ulcers** (stage 3-4)

Recurrent Fever

Other significant condition that suggests a limited prognosis

Inability to maintain sufficient fluid and calorie intake in the past 6months (**10% weight loss** or albumin $<$ 2.5 gm/dl)

7 A) Ability to speak limited to approximately $\leq$ 6 intelligible different words in the course of an average day or in the course of an intensive interview.

B) Speech ability is limited to the use of a **single intelligible word** in an average day or in the course of an intensive interview

C) Ambulatory ability is lost (**cannot walk without personal assistance.**)

D) Cannot **sit up** without assistance (e.g., the individual will fall over if

there are not lateral rests [arms] on the chair.)

E) Loss of ability to **smile**.

F) Loss of ability to **hold up head** independently.

*Scored primarily on information obtained from a knowledgeable informant.
Psychopharmacology Bulletin, 1988 24:653-659.

HEART DISEASE - on oxygen?

The patient has 1 and either 2 or 3.

1. CHF with NYHA Class IV* sx and both :

Significant sx at rest

Inability to carry out even minimal physical activity without dyspnea or angina

2. Patient is optimally treated

(ie diuretics, vasodilators, ACEI, or hydralazine and nitrates)

3. The patient has angina pectoris at rest, resistant to standard nitrate therapy, and is either not a candidate for/or has declined invasive procedures.

Supporting documentation includes:

EF $\leq$ 20%, Treatment resistant symptomatic dysrhythmias

h/o cardiac related syncope, CVA 2/2 cardiac embolism

H/o cardiac resuscitation, concomitant HIV disease



PULMONARY DISEASE

Severe chronic lung disease as documented by 1, 2, and 3.

1. The patient has all of the following:

Disabling dyspnea at rest

Little of no response to bronchodilators

Decreased functional capacity (e.g. bed to chair existence, fatigue and cough)

AND

2. Progression of disease as evidenced by a recent h/o increasing office, home, or ED visits and/or hospitalizations for pulmonary infection and/or respiratory failure.

AND

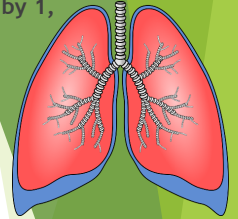
3. Documentation within the past 3 months $\geq$ 1:

Hypoxemia at rest on room air ($pO_2 < 55$ mmHg by ABG)

or **O2 sat $< 88\%$**

Hypercapnia evidenced by $pCO_2 > 50$ mmHg

Supporting documentation includes: Cor pulmonal and right heart failure Unintentional progressive weight loss



HIV/AIDS

The patient has either 1A or 1B and 2 and 3.

1A. CD4+ < 25 cells/mcL OR 1B. Viral load $> 100,000$

AND

2. At least one (1) : CNS lymphoma, untreated or refractory AND

wasting (loss of $> 33\%$ lean body mass), (MAC) bacteremia,

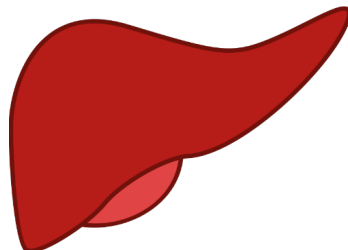
Progressive multifocal leukoencephalopathy

Systemic lymphoma , visceral KS, Renal failure no HD,

Cryptosporidium infection, Refractory toxoplasmosis

AND

3. PPS* of $< 50\%$



LIVER DISEASE

The patient has both 1 and 2.

1. End stage liver disease as demonstrated by A or B, & C:

A. PT > 5 sec OR B. INR > 1.5

C. Serum albumin < 2.5 gm / dl

AND

2. One or more of the following conditions:

Refractory Ascites, h/o spontaneous bacterial

peritonitis, Hepato-renal syndrome , refractory

hepatic encephalopathy, h/o recurrent variceal bleeding

Supporting Documents includes:

Progressive malnutrition, Muscle wasting with dec.

strength. Ongoing alcoholism (> 80 gm ethanol/day),

Hepatocellular CA HBs Ag positive, Hep. C refractory to

Treatment

NEUROLOGIC DISEASE

(chronic degenerative conditions

such as ALS, Parkinson's, Muscular Dystrophy, Myasthenia Gravis or Multiple Sclerosis)

The patient must meet at least one of the following criteria (1 or 2A or 2B):

1. Critically impaired breathing capacity, with all:

Dyspnea at rest, Vital capacity < 30%,
Need O₂ at rest,

patient refuses artificial ventilation

OR

2. Rapid disease progression with either A or B below:

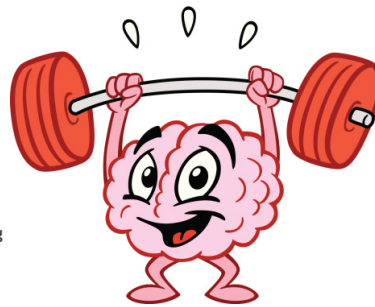
Progression from :

independent ambulation to **wheelchair or bed-bound status**

normal to barely intelligible **or unintelligible speech**

normal to pureed diet

independence in most ADLs to needing major assistance in all ADLs



AND

A. Critical nutritional impairment demonstrated by all of the

following in the preceding 12 months:

Oral intake of nutrients and fluids insufficient to sustain life

Continuing **weight loss**

Dehydration or hypovolemia

Absence of artificial feeding methods

OR

B. Life-threatening complications in the past 12 months as

demonstrated by ≥1:

Recurrent aspiration pneumonia, Pyelonephritis, Sepsis,

Recurrent fever, Stage 3 or 4 pressure ulcers

STROKE OR COMA

The patient has both 1 and 2.

1. Poor functional status **PPS* ≤ 40% AND**

2. Poor nutritional status with inability to maintain sufficient fluid and calorie intake with ≥1 of the following:

≥ 10% weight loss in past 6 months

≥7.5% weight loss in past 3 months

Serum albumin <2.5 gm/dl

Current history of **pulmonary aspiration** without effective response to speech therapy interventions to improve dysphagia and decrease aspiration events

Supporting documentation includes:

Coma (any etiology) with 3 of the following on the third **(3rd) day of coma**:

Abnormal brain stem response

Absent verbal responses

Absent withdrawal response to pain

Serum creatinine > 1.5 gm/dl

Benefit period:

90 + 90 = 180 days (6 months)

Face to face with physician BEFORE the next benefit period.

Indefinite 60 day period = every 2 month recertification period.

FREE STUFF: *FREE* medicines
FREE DME
FREE supplies
FREE home visits

After a lifetime of co-pay, FINALLY, something is free!!!



Goals of Care: To Be or Not to Be *That is the Question...*

Comfort vs. Curative
Home vs. Placement
911??? vs. 24 hr. Hotline



Non-emergency lift assist
Not related to primary diagnosis
If patient or family wants to be treated for primary diagnosis =
REVOKE ?

Levels of Care:

- ▶ Routine Home Care - home, apt., B&C, ALF, SNF, RV
- ▶ Respite - for caregiver relief



Symptoms out of Control: **CRISIS PERIOD**

- Inpatient Care - in contracted hospital/ hospice wing or SNF
- Continuous Care - in the home/B&C/ALF - 8 to 24 hrs of **mostly** nursing care, may be combined with aide services



POLST:

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact **Physician/NP/PA**. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

EMSA #111 B (Effective 1/1/2016)*

Patient Last Name: _____ Date Form Prepared: _____

Patient First Name: _____ Patient Date of Birth: _____

Patient Middle Name: _____ Medical Record #: (optional) _____

A **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment** – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ **Selective Treatment** – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ **Comfort-Focused Treatment** – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

☐ **Trial Period of Full Treatment.**

☐ **Request transfer to hospital only if comfort needs cannot be met in current location.**

Additional Orders: _____

Rights and Responsibilities:

- ▶ Choose own doctor or even change nurse providers
- ▶ Choose own Medicare certified hospice agency - may change 1x during each benefit period
- ▶ Will be discharged for extended prognosis
- ▶ May revoke hospice for curative treatments



CAREPLAN - our very favorite!
PATIENT = driver of his own care plan



Hospice - what a true blessing!



Hospice Care
is like having angels
to hold you until your
wings are ready.



LEGAL IMPLICATIONS OF HEALTHCARE DECISIONS AND DOCUMENTING ONE'S FINAL WISHES



The Law Offices of
Gary L. Fales & Associates

What is an Advance Directive?

- ❖ An advance directive is generally a written statement about how an individual wants medical decisions made on their behalf.
- ❖ Completed in advance of serious illness.
- ❖ Allows you to state choices for health care, or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment.

WHY DO I NEED AN ADVANCE DIRECTIVE?

- ❖ An advance directive is the best approach in letting your wishes be known and honored by your family, friends and health care providers during an emergency or illness.

WHO SHOULD KNOW ABOUT MY ADVANCE DIRECTIVE?

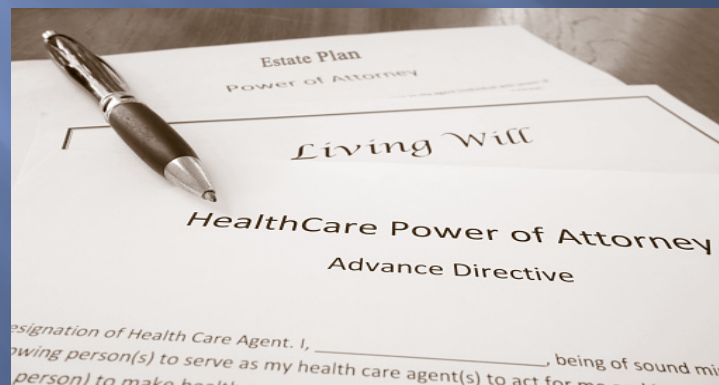
- ❖ Friends
- ❖ Family
- ❖ Health Care Provider

That way if a medical situation arises, you will appreciate that those you trust will know and honor your medical treatment decisions.

Two Most Common Forms of Advance Directives

LIVING WILL

DURABLE POWER OF
ATTORNEY FOR
HEALTHCARE



What is a Living Will?

- ❖ A Living Will directs a physician to withhold or withdraw life-sustaining treatment.
- ❖ Also known as a “Declaration” in Nevada.
- ❖ Only goes into effect under the following conditions:
 - You must have an incurable and irreversible condition that, without the administration of life sustaining treatment, will result in death in a relatively short time.
 - You are not able to communicate your desires.

Durable Power of Attorney for Healthcare

- ❖ In Nevada, a Durable Power of Attorney for Healthcare is a signed, dated, and witnessed paper naming another person as your “agent” or “proxy” to make medical decisions for you should you become unable to make them for yourself.
- ❖ May include instructions about any treatment you want or wish to avoid.
- ❖ Goes into effect whenever you are unable to make decisions. The medical problem does not have to be incurable or terminal.

What Should I Do With My Advance Directive if I Choose to Have One?

- ❖ Make sure that a close friend or family member is made aware of your advance directive and knows where it is located.
- ❖ Ask your physician to make your advance directive part of your permanent medical record.
- ❖ Keep a second copy of Advance Directive in a safe place where it can be easily found if needed
- ❖ If you have a Durable Power of Attorney, give a copy to your “proxy” or “agent”.
- ❖ Electronically and securely file your Advance Directive with the Nevada Living Will Lockbox.

The Nevada Lockbox

What is the Nevada Lockbox?

The Nevada Lockbox is an electronic registry securely maintained on the Nevada Secretary of State website, which contains an electronic reproduction of each document filed by the registrant.

Why file a copy of my advance directive with the Nevada Lockbox?

The lockbox ensures your voice is heard when end of life decisions arise. The electronically stored documents are immediately available to your health care provider.

NevadaLockbox.nv.gov



Protecting Your Wishes

Guardianship

- ❖ Senate Bill 229 of the 2017 Legislative Session established a process by which an adult person may request to nominate another person to serve as his or her guardian in the event that designation of a guardian becomes necessary.
- ❖ Once filed, your Request to Nominate Guardian Form will be readily available when needed, 24-7, to you and the authorized entities designated by law who have been set up to have access.

NevadaLockbox.nv.gov

Protecting Your Wishes

A no-cost service provided by the office of
Nevada Secretary of State
Barbara K. Cegavske



ABOVE SPACE IS FOR OFFICE USE ONLY

Request to Nominate Guardian Form

Registrant Information PLEASE TYPE OR PRINT CLEARLY USING INK

Legal First Name _____ Legal Middle Name _____ Legal Last Name _____ Suffix _____
 Last 4 of SSN: _____ Date of Birth: _____ Gender (Optional): _____
mm/dd/yyyy Male/Female

Address _____
 Street Address _____ Apt # _____ City _____ State _____ Zip Code _____

Phone: _____ Area Code _____ Number _____ Email Address: _____

Primary Nominee for Guardian of Person

Name: _____ Relationship: _____
 Address: _____
(No P.O. Boxes) Street Address City State Zip Code
 Telephone: (____) _____ Email (optional): _____

☐ Primary Nominee for Guardian of Person and Primary Nominee for Guardian of Estate are the same.

Primary Nominee for Guardian of Estate

Name: _____ Relationship: _____
 Address: _____
(No P.O. Boxes) Street Address City State Zip Code
 Telephone: (____) _____ Email (optional): _____

Alternate Nominee for Guardian of Person (Optional)

Name: _____ Relationship: _____
 Address: _____
(No P.O. Boxes) Street Address City State Zip Code
 Telephone: (____) _____ Email (optional): _____

☐ Alternate Nominee for Guardian of Person and Alternate Nominee for Guardian of Estate are the same.

Alternate Nominee for Guardian of Estate (Optional)

Name: _____ Relationship: _____
 Address: _____
(No P.O. Boxes) Street Address City State Zip Code
 Telephone: (____) _____ Email (optional): _____

Nevada Secretary of State
Form SPLB-0004 Version 2.0

Page 1 of 2

HIPAA Release

- ❖ The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 to protect your health information. It prohibits your health care provider from releasing your health care information.
- ❖ Unless you have provided a signed release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care.





Thank You!

End of Life Option Act and Other Ethical Issues

Maidaflor Rana-Maybir BSN, RN, MSN
August 3, 2018

Introduction

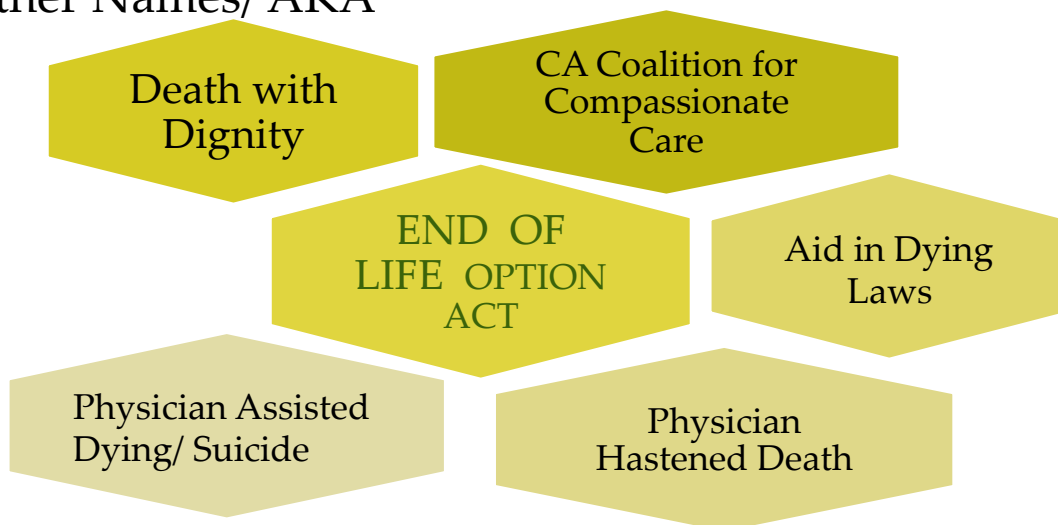
CHOICES!
???????



Main Objectives

- Participants will have a better understanding of the End of Life Option Act (EOLOA) from its description and mandated legal requirements
- Through a brief historical background, learners will discern similarities and differences between state enacted laws
- Participants will learn about different ethical issues concerning EOLO Act

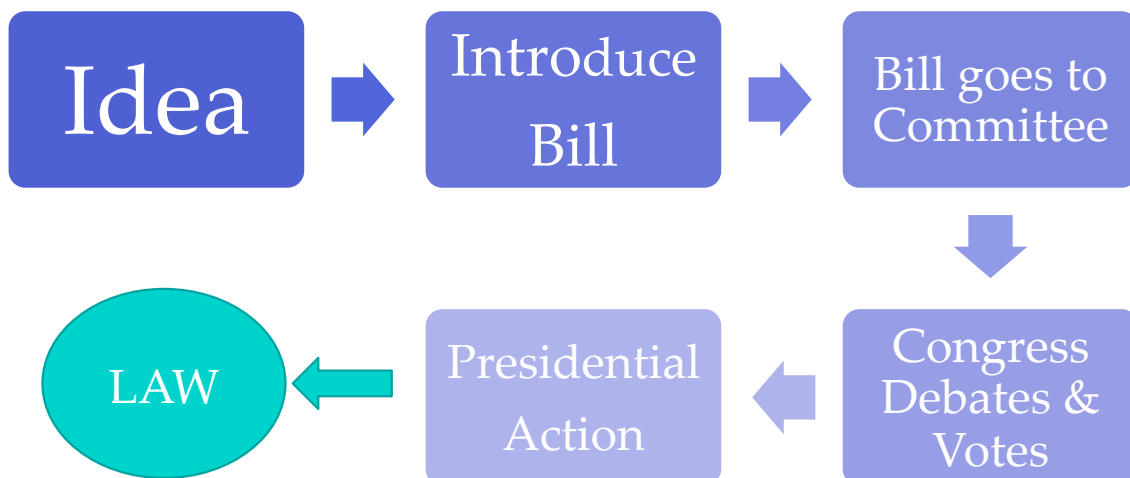
Other Names/ AKA



Brief Description of End of Life Option Act (EOLOA)

- A law that permits terminally ill adults who are medically capable of making healthcare decisions to be prescribed an end of life medication by eligible doctors with a prognosis of 6 months or less to live
- Legal resident= applicable to some states
- Voluntary participation of patients, MD's, & other healthcare providers

How a Bill Becomes a Law



6 US States with EOLOA



Death with Dignity Act 1994 / 1997

- 1st passed in Nov. 1994; In favor 51%; Repealed injunction
- First state to allow practice Nov 1997



Death with Dignity Act 2008

- Passed Initiative 1000 in 2008
- Became law on March 2009



Patient Choice & Control at the End of Life Act #39

- Gov Shumlin signed act May 2013
- Enacted June 15, 2013

Additional States



End of Life Option Act

- SB 128; 1002



EOLOA

- Signed into law Gov Gerry Brown Oct 2015 Effective June 2016
- 5th state to enact



End of Life Options Act 2016

- Voted Prop 106 in Nov. 2016
- Law in effect Dec. 2016

Continuation



HAWAII

Our Care Our Choice Act 2018 / 2019

Senate Bill 1129 1st intro Jan 2018; Hearing Feb 2018

Senate Com. Bill unanimously passed Mar 16, 2018 Effective Jan 2019



District of Columbia: Death with Dignity Act 2016/2017

- Not a state but a District



MONTANA

No statute or legislative passage but EOLO legal with State

- Supreme court ruling

Things to be thoroughly discussed by MD prior to prescribing aid in dying drugs

Pt's understanding of his or her diagnosis, prognosis, hopes & fears.

Benefits of hospice & palliative care

Other options for symptom management & pain control

Process for requesting aid in dying drugs

The patient must:

Step 1-2

- Verbalize 2 oral requests to PMD; 15 days apart
- Provide 1 written request signed by pt & 2 witnesses

Step 3-4

- Directly hand form to attending PMD
- Discuss aid in dying Rx alone with PMD

Step 5

- Consult a 2nd MD to confirm pt's diagnosis, prognosis
- Mentally capable of making sound decisions

If either MD's think pt is not mentally capable, they may refer to a mental health MD

The Law Mandates the following to be discussed between patient & physician



How the aid in dying drug (Pentobarbital) works & that pt may not die immediately



Realistic alternatives: comfort care, hospice or palliative care, & pain management



Pt Options: to withdraw, notify next of kin, have someone present, not to take drug in public

Continuation



MD must ensure pt who changes his mind they don't have to take acquired drug



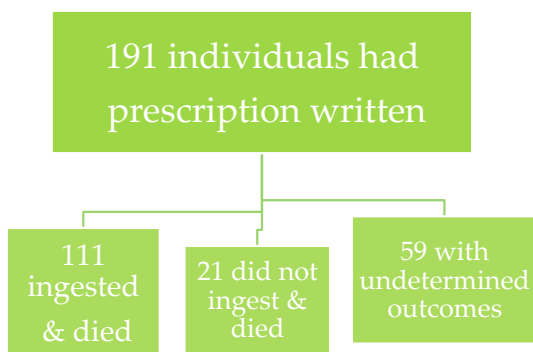
If pt still wishes to proceed, MD hands drug to pt directly or dispenses it through a pharmacy



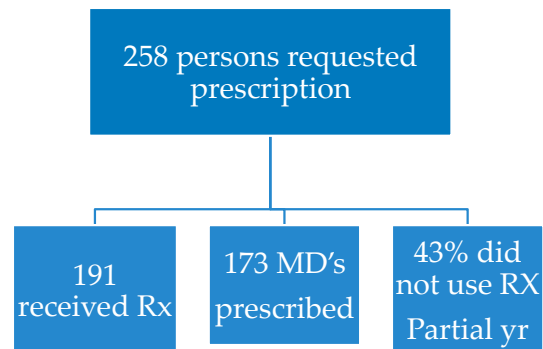
Before taking the drug, pt must sign a Final Attestation for Aid in Dying Form

California EOLOA statistics

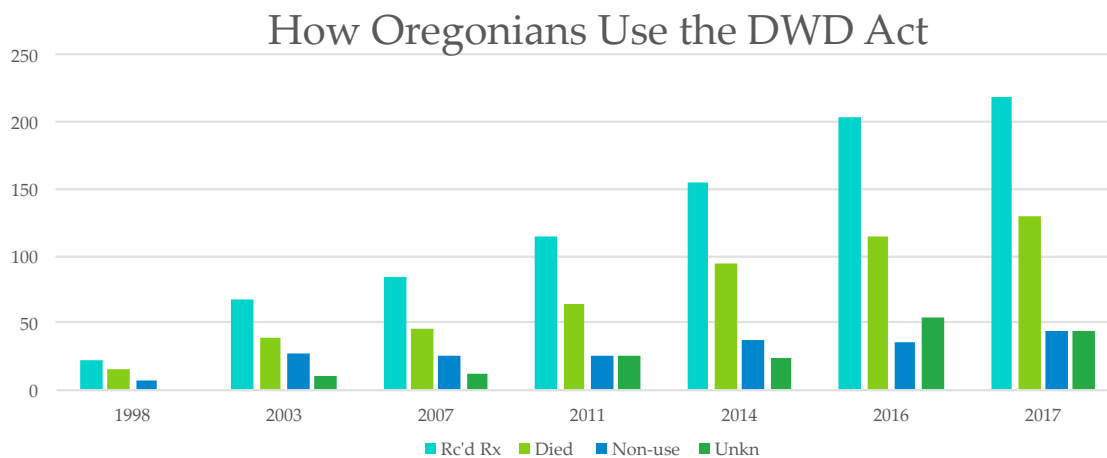
year 2016



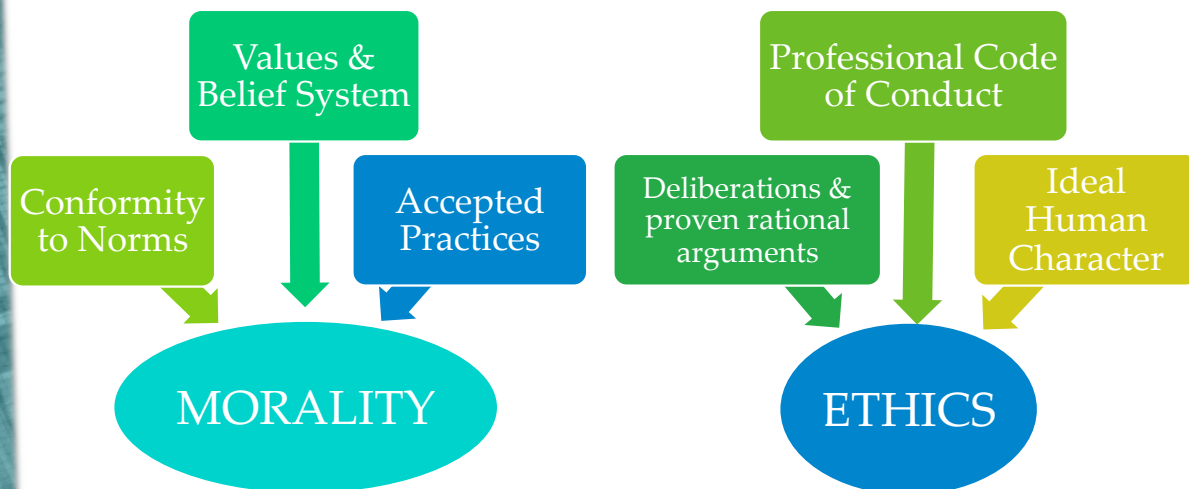
year 2017



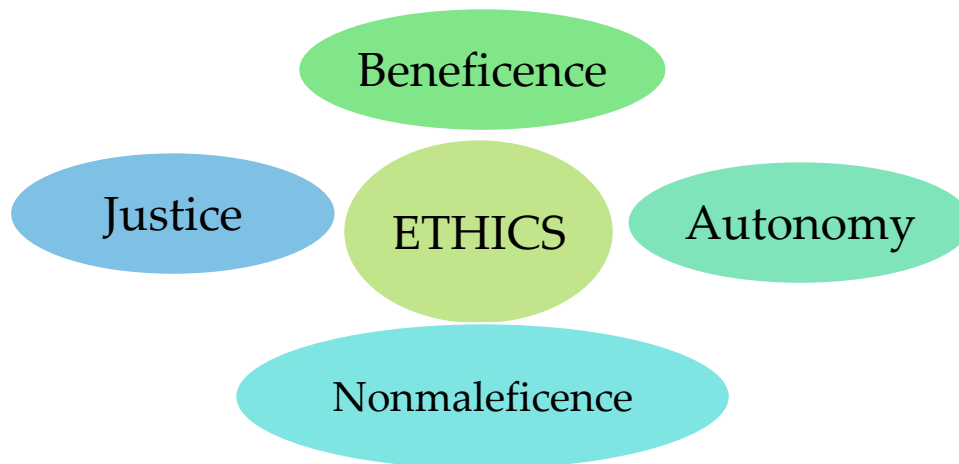
Oregon statistics



Morality vs Ethics



Four Pillars of Ethics



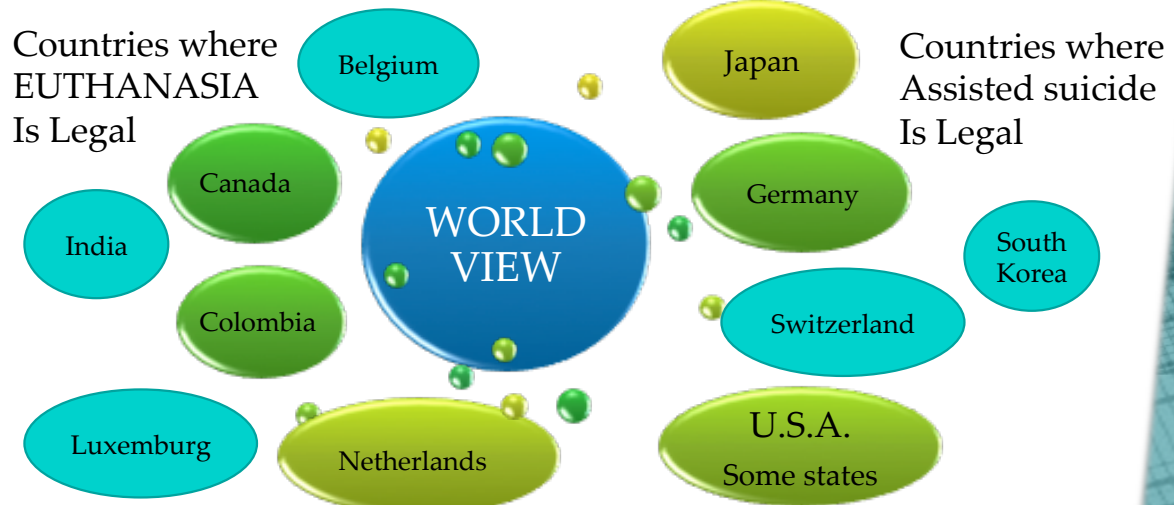
PRO Argument In Favor of EOLOA

	Pt Autonomy Compassion/Mercy	• Individual Liberty vs state interests • Relief of Suffering
	Non abandonment	• Short term obligation to render care thru dying process
	Justice Honesty	• Right to hasten death or shorten suffering • Acknowledgement of practice

CON Argument Against EOLOA or Ethical Issues

	Wrongness of Killing Physician Integrity	• Sanctity of Life • Do no harm
	Risk of Abuse Professional Fallibility	• Slippery Slope • Possibility of Error
	Religious Concerns Hospice/Palliative Care	• Stewards of Life & not cause one's death • Death thru natural causes

International Landscape



Conclusion

- Current trends show that more terminally ill patients are utilizing the EOLOA. Statistics & interviewed physicians also show that once patients are given a choice between using aid in dying drugs versus hospice or palliative care, patients chose the latter option. Approximately 40% of patients chose to die naturally from their diseases using hospice or palliative care services. It can be surmised that once patients are given choices, they inevitably do the right thing and make an informed decision.
- Position statements from various religious denominations and the American College of Physicians show that majority are not in favor of EOLOA. It is a common belief that life is truly a precious God given gift to humanity. We are mere stewards of this life. It would be frivolous to interfere with it's natural course of events.

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39th Annual UPNAAI Education Conference & Convention

HOW NURSES Can UPHOLD The DIGNITY of LIFE

SPEAKER: Rev. William J.M. Kenny

Concurrent Session B (Treasure Island C)

Friday, August 3, 2018

- 1. Catholic Teaching on Pro-Life and Medical Issues**
 - a. Papal Pronouncements**
 - b. United States Conference of Catholic Bishops (USCCB) Documents**
- 2. Specific Topics**
 - a. Birth Control**
 - i. Artificial Contraception**
 - ii. Natural Family Planning (NFP)**
 - b. In Vitro Fertilization**
 - c. Surrogate Motherhood**
 - d. Sperm Bank**
 - e. Life of mother vs. Life of child**
 - f. Abortion**
 - g. Euthanasia**
 - h. Death with Dignity**
- 3. Questions**

Trauma and Resilience Among Filipino American Women: Challenges and Ethical Issues

Presented by:

Andrew Thomas Reyes, PhD, RN

Assistant Professor

University of Nevada, Las Vegas (UNLV)

School of Nursing



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Acknowledgement

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Dean Research Support
Fund



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Asian American Pacific Islander Nurses Association (AAPINA) of Nevada



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Learning Objectives

- To discuss the results and implications of a study about resilience and posttraumatic stress among Filipino American women.
- To explore challenges and ethical issues related to conducting research about trauma and resilience among Filipino American women.



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Background

- Asian Americans: fastest growing racial group in the U.S. (U.S. Census Bureau, 2017)
- 19% of Asian Americans are Filipinos (Hoeffel et al., 2012)
- Third largest Asian group in the U.S. after Chinese and Asian Indians (Hoeffel et al., 2012; Lopez, Ruiz, & Patten, 2017)
- There are 67 males for every 100 females (U.S. Census Bureau, 2011).



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Background

- Filipino American women (FAW) have serious psychological and mental health problems:
 - Highest prevalence of moderate to severe postpartum depression (Huang, Wong, Ronzio & Yu, 2007)
 - More women reported being more depressed than men, and women reported more symptoms of depression than men (Espiritu & Wolf, 2001; David, 2008; Ying & Han, 2006)



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Background

- Filipino American women (FAW) have serious psychological and mental health problems:
 - Significantly higher proportion of FAW disclosed having considered suicide than male counterparts (Lim, 2011)
 - Highest rate of substance use, higher rates of depression, and lower rates of seeking mental health professional help (Appel, Huang, Ai, & Lin, 2011)



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Purpose of the Study

- Explore the level of resilience, PTSD symptom severity, and types of traumatic exposure
- Determine the relationship between trauma exposure, severity of PTSD symptoms, and resilience, and
- Examine the potential mediating effect of resilience on the relationship between types of traumatic exposure



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Definitions of Terms

- What is resilience?
- What is PTSD?
- What is betrayal trauma?



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Definition of Terms

- What is resilience?
 - “Personal qualities than enable one to thrive in the face of adversity” (Connor & Davidson, 2003, p. 76)



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Definition of Terms

- What is Posttraumatic Stress Disorder (PTSD)?
 - Criteria A: Exposure to a traumatic event (direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to trauma)
 - Criteria B: 4 clusters
 - Re-experiencing
 - Avoidance
 - Negative thoughts/feelings
 - Arousal



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Definition of Terms

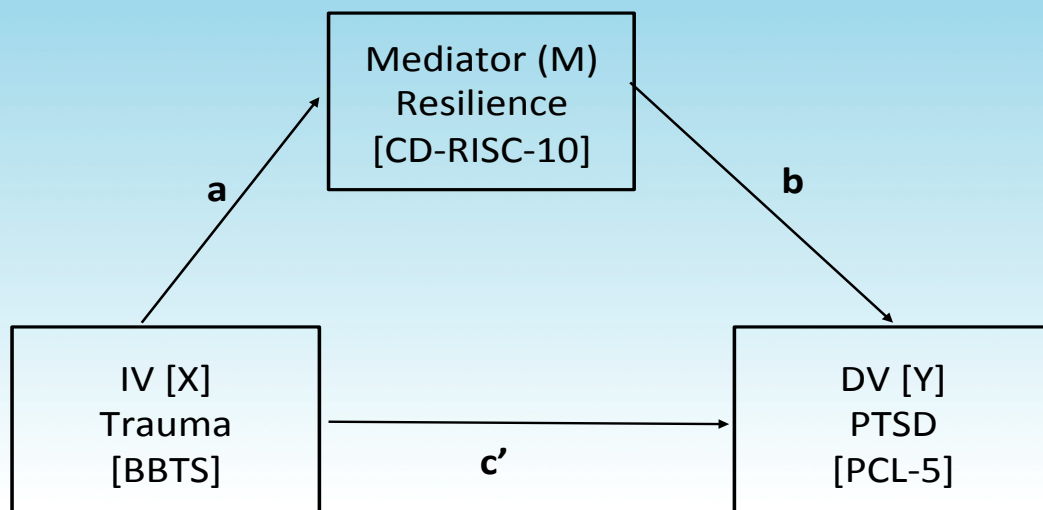
- What is betrayal trauma?
 - Three main types of trauma exposure:
 - High betrayal (HB): interpersonal, perpetrator is very close or intimate with the victim
 - Medium betrayal (MB): interpersonal, perpetrator is not close or intimate with the victim
 - Low betrayal (LB): non-interpersonal (natural disasters, automobile accidents)
 - Poorer mental health and psychological outcomes: high betrayal trauma (Freyd, 1996).



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Model to be Tested



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Measures

- Resilience
 - Connor-Davidson Resilience Scale (**CD-RISC-10**, Campbell-Sills & Stein, 2007)
- PTSD symptoms severity
 - PTSD Checklist (**PCL-5**, Weathers et al., 2013)
- Type of trauma
 - Brief Betrayal Trauma Survey (**BBTS**, Goldberg & Freyd, 2006).



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Procedures and Data Analyses

- Inferential statistical models were used
- Mediation models



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Results

- Participants ($n=188$):
 - Ages 35–64 years (55.9%)
 - Employed full time (56.7%)
 - First-generation (77.5%)
 - Income: \$10,000 - \$75,000 (62.4%)
 - Bachelor's degree (65.1%)



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Results: Resilience (CD-RISC 10)

- CD-RISC 10 overall mean score: 30.1 (SD = 7.54) (Cronbach's alpha=.924)
 - Indicates moderate to high resilience scores
 - FAW: higher than other women's studies that used CD-RISC 10 (Hébert, Parent, Simard, & Laverdière, 2018; Scali et al., 2012; Vitale, 2015).
 - FAW: higher resilience scores than male counterparts (Dial, 2007)



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Results: PTSD (PCL-5)

- PCL-5 overall mean score: 19.1 (SD=14.97) (Cronbach's alpha=.954)
 - Below the cut-point score of 33 (Weathers et al., 2013)
 - 88% of the sample: scored less than 33
 - Asian American women with low levels of PTSD (Alegria et al., 2013; Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010; Farley, Minkoff, & Barkan, 2001; Koo et al., 2014; Roberts et al., 2011)



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Results

- Type of trauma
 - Before age 18:
 - Low betrayal (LB): 54.1%
 - Medium betrayal (MB): 32.8%
 - High betrayal (HB): 27.0%
 - After age 18:
 - Low betrayal (LB): 70.1%
 - Medium betrayal (MB): 48.1%
 - High betrayal (HB): 38.2%
 - More respondents reported trauma occurrence after the age of 18 for LB ($\chi^2 = 7.26, p < .001$), MB ($\chi^2 = 6.15, p = .007$), but not for HB ($\chi^2 = 3.46, p = .062$).



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Results

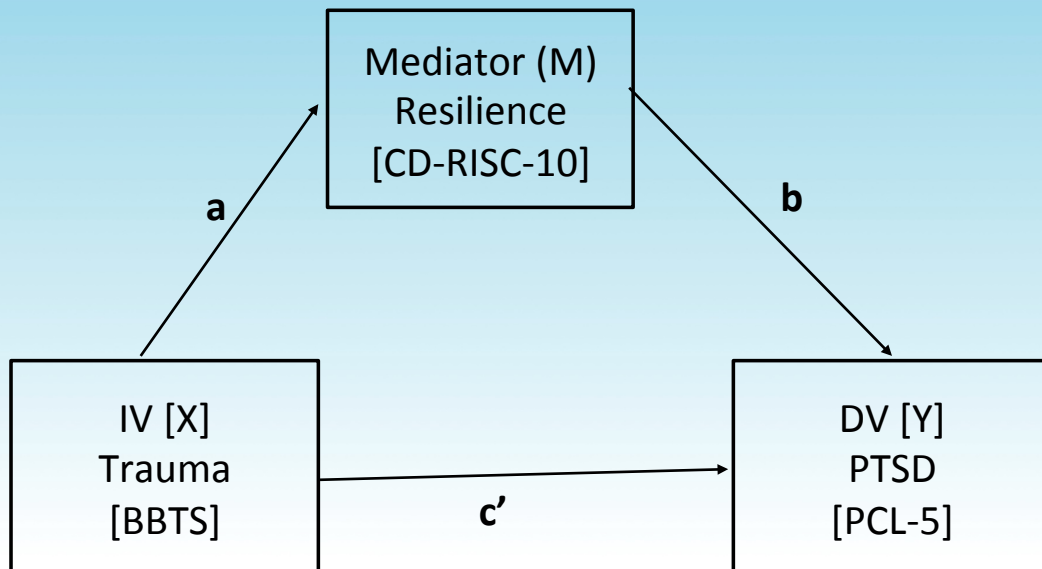
- Resilience and PTSD
 - Significantly negative correlation ($r_s = -.288, p < .001$)
- PTSD and type of trauma
 - Significantly positive correlation
 - Before age 18 ($r_s = .297, p < .001$)
 - After age 18 ($r_s = .330, p < .001$)
- Resilience and type of trauma
 - No significant correlation



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Model to be Tested



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Anonymous
 - But might have hesitated to fully disclose posttraumatic stress symptoms and past traumatic experiences



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Greater privacy and larger incentives: not necessarily associated with greater disclosure of sensitive information (Murdoch et al., 2014).



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Social desirability: tendency of some respondents to report an answer in a way they deem to be more socially acceptable than would be their "true" answer (Lavrakas, 2008)
 - To project a favorable image of themselves and to avoid receiving negative evaluations.



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Social desirability: related to underreporting of mental health problems among Filipinos to prevent shame on their families (Gong et al., 2003).



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Collectivistic cultures
 - Family support enhances resilience among Asian Americans (Ehrensaft & Tousignant, 2006)
 - Barriers to mental health interventions (Gong et al., 2003)



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Values such as *hiya* (fear of losing face)
 - Values such as *amor propio* (the need to maintain pride)



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Social desirability scale (i.e., Crowne & Marlowe, 1960)
 - Able to determine a significant relationship between risk of mental disorders and self-reported discrimination among Asian Americans (Gee et al., 2007)



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Challenges and Limitations

- Limited disclosure of sensitive information
 - Qualitative studies: explore factors that impact possible limited disclosure of traumatic experiences



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Implications

- Importance of trauma-informed care
- Resilience and posttraumatic stress symptoms
- *Cultural portals* as sources of resilience (Ferrera, 2017; Tintiangco-Cubales, 2013)
 - Points of access to our Filipino culture



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Cultural Portals: Resilience

- Family support
- Community support



Cultural Portals: Resilience

- Television and Social Media
 - Filipinos used to economic hardship: resilience (Tintiangco-Cubales, 2013)
 - Importance of education



Thank you.

Questions/Comments?

- Andrew Thomas Reyes
 - University of Nevada, Las Vegas (UNLV)
 - Email: andrewthomas.reyes@unlv.edu



Carmencita M. Abaquin, PhD, RN

2018 Julita V. Sotejo Medallion of Honor Recipient

Dr. Carmencita M. Abaquin is a 1962 graduate of the UP-PGH School of Nursing. She obtained a BS in Nursing at the UP College of Nursing in 1969. She was conferred a PhD in Nursing at the University of the Philippines College of Nursing in the year 2000. Her dissertation was "Prepare Me" Interventions and Quality of Life of Patients with Advanced Progressive Cancer. Dr. Abaquin currently holds varied positions in different nursing organizations in the Philippines. Among her various leadership roles it is especially worth mentioning that Dr. Abaquin is the President of the Secular Order of the Discalced Carmelites (OCDS) St. Teresa of Jesus. As PRBON chairperson and Project Lead, Dr. Abaquin has contributed significantly to the advancement of the nursing profession in the Philippines. During her tenure, full implementation of the Competency-based Test Framework for the Nurse Licensure examination was initiated. Revision of Policies and Standards for the BSN Program CMO No. 14 Series of 2009 occurred during Dr. Abaquin's term. On the international front Dr. Abaquin was the Project Lead in the development of "Comparative Analysis of Philippine Nursing Curriculum and Competencies with Selected Countries." The following is a list of some of Dr. Abaquin's notable accomplishments:

Current Positions

- President – Secular Order of the Discalced Carmelites St. Teresa of Jesus Manila Community (August 2017 to 2019)
- Member- Board of Trustees UPCN FOUNDATION INC. May 2016 to present
- Member- Board of Trustees, Manila Tytana Colleges, (2017 to present)
- Chairperson- Association of Nursing Service Administrators of the Philippines (ANSAP) Multi-Sectoral Council on Good Governance (2015-present)
- Vice President- UP PGHSNAA (2016 to present)
- Chairperson- UP PGHSNAA- Legacy Book Project (2017-2019)
- BOD- Gerontology Nursing Association of the Philippines (GNAP) October 2017-present

Previous Positions/Designations Prior To Current Positions

- Member- Commission on Higher Education, Technical Committee on Nursing Education (CHED-TCNE) (2007 – December 2017)
- Chairperson, Professional Regulatory Board of Nursing, PRC- (Nov. 2006-Jan. 12, 2016)
- Permanent Representative to ASEAN Joint Coordinating Committee for Nursing (AJCCN) 2007-January 12, 2016
- Formator and Councilor- Secular Order of the Discalced Carmelites (OCDS) ST. Teresa of Jesus Manila Community (2000 to 2017)
- Nursing Education (35 years)- Retired (June 2006) College Professor, UPMCN, assuming various administrative positions (College Secretary, Head Teaching Program, Head Continuing Education and Community Service Program, Coordinator Adult Health Specialty, Course Coordinator) and Undergraduate and Graduate Program Faculty, Affiliate Professor of UPOU
- Nursing Service ((years)- Highest position assumed- Head Nurse in PGH Ward 5 (a male medical unit), ICU, Orthopedic/Surgical Ward including staff nursing experience abroad (EVP): (Harper Hospital- Medical-Surgical Floor; Henry Ford Hospital- Neuro-Orthopedic floor: Cook County Hospital- Burn Unit and Recovery Room, Immediate Care of Open Heart Surgical Patients).

Membership in Professional Organizations

- Member PSI BETA CHAPTER, Sigma Theta Tau International Honor Society Nursing- August 2016 to present
- Member UP HONOR SOCIETY OF NURSING (UP-HSN)
- BOD Gerontology Nursing Association of the Philippines (GNAP)
- Abstract Reviewer- Asian Oncology Nursing Society 2015 Conference
- Life Member Philippine Association of Professional Regulatory Boards (PAPRB)
- Founding President/Adviser/Member – Philippine Oncology Nurses Association Incorporated
- Vice-President/Past President- UP-PGH School of Nursing Alumni Association 2017-2018/1989-1991; 2001-2006
- Member Board of Trustees UPCN Foundation Inc. May 2016- Present
- Life Member UP Nursing Alumni Association International, Inc. (UPNAAI) August 2012
- Life Member UPCN Alumni Association
- Life Member UP Alumni Association
- Life Member/Past President/VP – UP Manila Alumni Association
- Life Member Philippine Nurses Association Incorporated (PNA)
- Member/ Past VP & Board of Director – Philippine Association of Diabetic Educators (PADE)
- Past Adviser Association of Diabetes Nurse Educators of the Philippines (ADNEP)
- Member Pain Society of the Philippines
- Founding Member – Kapisanan ng may Kanser ng Pilipinas (KMKP)

Educational Background

- PhD Nursing UPM College of Nursing 2000
Dissertation: *"Prepare Me" Interventions and Quality of Life of Patients with Advanced Progressive Cancer*
- Master in Nursing UP College of Nursing 1975
- Bachelor of Science in Nursing UP College of Nursing 1969
- Graduate in Nursing UP-PGH School of Nursing 1962

Research Outputs Through Professorial Chairs

- Leonor Aragon Professorial Chair, University of the Philippines Manila
"Hope Perspectives of Cancer Patients and Their Family Caregivers" 2005
- Leonor Aragon Professorial Chair, University of the Philippines Manila
"Perceived Needs of Family Caregivers of Patients with Advanced Progressive Cancer" 2001
- Diamond Jubilee Professorial Chair, University of the Philippines Manila
"Perceptions of Three Groups of Respondents Regarding Quality of Life" 1995
- Diamond Jubilee Professorial Chair, University of the Philippines Manila
"Feasibility of a Home-based Hospice Care Program" 1994

Honors and Awards

- *Plaque of Appreciation* given by Human Resources for Health Network November 24, 2017
- *Outstanding Alumna In Nursing* given by UP Manila Alumni Association October 2016
- *Plaque of Appreciation as PRBON Chairperson* given by PRC June 2016
- *Professional Award in Nursing* given by UP Manila Alumni Association 2006
- *Outstanding Professional in Nursing* given by UP Manila Alumni Association 2005
- *Service Award for 40 Years* given by University of the Philippines Manila 2004
- *Outstanding Alumna in Nursing Education* given by UP-PGH School of Nsg Alumni 2001
- *Outstanding Professional in Nursing* given by UP Manila, College of Nursing 1993

Professional Activities with Professional Organizations

- Participated in the Philippine Nursing Competitiveness Conference (PNCC) I (2008) and PNCC II (2009) to address issues and concerns of the Nursing Profession
- As PRBON Chair, signed the Memorandum of Agreement as part of the engagement process with the Institute for Solidarity in Asia (ISA) of the PRBON, PNA, ADPCN and ANSAP for revisiting the Nursing Profession Roadmap Towards Good Governance. (2007)
- Presented the "VISION, MISSION, OBJECTIVES AND INITIATIVES OF THE NURSING PROFESSION ROADMAP TOWARDS GOOD GOVERNANCE" to the ISA for the first time in August 30, 2007- after which we were given the citation as Compliant (2nd) level of the ISA Performance Governance System Pathway.
- Presented the "VISION, MISSION, OBJECTIVES AND DEVELOPMENTS OF THE NURSING PROFESSION ROADMAP TOWARDS GOOD GOVERNANCE" during a revalida before 10 judges during the Public Governance Forum of the ISA and we were granted the PGS Proficient Status in March, 2010. The vision of our nursing profession roadmap is to **"provide professional nursing care that is best for the Filipino and the choice of the world."**
- Presented paper on **"AEC 2015- ASEAN MRA, PQF AND AQRf WITH IMPLICATIONS TO THE NURSING PROFESSION INITIATIVES"** in several professional fora/conventions (PNA, ADPCN, NLPGN, OHNAP; Graduate and Undergraduate HEIs Seminar/Conferences (UPMCN, CNU, WVSU, EURMMC, XU) 2007-2015.

Contributions To The Advancement Of The Profession: Significant Accomplishments as PRBON CHAIRPERSON and PROJECT LEAD

- Resource Speaker- “Historical Perspective on the Development of the 2012 National Nursing Core Competency Standard”
- Program Coordinator during various workshops (PRC, ADPCN, UPMCN, WVSU, CNU, WMSU)
- Resource Speaker-“ Present Status and Direction in Integrating the 2012 NNCCS in the BSN Program” during the workshop on “Embedding and Spreading the 2012 NNCCS for the BSN Program at the UPMCN July 27-31, 2015
- Philippine Nurse Licensure Examination Development Project Lead – 2007-2015
 - Initiated full implementation of the Competency-based Test Framework for the Nurse Licensure Examination
 - Revised the Table of Specification to ensure inclusion of core competencies
 - Together with the PRBON members, reviewed the NLE process, from Application, Test development and test question data banking system, to printing, correction and release.
 - NLE Printing of Test booklets done by a private printing press observing the four factors to ensure NLE integrity (person, process, product, and post licensure activities)

Rev. Fr. Joseph Walter M. Villamiel, NDV, BSN’92, MA’98, RN, STB, STL

Fr. Walter, as he is fondly called, is an alumnus of the University of the Philippines College of Nursing. He is an ordained Roman Catholic priest and he belongs to the order of Notre Dame de Vie. He worked as a registered nurse and Staff Training Coordinator at the Central Intensive Care Unit, UP-Philippine General Hospital. He also worked as an ER Nurse at Accident and Emergency Department Selly Oak Hospital-University Hospital Birmingham (England, United Kingdom). Presently, he is a full-time priest ministering to the faithful as a pastor and as a teacher/lecturer to those aspiring to be priests. Fr. Walter has garnered many awards and citations from the University of the Philippines College of Nursing, UPCN Alumni Association, Inc. Philippine Professional Regulation Commission- Board of Nursing, Kiwanis Club, Critical Care Nurses Association of the Philippines, Inc., Studium de Notre Dame de Vie, Our Lady of the Angels Credit Coop, and Banal na Sakramento, Novaliches.

Finnette Castaneda, RN, BSN’92, PHN

Finnette Castaneda is also an alumna of the University of the Philippines College of Nursing. Finnette has worked in different capacities as supervisor, patient care coordinator, manager and as a public health nurse. Her specialty is palliative care and hospice care. She is a licensed Public Health Nurse. Finnette is a member of the United Nurses Association of California. She has served as a Contract Specialist and a Hospice and Palliative Union Steward in the United Nurses Association of California. Finnette has worked at Kaiser Permanente, Panorama City Medical Center, Procure Home Health, Convalescent Care Center and Good Care Home Health. Finnette keeps current in her practice by participating in continuing education such as Transitions and Best Practices, Hospice and Palliative Care Conference (2012), HHCAPS, RN-MD Collaboration and Mentoring Students (2011), Strengthening Nurse-Physician

Relationships (2010), Home Care Training Program, Cedars Sinai (1996), California Association for Health Services at Home Annual Conference and Home Expo (1996)

Gary L. Fales, Esq.

Atty. Gary Fales' estate planning practice focuses on helping families achieve harmony and security for their future. His considerable legal experience includes wealth preservation, family protection and charitable planning as well as planning strategies for unmarried couples and divorced individuals. Gary has a broad range of experience in helping families of all types to find peace of mind through creative trust planning. Mr. Fales holds a Bachelor of Science degree in Economics from Brigham Young University and a law degree also from Brigham Young where he was a member of the Law Review Board. He is a member of the bar in Connecticut, Idaho, Nevada and New York. Gary is a member of WealthCounsel, a national organization of trusts and estates attorneys and other legal, tax and business professionals who engage in sophisticated planning techniques. Atty. Fales is a frequently requested lecturer for financial planners, CPAs, real estate professionals and other attorneys on a variety of topics including family wealth planning, wealth preservation, and asset protection. Mr. Fales has chosen to concentrate on the Asset Protection and Estate Planning area because our society is willing to sue anyone for any reason at any time.

Maidaflor Rana-Maybir, MSN, BSN'89, RN, CCRN

A highly motivated, dedicated, and hard-working Registered Nurse, Maida possesses extensive clinical background knowledge and clinical nursing experience. Always ready and eager to learn new things and acquire new skills, Maida is able to adapt and adjust to any kind of emergency situation. A caring and skilled professional with excellent communication and management skills, Maida enjoys working in a team. As an RN, Maida has varied functions. As a teacher Maida developed a syllabus and course instruction for St. Francis Medical Center Lecturer Discharge Criteria Event (2015). She has worked in the adult ICU, neonatal ICU and post-anesthesia units. Maida recently completed a Master of Science degree in Nursing from the University of Phoenix.

Rev. William J.M. Kenny

Rev. William J.M. Kenny or Fr. Bill, as he prefers to be addressed, is a Roman Catholic Priest. He was the Founding and Former Pastor of Christ the King Catholic Church, Las Vegas, NV. He is also the Founding and present Pastor of Holy Spirit Catholic Church, Las Vegas, NV. Fr. Bill also serves as the Chaplain of Bishop Gorman High School, Las Vegas, NV, and as Director of the Permanent Diaconate for the Diocese of Las Vegas (NV). Fr. Bill has held other positions previously such as: Director of Liturgy/Worship for Diocese of Las Vegas; Director of Youth Ministry, Director of Interfaith Activities.

Here is a list of initiatives that Fr. Bill either founded or co-founded:

- Co-founder of Las Vegas' based "Family Promise"- a program to house homeless families in church facilities
- Founding member of Interfaith Council of Southern Nevada
- Founding Pastor of Las Vegas "Mustard Seed" missions with annual summer mission to Jamaica
- Founding Director of Imago Dei, a Roman Catholic Ministry for Gay and Lesbian Catholics

Fr. Bill is an alumnus of The Catholic University of America, where he has obtained a BA and MA in Philosophy and a BA and MA in Theology.

Andrew Thomas Reyes, PhD, MSN, RN

Dr. Andrew Thomas Reyes is a multi- published and multi-awarded Registered Nurse. He earned a Bachelor of Science in Nursing from Remedios T. Romualdez College of Nursing , Tacloban City, Philippines. He went on to pursue higher studies and obtained a Master of Science in Nursing at D' Youville College, Buffalo, New York, USA. Finally, a Doctor of Philosophy in Nursing was conferred on him by the University of Western Ontario, London, Ontario, Canada. From 1995 to 2015, Dr. Reyes has worked as a Psychiatric staff nurse and/or as a Psychiatric Clinical Instructor in different clinical and nursing school settings. Presently he is an Assistant Professor at the University of Nevada Las Vegas, School of Nursing, Las Vegas, Nevada, USA. Dr. Reyes has been published many times and has received honours and awards. Following is a list of his accomplishments and accolades:

PEER-REVIEWED JOURNAL PUBLICATIONS

Reyes, A. T., Kearney, C. A., Lee, H., Isla, K., & Estrada, J. (2018). Interventions for posttraumatic stress with resilience as outcome: An integrative review. *Issues in Mental Health Nursing*, 39, 166-178.

Reyes, A. T., Kearney, C. A., Isla, K., & Bryant, R. (2018). Student veterans' construction and enactment of resilience: A constructivist grounded theory study. *Journal of Psychiatric and Mental Health Nursing*, 25, 37-48. doi:10.1111/jpm.12437.

Reyes, A. T., & Constantino, R. E., (2016). Asian American women's resilience: An integrative review. *Asian/Pacific Island Nursing Journal*, 1, 105-115. doi: 10.9741/23736658.1048

Reyes, A. T., Andrusyszyn, M. A., Iwasiw, C. L., Forchuk, C., & Babenko-Mould, Y. (2015). Resilience in nursing education: An integrative review. *Journal of Nursing Education*, 54, 438-444.

HONOURS AND AWARDS

Okura Leadership Nurse Scholar Award Asian American Pacific Islander Nurses Association	2016
Research Award, Sigma Theta Tau, Ioata Omicron Chapter University of Western Ontario, Canada	2007

Research Award, Provincial Nurse Educator Interest Group Award Registered Nurses' Foundation of Ontario, Canada	2007
Scholarship Award, Irene E. Nordwich Foundation	2007
Scholarship Award, Program Merit Scholarship D' Youville College, Buffalo, New York	2000-2001

MOST RECENT PRESENTATIONS IN PROFESSIONAL CONFERENCES

Estrada, J., Isla, K., & **Reyes, A. T.**, (2017). *Trauma-focused interventions with resilience as outcome: an integrative review*. University of Nevada Las Vegas (UNLV) Fall 2017 Undergraduate Research Showcase. Las Vegas, NV. October 2017.

Reyes, A. T. (2017). *Male university student veterans' understanding and enactment of resilience: A qualitative study*. 2017 American Association for Men in Nursing Annual Conference. Las Vegas, NV. September 2017.

Reyes, A. T., & Constantino, R. E. (2017). *Asian American women's resilience: An integrative review*. 14th Annual Conference of the Asian American Pacific Islander Nurses Association. Honolulu, Hawaii. March 2017.

Estrada, J., Isla, K., Tejada, M., **Reyes, A. T.**, & Lee, H. (2017). *The association between posttraumatic stress disorder and telomere length: An integrative review*. 14th Annual Conference of the Asian American Pacific Islander Nurses Association. Honolulu, Hawaii. March 2017

Reyes, A. (2016). *Exploring the global impact of a grounded theory study about nursing students' understanding and enactment of resilience*. 13th Annual Conference of the Asian American Pacific Islander Nurses Association. Baja, Mexico. March 2016.

Reyes, A. (2015). *Strategies for enhancing resilience of new graduates practicing mental health nursing*. 2015 National Conference of the Canadian Federation of Mental Health Nurses. Niagara Falls, Ontario, Canada. October 2015.

PROFESSIONAL INVOLVEMENT (Community Service):

2016	Editorial Board Member Peer-Reviewed Journal: <i>Annals of Nursing Research and Practice</i>
2016	Conference Evaluation Committee Member 13 th Annual Conference of the Asian American Pacific Islander Nurses' Association Baja, Mexico. March 2016 <i>Role:</i> Developed a summarized report of all participant evaluation of the conference and Actively participated in meetings of the Planning Committee before & after the conference
2016- present	Manuscript Reviewer to the following peer-reviewed professional journals: <i>American Journal of Critical Care</i> <i>Annals of Nursing Research and Practice</i> <i>Asian/Pacific Islander Nursing Journal</i>

Biological Research for Nursing
International Journal of Nursing Studies
International Journal of Nursing Education and Scholarship
Japan Journal of Nursing Science
Nursing Health and sciences
Sage Open
Social Work in Mental Health

POSTER PRESENTATIONS

Poster 1

Marife Aczon-Armstrong, PhD, MSN, MSCP, CCM, RN-BC
Assistant Professor
Roseman University of Health Sciences, College of Nursing
maczon-armstrong@roseman.edu

Title: International Clinical Immersion for Undergraduate Nursing Students: The Concept of Service Learning

Learning Objective: By the end of the presentation the participants will identify potential opportunities for international service learning at their school or work

Abstract:

Introduction: Community engagement, often called “service learning”, aims to combine learning goals and community service as opportunities to enhance both student growth and the common good of the community. In this clinical immersion program a group of undergraduate nursing students at Roseman University traveled to foreign countries to provide community outreach services while at the same time completing the clinical requirements of the nursing program.

Service Learning Concept: The National Service Learning Clearinghouse defined service learning as “a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach civic responsibility, and strengthen communities.”

Engaging students in service learning experience helps them to develop awareness of civic responsibility and to improve cultural competence.

Implication for Nursing: Service learning is one of the most significant teaching methodologies that is gaining momentum on many campuses. Further studies on how international immersion can be successful in promoting global healthcare in nursing is warranted.

Poster 2

Rowena Bermundo, MN, RN
Assistant Professor
Roseman University of Health Sciences, College of Nursing
rbermundo@roseman.edu

Title: Developing Cultural Competency Tools to Improve Cultural Awareness in an Accelerated Health Program

Learning Objectives:

- To determine if the education materials improve students' awareness in caring for culturally diverse patients
- To increase awareness of cultural competency resources

Methods: Nursing and Pharmacy students in a healthcare program participated in interprofessional education that evaluated complex cases. A multidisciplinary faculty and library staff created cases that mirror diverse community and online resources to help students assess the cases.

Results: A total of 93 students participated. 95% strongly agreed or agreed that the activity improved cultural competency. 36% reflected that they were more aware of available community and online resources. 78% discussed how the activity helped realize the importance of being culturally competent.

Implications: Cultural competency is essential in providing effective patient-centered healthcare. Offering diverse patient cases based on the program's community can improve students' cultural awareness. Creating an accessible repository of resources can help students become more aware of the tools available.

Poster 3

Fred Calixtro, DNP, MSN, EdS, CDE, RN
Associate Professor
Roseman University of Health Sciences, College of Nursing
fcaliistro@roseman.edu

Robert Fox, MSN, BS, RN
Assistant Professor
Roseman University of Health Sciences, College of Nursing
rfox@roseman.edu

Title: Student-Led Health Promotion Interventions in Cameroon, Africa

Learning Objective: To describe a health promotion intervention project, developed by baccalaureate nursing students, and that targets women and children in Cameroon

Abstract:

The purpose of this presentation is to describe a health promotion intervention project that was developed by baccalaureate nursing students with the guidance of nursing and history faculty. This project targets women and children in the African country of Cameroon. A healthcare team of baccalaureate nursing students and history faculty partnered with a non-governmental organization (NGO) in Cameroon. Together, they implemented a health promotion intervention project. Windshield surveys and interviews with key informants in the community were also undertaken. The project resulted in the completion of health assessments on n=157 children. Approximately 81% of all children had received some vaccinations. Only 12% of those assessed had access to mosquito nets. The baccalaureate nursing students created instruction materials such as a malaria game, diarrhea doll, a menstruation bracelet, and a demonstration on how to clean a wound. Among the community health prevention measures that have been implemented, vaccination appears to be the most successful.

Poster 4

Elisa Castillo, MSN, RN, ACNS-BC, CCRN
Clinical Nurse Specialist
VA Greater Los Angeles, California
castilblue@aol.com

Title: Improving Patient Safety Through Shift Report

Learning Objectives:

- To identify the process of how Critical Care Nurses give shift reports in the ICU
- To explore the nurses' perspective if there is a need to revise the handoff process in the ICU

Methodology:

Survey questionnaires were given to RNs working in a 45-bed ICU. The unit had 4 PODS. Three PODS for Medical and Surgical ICU patients and one POD was dedicated for Cardiothoracic patients. Questionnaires included participants' demographic information and their perception of how shift report was given and how they think it should have been given using Likert scale. Data were measured in frequencies and percentages.

Findings:

Respondents agreed that patient assessments and outcomes are not properly communicated during shift report. 61% are not satisfied with the current shift report process. A combined bedside and verbal report was preferred.

Implications:

A combined verbal and bedside shift report will enable the nurse to visualize the patient immediately and prioritize care for the shift. This will improve patient safety, staff relationships, and teamwork.

Poster 5

Maria Minerva Favila, BSN, RN, CCRN
PACU RN
Advocate CHMC PACU
mbvfavila@gmail.com

Title: Advocate Christ Medical Center Post Anesthesia Care Nurses Inspire, Innovate & Influence with the Surgical Team Approach to Advanced Recovery Program

Learning Objective: To showcase how the components of Advocate Health Care Institution's Nurse Integrated Model of Care and Practice align with the American Nurses Association's 2018 Nurses' Week Theme: "Nurses Inspire, Innovate and Influence."

Abstract:

In celebration of ANA's Nurses' Week 2018's theme, Advocate Christ Medical Center's (ACMC) Shared Practice Council spearheaded a poster contest wherein each unit is to display how their staff "inspire, influence and innovate" using the components of the Advocate Nurse Integrated Model of Care and Practice (ANIMC&P). Aptly, the newly rolled out evidence-based Surgical Team Approach to Advanced Recovery (STAAR) Program is how ACMC's Post Anesthesia Care Unit (PACU) nurses knew they can best illustrate how "they inspire, influence, and innovate." The poster clearly exhibits and

narrates how the post-operative aspects of the STAAR Program specific to PACU is represented in each of the components of the ANIMC&P. In addition, the poster also highlights PACU's unique role and contribution to the ultimate goal of the STAAR Program, which is the patient's quicker recovery from surgery.

Not only is the poster informative but it is also a fun and eye-catching educational tool as it mirrors this year's multi-colored ANA theme and features the star design all over as a play on the STAAR program.

Poster 6

Katherina Fontanilla, DNP, MSNeD, RN
Nursing Faculty
College of Southern Nevada
kfonta@gmail.com

Title: Team-based Learning in Nursing Education: A Student-Centered Teaching and Evaluation Strategy

Learning Objectives:

- To understand Team-Based Tool
- To gain knowledge on how IRAT/GRAT and IF-AT will increase learning outcomes

Abstract:

The evolution in the current healthcare has led to reform in nursing education, nursing practice, and regulations. There is need to gather evidence-based knowledge and to translate it into practice to ensure that healthcare needs are met (Ahmed et. Al, 2013, p.35). Nurse educators must develop strategies to bridge the gaps in applying knowledge to practice.

The aim of the project was to introduce evidence-based (EBP) practice Team-Based Learning (TBL) activity IRAT/GRAT to Nurse Educators/Professional Nurses. The tools presented were the Individual Readiness Assurance Test (IRAT)/Group Readiness Assurance test (GRAT) and the Immediate Feedback Assessment Technique (IF-AT).

The IRAT, GRAT, and IF-AT were found to be effective in increasing students' critical thinking skills. Due to the overwhelming literature revealing that TBL improves critical thinking, it is imperative that IRAT/GRAT and IF-AT be incorporated into nursing education to impact student learning and positive patient outcomes.

Poster 7

Zarah Gayrama-Borines, DNP, RN
Lecturer/Clinical Instructor
Nevada State College, College of Nursing
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Title: Implementation of the Mentorship Program in the Emergency Department

Learning Objective: To discuss the significance of the Mentorship Program and the impact to nursing profession

Abstract:

A mentorship program has been developed as an evidence-based practice that could help new and transitioning registered nurses (TRNs) be successful within the nursing profession. One of the problems in the healthcare industry is the national nursing shortage, influenced currently by workforce reduction as RNs retire and by the decrease in students graduating from nursing programs (Vatan, 2016). One way to promote positive outcomes is to encourage the transfer of experienced nurses into other areas of the hospital. The job transfer caused the TRNs to be uneasy because they are not skillful enough in their new role after 10 weeks of orientation. One solution was the ED Mentorship program which encourages teamwork, promotes self-assertiveness, cultivates competency, efficiency, effectiveness, camaraderie, professionalism, and collegiality among nurses. This creates positive patient outcomes.

Poster 8

Jennifer Kawi, PhD, MSN, APRN, FNP-BC, CNE
Associate Professor
University of Nevada, Las Vegas, School of Nursing
jennifer.kawi@unlv.edu

Title: Epigenomics and Exercise among Disadvantaged Women with Chronic back Pain

Learning Objective: Describe the relationship between epigenomics and exercise among adult women at low socioeconomic level and who suffers from chronic low back pain.

Abstract:

Human genome modifications (epigenomics) have shown to turn genes off or on. This can result into persistent chronic pain and decreased response to treatment. Global DNA methylation is a key manner by which the epigenome marks the genome. Investigations on epigenomic alterations among women with chronic low back pain (CLBP) are lacking.

Exercise is strongly recommended in CLBP management guidelines. This IRB-approved descriptive, cross-sectional, pilot study evaluated the association between global DNA methylation and exercise to assist in advancing genomic science in CLBP.

Participants' ($N=39$) ages ranged from 32-64, 48.7% Black and 38.5% White. Mean CLBP duration was 11.7 years, using various pain treatments (mean=6.36). Overall health was poor to fair (76.9%); all belonged to low socioeconomic class. They spent a mean of 96.64 minutes/week of aerobic exercise ($r=.399$, $p=.012$). Results suggest a significant role of exercise in global DNA methylation.

Poster 9

Cynthia Maglasang, MN, RN, CCRN
ICU RN/Charge/Preceptor
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Title: Improving Patient Care Outcomes on Pain Management in the ICU Through the Implementation of the Critical Care Pain Observation Tool (CPOT) as an Instrument for Pain Assessment among Nonverbal Patients, Specifically, Patients on Ventilators

Learning Objective: This study aimed to conduct a post evaluation of the implementation of CPOT on pain assessment by ICU nurses among patients on ventilators.

Abstract:

Background: The ICU has recently obtained the lowest score in the 2016 Hospital Consumer Assessment of Health Care Providers and Systems Survey (HCAHCAPS) among the rest of the departments in the Hospital. Concomitantly, the Joint Commission (JCAHO) on April 18, 2016 has issued its Statement on Pain Management in response to the national outcry about the widespread problem of under treatment of pain. The CPOT has been one of the behavioral pain scales which has been validated for the purpose of detecting pain among nonverbal critically ill patients. For this particular study, the patient population referred to patients on ventilators.

Design: an after study design was used

Participants: the critical care nurses taking care of patients on ventilators

Methods: After IRB approval, the implementation of this study comprised of the following:

1. The nurses were educated on the use of the CPOT.
2. The CPOT was distributed as the instrument for pain assessment among patients on Ventilators.
3. The results were collected after each shift.
4. The nurses were interviewed regarding the use of CPOT

Results: After two months of implementation, the following outcomes were reported:

1. The nurses found it "easy to use."
2. The nurses reported "it made sense because it showed improvement as the pain drips were titrated.:
3. One nurse reported that it made it easy for her to suggest starting the pain management on a vented patient who was only on sedation for the past two days and still remained restless.

Conclusion: The utilization of CPOT as an instrument for pain assessment among patients on ventilators seem to have a positive effect on pain assessment nursing practice in the ICU. Further research is needed in order to evaluate its full impact on patient outcomes. (For this specific short term outcome, the

HCAHCPS result at the end of the year is awaited to find out if this performance improvement project brought an impact to patient care).

Poster 10

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Title: Resilience and Acculturative Stress among Foreign-Born Filipino American Women

Learning Objective: To describe the correlation between resilience and acculturative stress among Foreign-born Filipino American women.

Abstract: The present study explores the relationship between resilience, acculturative stress, and family norms against disclosure of mental health problems among foreign-born Filipino American women. The sample consisted of 159 foreign-born Filipino American women aged 18 years and above and residing in Las Vegas, Nevada, United States. Participants completed paper-and-pencil questionnaires. Results indicated high levels of resilience and moderate levels of acculturative stress. Findings also showed a significant negative correlation between resilience and acculturative stress, and a significant predictive effect of resilience on acculturative stress. We also found a significant negative relationship between resilience and family norms against disclosure of mental health problems. Our findings confirm the need

to develop interventions and resources that ameliorate acculturative stress and promote an increase of the disclosure and reporting of mental health problems among Filipino American women.

Poster 11

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Title: An Inquiry to Staff Perceptions of a Safe Handoff during Patient transfer from ICU to a Medical-Surgical Unit

Authors: *Santos, T., Hoogerhyde, C., Husser, M., Miller, M., Reicks, K., Spacciante, L., Valdez, J., Windsor, B.,*

Learning Objectives:

- The learner will describe the process taken to identify staff perceptions of a safe handoff during patient transfer from intensive care unit to an acute med-surg unit
- The learner will state one innovation implemented to improve handoff during patient transfer

Purpose: To explore perspectives of nurses on a medical-surgical unit on the current handoff communication during transfers from ICU to acute care unit and to identify opportunities for improvement to the handoff process.

Background/Significance: In the 2015 Employer Choice Survey, our unit's staff rated handoff satisfaction as substandard. By rounding with staff by unit leaders found that nurses frequently reported a need to improve handoff with ICU because of communication breakdown. The current practice of telephone report between nurses and care assistant bringing patient over was inadequate. Patient safety and continuity of care can be compromised when gaps in the handoff exist as patients transfer out of the ICU.

Description: The 5NE Practice Council considered a process improvement project on handoffs of patients transitioning from ICU. Gaining confidence from a successful roll out of intrashift bedside report on our unit more than a year ago, we plan to switch to a structured report at the acute care bedside as patients are transferred out of ICU. The initial phase of the project was to explore the perceptions of the nurses receiving handoffs from ICU through a written survey. Nurses responded to three questions using Likert scale choices and two open-ended questions asking what information they needed to safely continue care of patients and recommendations to improve handoff.

Evaluation and Outcomes: Fifty percent of the targeted nurses responded to the survey. Information listed by the nurses as expected or needed for safe patient care included items such as: current orders needing to match IV infusions, recent vital signs or labs, current need for pain medications, social support, tasks that needed to be completed during the remainder of the shift and current drains, tubes or lines.

Conclusions: Our survey results showed potential improvement in keeping physician orders updated, accurately reporting patient acuity (such as potential to deteriorate, current drips, and mobility), and communicating the plan of care for the patient being transferred. Some responders recommended a bedside safety check and face to face handoffs rather than telephone report with care assistant transferring the patient to the unit.

Poster 12

Teresita Santos, MSN, BSN, RN
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Title: A Progressive Care Unit's Journey to Zero: Say No to CAUTI, No Falling Here

Learning Objectives:

- The learner will describe best practices implemented related to bundled care on foley catheter maintenance on a Progressive Care Unit
- The learner will state one innovation implemented to reduce falls on a Progressive Care Unit

Purpose: To characterize process improvement projects undertaken by a progressive care unit towards reduction to catheter acquired urinary tract infection and fall with harm using best practices and evidence-based strategies.

Background/Significance: It is known that CAUTI and fall with harm negatively affect patients, increase length of stay and hospital expenses. In our Progressive Care Unit, our target patient populations comprise of advanced heart failure, mechanical ventricular devices and cardiothoracic surgical patients. These patients have high acuity and complex comorbidities that place them at risk for infections and falls.

Description: The 5NE Unit Practice Council worked on process improvement projects to: a. reduce CAUTI incidence to zero using bundled care related to foley catheter maintenance care; b. reduce total number of falls and falls with harm by 35% using bundled care on fall prevention.

Evaluation: Results showed reduction on total number of falls with harm but unit is still challenged with fall events. CAUTI incidence was down to zero for 14 months.

Poster 13

Reimund Serafica, PhD, MSN, RN
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Title: The Use of mHealth to Assist Self-Management and Access Services in a Rural Hawaii

Learning Objective: To describe unique barriers and facilitators of mHealth users in a rural community

Abstract: The purpose of this study was to explore the barriers and needs of using mobile health (mhealth) technology to assist low income Asian Pacific Islander (AAPI) participants living in rural Hawaii in their healthcare management. Three focus groups consisting of patients, family support/significant others and providers ($N=19$) was conducted to access the unique needs of low

income AAPI patients in rural Hawaii. The eHealth literacy scale was also measured among participants ($SD=9.71$) among participants in the patient group and 34.50 ($SD=7.78$) in the family support / significant others group. The qualitative analysis yielded categories with three main themes: value of mHealth, stumbling blocks to mHealth, and mHealth expectations and subthemes. Practice Implications include uses of these findings to integrate future versions of mHealth specifically to the diverse low income population.

Poster 14

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Title: Acculturative Stress and Dietary Indicators among Older Filipino Men with Chronic Diseases in Southern Nevada

Learning Objective: After this presentation the audience will identify the current nutritional status of older Filipino men with chronic disease and factors that contribute to their stress.

Abstract: The relationships between aging, stress, quality of life, chronic illnesses and dietary management are multifaceted. Challenges of immigration cause significant changes in interpersonal roles of an older immigrant. Our study explored the perceptions of acculturative stress and quality of life among older Filipino men (> 65) with chronic diseases in Southern Nevada. We also assessed their current nutritional status. Four themes were generated from this study: Cultural Factors, Family Expectations, Role Reversal, and Lack of Emotional Support. The study findings revealed that acculturative stress played an important contributing factor in this topic. Interprofessional approaches are key to appropriate assessment and intervention in the attainment of adequate nutrition among older men. Diet can affect longevity and when combined with lifestyle changes, can influence chronic disease management.

Poster 15

Camille Ungco, M.Ed
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Title: The effects of U.S. reconstructed education in the Philippines and its implications to Filipino and Filipino-American students and nurses

Learning Objective: At the end of the presentation the audience will understand the continuing effects of US colonial education interventions on current English Language Learners and its implications to nursing education.

Abstract:

The United States of America has long been a strong influence in education around the world, including in the Philippines and its nursing degree programs. U.S. school districts have observed a significant increase of English Language Learner (ELL) student enrollment since the 1970s. But the predominance of U.S. influence in global education began even long before the 1970s. Often, ELL texts (Wright, 2010, Herrera & Murray, 2016) that trace historical and current ELL demographic trends also attribute the increase in enrollment to the U.S. as “always [being] a nation of immigrants and is currently experiencing high rates of immigration.” While census data and immigration histories are frequently used to explain the U.S. as an immigrant nation, this often neglects and possibly glosses over fraught legacies of U.S. imperialism (Rodriguez, 2016) that have directly influenced the increase of specific immigrant populations. For its influence in nursing, not only did the U.S. influenced its nursing curriculum and training, it became the primary employer of Filipino-educated nurses during its decades-long nursing shortage.

This study examined the continuing effects of the United States’ colonial education interventions on current English Language Learners and its implications to nursing education. It described U.S. sponsored education interventions during the colonization and occupation of countries such as the Philippines through a review of historical literature. Formal and group interviews were also utilized to gather demographic data as well as attitudes and beliefs from adults and nurses of Filipino-American heritage who were former students, current employees in Nevada’s Clark County School District, and informal group discussions with Filipino nurses working in various cities and towns in the United States of America.

Poster 16

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Title: EARLY PROGRESSIVE MOBILITY Part 2: A Sensitive Indicator of Positive Outcomes

Authors: *Ungco, W., Calivo, R., Fiore, N., Gull, N., Illes, L., Sarnillo, G., & Trinidad, D.*

Learning Objectives:

- The learner will understand the impact of early progressive mobility in reducing cost of care via decreased LOS, HAIs, HAPUs, CAUTIs, and CLABSIs
- The learner whether actively employed or retired will adopt an early progressive mobility program in his/her work unit or home setting.

Abstract: Since 2012 St. Peter’s University Hospital Adult ICU has consistently implemented an early progressive mobility program. Everyday, at the start of the shift every patient was assessed using the safety screening tool recommended by AACN. At 0800 am, sedation vacation was implemented on mechanically ventilated patients. Rapid Shallow Breathing Index (RSBI) was obtained. If RSBI was

acceptable (< 100), the ventilator setting was switched to a weaning mode (Pressure Support). After an hour or two, if the vital signs (VS) and clinical presentation remained stable, the patient was extubated. If the patient remained stable out of bed activity into a chair followed. Patients on low dose IV vasopressors and/or IV anti-arrhythmics that have not been titrated up for 2 hours were progressively mobilized out of bed into a chair. Patients who were able to ambulate within their room and were not on any form of isolation were ambulated outside in the hallway.

This poster presentation illustrates an ongoing data collection to document the effects of early mobility on the above mentioned causes of increased cost of care and prolonged ICU LOS.

*******END OF CONFERENCE PROCEEDINGS*******