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The aim and scope of nursing

Introduction

The aim and scope of nursing encompass a variety of practices in different health care settings. The core focus is on providing care that promotes health, prevents illness, manages symptoms, and supports individuals and families through all stages of life. Nursing involves collaboration with other health care professionals to ensure holistic care for patients. The role of the nurse is multifaceted, requiring critical thinking, empathy, and strong interpersonal skills. This involves not only direct patient care but also health education, advocacy, and research to improve health outcomes.

International Problems and Issues

Nurses, as global citizens, are crucial in addressing the challenges of healthcare access, public health, and global pandemics. They work in diverse settings, from hospitals to remote communities, providing vital services to populations worldwide. Challenges include shortages of healthcare workers, inadequate infrastructure, and the need for culturally sensitive care. The international community recognizes nurses' contributions and the importance of investments in nursing education and practice to achieve universal health coverage.

Conclusion

The nursing profession continues to evolve, adapting to meet the changing needs of society. Nurses are at the forefront of innovation, driving advancements in patient care and public health. It is essential to support nurses' education, professional development, and well-being to ensure the highest quality of care for patients globally.
Chapter 2

Caregivers’ emotional wellbeing and their capacity to learn about stroke

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This chapter examines the effects of distress on the capacity of informal caregivers of stroke patients to absorb information about stroke and caregiving. Thirty-seven caregivers took part in a stroke seminar. Minor psychiatric symptoms were related to caregivers’ knowledge prior to the seminar, with the more emotionally distressed being the least knowledgeable. The emotional state of the caregivers, however, did not affect how much they learnt. Knowledge after the seminar was best predicted from pre-seminar knowledge and age. Older caregivers were less well-informed afterwards, although they did not differ significantly from younger caregivers in their scores initially. These findings do not discount the possibility that emotional carers are too shocked to take in information from hospital staff at the time of admission. The data do demonstrate that, given time to accept the caregiving role, emotional carers are receptive to learning about stroke and the stroke patient’s needs.

Home-based care

Home-based care for stroke patients has long been recommended, and increasingly patients are being discharged from hospitals as soon as possible to continue their rehabilitation from home (Bonita et al. 1987; Brocklehurst et al. 1981; Mulley & Arie 1978; Wade & Hewer 1983; Wright & Robson 1980). Arguments in favour of home care centre on cost containment and effective rehabilitation. Stroke survivors are unlikely to require medical treatment within the hospital so that their occupying a much needed bed is difficult to justify (Mulley & Arie 1978; Wade & Hewer 1983). However, they do need rehabilitation to assist them to resume independent living to the greatest degree possible.
Motivations to help the patient and ensure that the best care is provided are high in the relatives of hospital patients. Distress over the wellbeing of another person may lead to the facilitating effects of anxiety outweighing the debilitating effects, with the family's motivation to know and understand particularly high.

The study

The purpose of this research was to explore the capacity of more emotional caregivers to learn about stroke in an applied setting. As a first step in challenging and questioning biases against emotional relatives, caregivers were recruited for a stroke education seminar. The dependent variable was knowledge gained through the seminar.

Emotionality was operationalized in two ways. First, emotionality was defined in terms of mental wellbeing, or more specifically by symptoms of anxiety and depression. The second definition focused on the caregiving burden and the stress associated with providing care.

Emotionality was reflected in the extent to which caregivers felt inadequate in the caregiving role and were experiencing disruption. Feeling inadequate as a caregiver was considered particularly important because of a possible relationship with Wicklund & Frey's (1980) notion of objective self-awareness. When objectively aware, the individual directs attention inward, evaluating the self, and is not receptive to happenings in the outside world. Carers who express personal inadequacy may be in a state of objective self-awareness, and therefore be unable to take in the information that medical staff have given them about the stroke survivor's condition.

The association between emotionality and knowledge among experienced caregivers is likely to be affected by a third variable, the intensity of care required by the stroke survivor. Well-informed caregivers could be the more emotional caregivers because of the demanding nature of their role and their motivation to meet these demands. In contrast, caregivers with fewer demands may not only be less interested in acquiring information but also less emotional. The demands of caregiving were defined in terms of the functional health of the stroke survivor and in terms of deficits in his or her social and psychological functioning.

Method

Participants

Thirty-seven stroke carers volunteered to take part in the seminar: 28 females and nine males. Because they are not patients, carers were difficult to contact through the traditional health system. This study used snowballing or network sampling to contact them, a strategy often used to locate subjects from less accessible groups (Burns & Grove 1987). Stroke clubs were the first point of contact. When interviewed, these volunteers were asked to help the researchers find other stroke carers. While the representativeness of such samples is always open to question, the demographic profile was not dissimilar from that reported in other caregiving studies (Braithwaite 1990), with one exception. The present study had a disproportionately large number of spouse caregivers.

Participants ranged in age from 45 to 87 years (M = 61.11, SD = 10.38), with the majority (62%) being over 60 years of age. Thirty-one were caring for a spouse, five were caring for a parent and one for a parent-in-law. The sample comprised relatively experienced caregivers, all but two being in this role for more than one year. On average, the time that had elapsed since the stroke was 3.7 years (SD = 2.77). Participants were assured that any information they provided would be treated confidentially.

Design

The dependent variable, knowledge about stroke, was assessed by a multiple choice test taken by participants before the seminar and afterwards. The seminar lasted for two hours and covered:

1. The prevalence of stroke.
2. Risk factors.
3. Hospitalization practices.
4. The treatment of stroke and its effects.
5. The stresses of caregiving.
6. Resources available to caregivers.

A lecture format was adopted, interspersed with questions from participants and discussion of issues raised. Seminars were offered at a number of different times to accommodate as many interested caregivers as possible.

The seminar and the multiple choice test were pre-tested on a sample of 26 nurses to ensure that both gave adequate scope for caregivers to demonstrate and improve their knowledge. These data also provided a baseline for interpreting how knowledgeable the caregivers were and how able they were to learn in this setting. It is important to note, however, that the nurses were not representative of the nursing population. They were volunteers from two major hospitals.

Prior to the seminar, caregivers completed a short questionnaire which was appended to the multiple choice test. Symptoms of depression and anxiety in the caregiver, caregiving burden, functional disability of the stroke survivor,
Nursing Care of Adults

Table 2.1 Correlations of emotionality and caregiving characteristics with pre-seminar and post-seminar knowledge and change scores.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre</th>
<th>Post</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>0.08</td>
<td>0.13</td>
<td>0.05</td>
</tr>
<tr>
<td>Age</td>
<td>-0.16</td>
<td>-0.39*</td>
<td>-0.27</td>
</tr>
<tr>
<td>Spouse</td>
<td>0.12</td>
<td>-0.02</td>
<td>-0.22</td>
</tr>
<tr>
<td>Time Caring</td>
<td>0.02</td>
<td>-0.11</td>
<td>-0.18</td>
</tr>
<tr>
<td>Emotional status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td>-0.40**</td>
<td>-0.35*</td>
<td>0.18</td>
</tr>
<tr>
<td>Burden</td>
<td>0.00</td>
<td>0.08</td>
<td>0.11</td>
</tr>
<tr>
<td>Inadequacy</td>
<td>0.14</td>
<td>0.25</td>
<td>0.11</td>
</tr>
<tr>
<td>Disruption</td>
<td>-0.12</td>
<td>-0.08</td>
<td>0.09</td>
</tr>
<tr>
<td>Caregiving demands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional disability</td>
<td>0.20</td>
<td>0.06</td>
<td>-0.26</td>
</tr>
<tr>
<td>Psycho-social loss</td>
<td>-0.14</td>
<td>-0.02</td>
<td>0.19</td>
</tr>
</tbody>
</table>

*P < 0.05; **P < 0.01.

Knowledge

The greater knowledge of caregivers with better mental health after the seminar appears to be more a function of their knowledge initially than of their greater capacity to learn. The low correlation between symptoms and change in knowledge scores is consistent with this interpretation. Another way of examining the effect of symptoms on a caregiver's capacity to learn was through a regression model in which post-seminar knowledge was regressed on symptoms of poor mental health, once the pre-seminar knowledge of the caregivers was controlled. This strategy was considered preferable to using change in knowledge scores because it avoided the problem of increasing the error term in the dependent variable with a relatively small sample. Also included as a control variable in the regression model was the caregiver's age.

From Table 2.2, the major predictors of knowledge after the seminar were age and pre-seminar knowledge. Those who were younger and who were better informed initially were more likely to be more knowledgeable after the seminar. Of importance is the finding that minor psychiatric symptoms, the major correlate of pre-seminar knowledge, did not contribute to explaining the gains in knowledge made during the seminar.

Table 2.2 Beta coefficients and R² values for a hierarchical regression analysis predicting post-seminar knowledge.

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Model 1</th>
<th>Model 2</th>
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<tbody>
<tr>
<td>Age</td>
<td>-0.26*</td>
<td>-0.25*</td>
</tr>
<tr>
<td>Pre-knowledge</td>
<td>0.77**</td>
<td>0.73**</td>
</tr>
<tr>
<td>Symptoms</td>
<td>0.12</td>
<td>0.12</td>
</tr>
<tr>
<td>R²</td>
<td>0.73***</td>
<td>0.74***</td>
</tr>
<tr>
<td>Change R²</td>
<td>0.01</td>
<td>0.01</td>
</tr>
</tbody>
</table>

*P < 0.05; **P < 0.01; ***P < 0.001.

These data suggest that emotionally unstable caregivers are as capable of learning about stroke as those who are emotionally stable. Such an inference needs to be made with caution because it involves accepting the null hypothesis in a situation where the statistical test has low power. An interesting question to ask in conjunction with this conclusion, therefore, is whether or not emotional caregivers improved on their pre-seminar scores as much as unemotional caregivers. Two subgroups of caregivers were formed: those without any symptoms and those who reported two or more symptoms prior to the seminar. The mean knowledge scores of caregivers without
Discussion

The findings indicate significant differences in the knowledge of men and women. The results support previous research that women participants performed better than men on the knowledge test. This could be due to the fact that men were more familiar with the topics covered in the questionnaire or that they had more experience in the field. The study also highlights the importance of gender in knowledge acquisition and retention. Further research is needed to understand the underlying reasons for these differences.

Table 1: Gender Differences in Knowledge Test Performance

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
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<tbody>
<tr>
<td>Men</td>
<td>25.3</td>
<td>4.2</td>
</tr>
<tr>
<td>Women</td>
<td>30.2</td>
<td>3.8</td>
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</table>

**Note:** Higher scores indicate better knowledge performance. The difference is statistically significant (t-test, p < 0.05).

Comprehension Group

Students were provided with peer feedback and discussion after each session. The group that received peer feedback and discussion performed significantly better on the test compared to the control group (t-test, p < 0.05). The mean score for the comprehension group was 32.1, while the control group scored 23.5. The results suggest that peer feedback and discussion are effective strategies for improving knowledge acquisition.

**Table 2:** Comparison of Comprehension and Control Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehension</td>
<td>32.1</td>
<td>3.4</td>
</tr>
<tr>
<td>Control</td>
<td>23.5</td>
<td>4.1</td>
</tr>
</tbody>
</table>

**Note:** Higher scores indicate better knowledge performance. The difference is statistically significant (t-test, p < 0.05).
Informal caregivers of stroke patients

These data demonstrate that the stigmatizing of emotional carers as being unable to absorb information is unjustified. They may initially forget what they have been told. They may irritate staff by repeating the same question and making unrealistic demands. But after they have had time to adjust to their new role, emotional carers can become more knowledgeable about stroke. Heightened emotionality need no impair capacity to learn.

Acknowledgements

The authors wish to thank the Department of Psychology, The Australian National University, and the Butcher Center for Aging, Northwestern University, for their support for this project.

References


Emotional caregivers

If emotional caregivers miss out on information at the time of the stroke crisis, is the problem one of not being told or not being able to comprehend what they are told? It is tempting to infer from these data that the problem is one of not being told. Such a conclusion assumes that the emotionality carers experience in the caregiving role is comparable to that which they experience in the crisis situation. This may not be the case. At the time of the stroke, emotionality may involve shock, passivity and self-protection; a shutting down response to avoid further threatening information. This is consistent with clinical descriptions of carers as shocked, numb, and unable to comprehend or make decisions in the early stages of the illness (Kinsella & Duffy 1988; O'Keeffe & Gillis 1988).

When the responsibility for care is transferred to family carers, emotionality may be no longer an expression of shock, but rather of responsibility, dread and worry about what to do. In this state, carers may be aware of their need for information and be more receptive to those who are willing and able to provide it. Although this qualification of the data is speculative, it offers the advantage of accommodating disparate clinical observations and research findings.

Conclusion

Whether or not the emotionality of carers in the crisis situation can be shown to be functionally different from emotionality in the caregiving role is a question for future research. In the meantime, successful intervention with stroke survivors may be increased by the adoption of a more dynamic conception of caregivers' needs. The challenge facing nursing and medical staff is to recognize the right time for providing information.
I. Introduction

Background

The increase in the prevalence of chronic disease in the United States has been accompanied by an increased emphasis on the importance of lifestyle modifications to prevent and manage these conditions. The American Heart Association and other organizations have identified 'teachable moments' as critical points in the patient's journey where education and support can significantly impact health outcomes.

II. Teasing Out the Pressure

Monitoring the Pressure: New Developments in a Digested Approach

Chapter 3

Conclusion