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# CARING PROCESSES AND LEVEL OF ENGAGEMENT AMONG INFORMAL CAREGIVER OF OLDER PERSONS IN A TERTIARY HOSPITAL IN METRO MANILA, PHILIPPINES

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13 June 2022

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**Acceptance Page:**

This Special Project titled: **"CARING PROCESSES AND LEVEL OF ENGAGEMENT AMONG INFORMAL CAREGIVER OF OLDER PERSONS IN A TERTIARY HOSPITAL IN METRO MANILA"** is hereby accepted by the Faculty of Management and Development Studies, U.P. Open University, in partial fulfillment of the requirementsfor the degree Course.

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## APPROVAL SHEET

We, the members of the oral examination panel for **MS. MARIA VICTORIA T. RAMOS** unanimously approved the thesis entitled **"Caring Processes and Level of Engagement Among Informal Caregiver of Older Persons in a Tertiary Hospital in Metro Manila, Philippines."** The thesis attached hereto was defended on 30 August 2022 via Zoom for the degree of **Master of Arts in Nursing** is hereby accepted.

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We therefore recommend that **MS. MARIA VICTORIA RAMOS** be awarded the degree of **Master of Arts in Nursing** from the **Faculty of Management and Development Studies**.

Very truly yours,

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## Biographical Sketch

Maria Victoria T. Ramos, RN is a nurse currently working at Philippine General Hospital. She has worked as a nurse for five years consecutively, with two years of experience in Perpetual Help Medical Center Las Pinas. She is now currently working in Philippine General Hospital for almost three years. She has been providing healthcare as a ward nurse to various patients of all ages, in which she has noted the significance of watchers or informal caregivers in helping the patients in their overall health. She has seen their importance also in helping the patients adapt to their health changes even after discharge. The masteral research topic of Maria Victoria Ramos is “Caring Processes and Level of Engagement among Informal Caregivers of Older Persons in a Tertiary Hospital in Metro Manila, Philippines” under the University of the Philippines Open University. The data was collected from her previous workplace at Perpetual Help Medical Center Las Pinas, in which she fully taken note of the informal caregivers help especially to the older people. Maria Victoria is interested in being a clinical educator in the future.

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**TABLE OF CONTENTS**


| | |
|---|---|
| Title Page | i |
| University Permission Page | ii |
| Acceptance Page | iii |
| Biographical Sketch | iv |
| Acknowledgment | v |
| Dedication | vi |
| Table of Contents | vii |
| List of Tables | ix |
| List of Figures | x |
| ABSTRACT | xi |
| CHAPTER I: THE RESEARCH PROBLEM | 1 |
| Background of the Study | 1 |
| Statement of the Problem | 3 |
| Objectives of the Study | 3 |
| Significance of the Study | 4 |
| Scope and Limitation of the Study | 6 |
| CHAPTER II: THEORETICAL BACKGROUND | 8 |
| Review of Related Literature | 8 |
| *Filipino Culture* | 8 |
| *Health Engagement* | 11 |
| *Caregiver Engagement* | 12 |
| *Procedures* | 14 |
| *Nursing Homes and the Philippines* | 22 |
| *Institute on Aging* | 24 |
| Synthesis | 25 |
| Theoretical Framework | 26 |
| Conceptual Framework | 34 |
| Operational Definition of Terms | 36 |
| Hypothesis | 37 |
| CHAPTER III: RESEARCH METHODOLOGY | 38 |
| Research Design | 38 |
| Sampling Technique | 38 |
| Research Setting | 38 |

Data Collection 38
Research Instruments 42
Data Management 45
Ethical Considerations 47

CHAPTER IV: RESULTS AND DISCUSSION 49
Results and Discussion 49

CHAPTER V: SUMMARY, CONCLUSION AND RECOMMENDATIONS 65
Summary and Conclusion 65
Recommendations 66

REFERENCES 69

APPENDICES 75
Appendix A: Letter to Perpetual Help Medical Center 76
Appendix B: Letter to PHMC for Commencement of Research 78
Appendix C: Data Privacy 81
Appendix D: Research Instrument for Caring Process 84
Appendix E: Questionnaire for Informal Caregiver Engagement 86
Appendix F: Curriculum Vitae 88

## List of Tables


Table 1 Swanson's Theory of Caring Questionnaire 42

Table 2 Caregiver Engagement Scale 43

Table 3 Plan for Data Analysis and Interpretation Table 44

Table 4 Sociodemographic Profile 49

Table 5 Descriptive Statistics of Knowing 51

Table 6 Descriptive Statistics of Being With 52

Table 7 Descriptive Statistics of Doing for 53

Table 8 Descriptive Statistics of Enabling 55

Table 9 Descriptive Statistics of Maintaining Belief 56

Table 10 Descriptive Statistics of Caring Process 57

Table 11 Descriptive Statistics of Informal Caregiver Engagement Policy Structure 58

Table 12 Descriptive Statistics of Informal Caregiver Engagement Culture and Mindset 59

Table 13 Descriptive Statistics of Informal Caregiver Engagement Procedures 60

Table 14 Means and Standard Deviation of Informal Engagement 61

Table 15 Correlation Between Informal Caregiver Engagement and Determinants of Swanson's Caring Process 62

## List of Figures

Figure 1 Conceptual Framework 34

Figure 2 Sequential Illustration 35

Figure 3 Data Collection Process 41

**Abstract**

Informal caregiver care is a critical aspect that is involved among hospitalized older persons. The study aims to identify the association between the caring processes and the level of informal caregiver engagement. The Caring process among informal caregivers of older persons was identified using a Likert style questionnaire. It is composed of five determinants, namely Knowing, Being With, Doing for, Enabling, and Maintaining Belief. The first phase of Knowing involved being overall aware of the condition of the informal caregivers admitted older person. Being with is the second caring process in which the informal caregiver was physically and emotionally with the patient. Doing for is the third phase in which care was rendered with dignity, as if the older person were doing it for himself. The fourth process is enabling, in which the transition of care was facilitated towards self-care. Lastly, maintaining belief focused on maintaining the older person's hope and faith-filled attitude as he or she continued with his or her life. The level of informal caregiver engagement was identified following the principles of caregiver engagement with a Likert scale questionnaire. This involved three categories namely Policy and structure, Culture and Mindset, and Procedures. The study is a correlational quantitative study that involved informal caregivers answering printed questionnaires within 30 minutes. The results involved obtaining the frequency and percentage among informal caregivers' age, gender, and relationship with the patient. The dominant relationship in informal caregiving was spouse, the gender for informal caregiving was female and the result of age range was 48-58 years old. The descriptive statistics for the mean and standard deviation of the caring process determinants and level of informal caregiver engagement were then obtained. Finally, the mean and standard deviation of the caring process and the level of informal caregiver engagement were correlated using the IBM SPSS statistics software for identification of association. Results showed a positive correlation between the caring processes and the following: Policy and Structure, Culture and Mindset, and Procedures.

# Chapter I

# THE RESEARCH PROBLEM

## Background of the Study

Back in 2018, when the researcher was working as a staff nurse in the selected tertiary hospital in Metro Manila, it was highly noticeable how caring and helpful the informal caregivers were to their admitted older people. In any way possible, the informal caregivers helped the older person adjust with their daily routine in the hospital. They provided not only physical care but psychosocial support as well, making the patient feel better. Aside from that, the informal caregivers were knowledgeable on the patient's history on health. The informal caregivers were able to serve as vital sources of information about the patient, thus increasing the health care providers' knowledge. The researcher realized that informal caregiver engagement is a topic that must be focused on. Although the informal caregivers pertain to family, relatives, or friends who take care of the older person and are seen as social support to the older person, it is noted in local and international articles that they are still not fully seen as vital backbone to the healthcare system. Since informal caregivers give tremendous insight into the patient's health, their engagement is indeed very important. (Alloway et al., 2019). This led to the questions as to what the current caring process among informal caregivers is, what is their current level of informal caregiver engagement, and what is the correlation between these two factors.

Currently, the informal caregivers in the selected tertiary hospital of this study were only limited to one per patient. The hospital, however, allowed switching of informal caregivers when necessary. During the doctor and nursing rounds, the informal caregivers were usually given updates on their admitted loved one. Any

changes in therapeutic regimen were briefly explained to the informal caregiver. The informal caregivers were free to ask questions and clarifications in care. They were more engaged when they were fully informed of the current situation. The common challenge being experienced by informal caregivers there is balancing their engagement in their duties and responsibilities in and out of the hospital (employment duties, family duties, financial restraints) (Hsin-Fang et al., 2021).

The independent variable is caring processes. The caring process of an informal caregiver is based on Kristine Swanson's theory of care. The caring processes of Swanson's theory of care was chosen because it highlights care in a more humanistic, optimistic, and dignified approach. It also saw care as a behavior that can be personal yet still with a sense of duty. This more personal approach made it suitable for informal caregivers. Kristen Swansons Theory is composed of caring processes, namely Knowing, Being With, Doing For, Enabling, and Maintaining Belief. It has been noted that each process boosts the informal caregivers' attitude in care (Lillykutty & Samson, 2018).

Since most families live with their older people, they also stay and care for them when they are admitted (Kashiwagi 2017). Similar to other Asian countries, Filipinos are closely knitted with their families; despite developments in health care, they still uphold their caring touch and respect for their older people. Hence involvement of family members in caring for the older person is common, especially when they get sick.

By identifying and correlating the caring processes and levels of informal caregiver engagement, the study can generate baseline data on the association of each process to informal caregiver engagements. This can surely be helpful in promoting family engagement, helping the older person in the long run.

Since similar studies focus on the benefits of the presence of informal caregivers, their presence must be focused on. They are the backbone in the care of older people, especially at home. If they are engaged well, they have a positive correlation to preventing hospital readmission and maintain good health (Heath, 2017). Although it is common for informal caregivers to be included in studies, little is done to assess their levels of in informal caregiver engagement.

## STATEMENT OF THE PROBLEM

This study focused on the level of informal caregiver engagement. The problems of this study are:

1). What are the caring processes among informal caregivers in terms of:

a) knowing

b) being with

c) doing for

d) enabling

e) maintaining belief

2). What is the level of informal caregiver engagement?

3). What is the relationship of the level of engagement (policy, culture and mindset, processes) and caring processes (knowing, being with, doing for, enabling, maintaining belief)?

## OBJECTIVES OF THE STUDY

The objectives include:

1. To determine the caring processes among informal caregivers in terms of

1.1. knowing

1.2. being with

1.3. doing for

1.4. enabling

1.5. maintaining belief

2. To identify the level of informal caregiver engagement.

3. To determine if there is a relationship between the level of informal caregiver engagement and the determinants of Swanson's theory of care to them. The determinants are:

3.1. knowing

3.2. being with

3.3. doing for

3.4. enabling

3.5. maintaining belief

## SIGNIFICANCE OF THE STUDY

The research study was conducted in a tertiary hospital in Las Pinas City. The study benefits hospitals who generally have informal caregivers caring for older persons. It also helps institutions take a family-oriented health care approach by generating data that will identify the factors affecting caregiver engagement and levels of informal caregiver engagement. The study also elucidated the perspective of informal caregivers who are backbones in patient care and eventually show how the health care system may support them.

Administrative authorities in the hospital – the study helped identify factors that affect informal caregiver engagement. By correlating each caring process of Swanson's theory to the level of informal caregiver engagement, the administrative authorities can identify which level of informal caregiver engagement is high and

low. Proper identification enabled the administrative authorities to know which aspect of their hospital (policy and structure, culture and mindset, and procedures) can be strengthened to promote the informal caregiver's engagement with the patient.

Informal Caregivers – the informal caregivers received researched data that was more focused on a more emotional perspective of care (using Swanson's theory of care) and on their engagement. It helped them know the strongest and weakest factors affecting their levels of engagement. Afterwards, the informal caregivers also knew what aspects they might request support on to enhance their informal caregiver engagement.

Older Persons –The study gave general data on what care domain the older person usually receives. The family now knows the lower caring processes and is thus able find ways on how to meet these domains. The community as well obtained a general idea on what caring process is usually received by older people and what needs to be focused on. This gave the community an opportunity to establish more programs based on what caring process is still lacking (low result).

Patients – After the identification of caring and level of engagement, the informal caregivers also knew what to improve in the future. If improved, the older patients will benefit by earlier discharge from the hospital (due to earlier engagement identification and proper narrowing of problems encountered by informal caregivers in care).

Researchers – the study provided baseline data on factors affecting informal caregiver engagement alongside with the levels of informal caregiver engagement which can encourage more studies on informal caregiver engagement in the future.

Clinical Practice – the study guided the clinicians on making further family-oriented effort to include informal caregivers in the health care decision making process. Generating data on informal caregiver caring process enabled the nurses to know which domain is high and low. The healthcare providers then placed more focus on the lower aspects and boosted it through focused care. The levels of engagement, on the other hand, let the clinicians know which can be improved (policy and structure, culture and mindset, and procedures) to modify their existing structures. Once modifications are done, the clinicians were able to further include informal caregivers in their usual care for the patients.

## SCOPE AND LIMITATION OF THE STUDY

The study focused on medical surgical wards in the selected tertiary hospital in Las Pinas City to identify factors affecting the informal caregiver engagement of those caring for the older persons. The study collated these factors and correlated it with the level of engagement of the informal caregivers. The sample included informal caregivers of the select institution who are taking care of their loved ones that are 60 -74 years old and above. The study limited its age range to 74 years old because it followed the age classification proposed by the works of Akishita and colleagues (2017). 60-74 are considered as pre-old and are the younger age group in the older persons. 75 is considered the old age group and 90 and above is considered super old. Due to the complications that may be accompanied with aging, the study chose a younger ‘old’ age group to avoid complexities in the study. The study will have no specific category in disease classification required (cardiovascular, pulmonary, neurological cases, etc. are included).

The theory included in this study is the Kristen Swanson theory of nursing care. The study did not include informal caregivers who are sick in any manner or

are not feeling well. This study did not include informal caregivers who did not want to participate in this study for any reason whatsoever for the meantime. This study also did not include informal caregivers who verbalize that they are not cognitively prepared to answer the questionnaire.

# Chapter II
# THEORETICAL BACKGROUND

## Review of Related Literature

### Filipino Culture

Aging is not nice to many. It is seen as a dreadful process where the older persons become dependent; hence, some progressive countries place their older persons in nursing homes. Not because they look dreadful, but because the children are too busy to care for their parents. The children only make time to visit their older persons during holidays. In the Philippines, the situation is totally different. Family members always take care of their older persons. Therefore, whenever the older persons are confined in the hospital, the family or relatives are usually the ones who personally choose to take care of their older persons thus becoming the informal caregivers of the patient (Binay, 2017). The article XV Section 4 of the Philippine constitution also states that (Official Gazette of the Republic of the Philippines, 2021):

> *"The family has the duty to care for its elderly members but the State may also do so through just programs of social security."*

### The older persons and aging

Aging is always a part of life. As time passes by, people grow old and eventually become one of the people called 'older persons'. The term older persons can be defined in many ways. Usually, it cannot be singularly defined. It can be affected by genetic, lifestyle, and health factors; but in general, older persons are usually a term used to pertain to an aging population. One study (Bajorek & Singh, 2014) defines older persons in terms of chronological age (years since date of birth). This study states that older persons are defined as any person who is 65 years and older; however, this is affected by various factors thus failing to

concretely define the heterogenicity of the word older persons. Using Australian guidelines, a search was made to identify older persons. 20 guidelines were noted. Three guidelines defined older persons as chronological age, in which two defined it as 65 years older or more while the other one defined it as 75 years older or more. The other 17 guidelines did not give any specific chronological age to it.

In Japan, the concept of older persons continues to change as Japan continues to have a more vigorous and robust aging population. Originally, an older person is defined as 65 years or older; however, studies show that Japan's older persons decrease of gait speed and grip strength has significantly been delayed due to the age of rejuvenation (1992 study vs 2002). Because of this, Japan Gerontological Society and the Japan Geriatrics Society would like to propose a new classification of older persons to be defined as follows (Akishita et al., 2017).

* Pre - old age - aged 65 to 74 years
* Old age - over 75 years
*Oldest old or super-old - above 90 years old.

According to the Philippine Statistics Association (2019), the older person in the Philippines is defined as being 60 years old and over. The aging population in the Philippines is increasing rapidly in which the older persons are projected to make around 16.5% of the population by 2050 (HelpAge Global Network, 2019). It is thus very important to address the growing needs of the older persons. Authors Andel and Badana (2018) wrote an article entitled Aging in the Philippines (2018) in which the demographic data, current research, and family caregiving issues in relation to the older persons in the Philippines were discussed. In this article, the older persons aged 69 years old and above are expected to experience an increase in their population by 4.2% from 2010 to 2030, while those aged 80 years old and

above are expected to increase by 0.4% from 2010 to 2030. Although studies on older persons appear in national reports, little empirical studies are found about them in the Philippines. More attention is needed in the field of aging research because of the expected increase of older persons population in the future.

The Philippines previously relies on qualitative study designs to obtain perception of aging among Filipinos. A quantitative or mixed methods research may be more useful to provide more insight on the field of aging research. The presence of the Institute of Aging at the University of the Philippines signifies the onset of revitalization of gerontologic research here in the Philippines (Andel & Badana, 2018).

Qualitative research on the experiences of informal caregivers is done by authors Blazeviciene et al., (2021) entitled Qualitative research of informal caregivers' personal experiences caring for older adults with dementia in Lithuania. Five semi-structured focus group discussions were held with 31 participants. The audio recordings were transcribed. With 31 participants, 28 were female caregivers. The interquartile range of the caregiver is 48-58 years old. The interquartile range of caring for the care recipient was 2.5 - 8 years old. Thematic analysis was done. The four categories include:

(a) Learning caregiving through experience

(b) Implications of caregiving on social well-being

(c) Caregivers' contradictory emotions regarding care delivery

(d) Addressing challenges regarding care provision

During this group discussion, the participants expressed their engagement in care with their loved one; however, the participants experience anxiety as well

because of its effect in their overall aspects in life. Increased time of caregiving equates to less time in the workforce, causing a reduction in salary and anxiety in the pension. Also, the participants expressed a wide spectrum of positive and negative emotions in providing care. The challenges on care provision were shared among the participants.

Informal caregiving can affect the overall state of an individual. It is thus recommended that an individual have a program training that is very useful for educating informal caregivers. The study recommends a comprehensive approach to supporting these individuals. Several studies state that informal caregivers need formal training and a support program to help them in their roles of caring. Other studies emphasized the importance of giving formal training to caregivers. Researching on this topic will be helpful for these carers. The study states that informal caregivers are vital yet unsupported in the health care system. Since becoming an informal caregiver causes a transformation in the individual, it is emphasized to involve informal caregivers in the health care system. This can start with positive social positioning and helping the informal caregivers gain more access to support groups.

Burnout is included in this study because it also serves as a major factor that potentially prevents informal caregiver engagement.

**Health Engagement**

Health engagement is very crucial. It involves collaboration with health care providers, stakeholders, and others to obtain ideas and do activities that improve health care outcomes. Involvement in managing a person's health, if done positively, promotes overall efficiency and positive effects to a person's overall well-

being. It lowers healthcare costs because proper engagement has been observed. That health engagement must be improved.

Ways of increasing engagement include (Moore, 2019):

Patient ownership – it is important to emphasize patient ownership to the patient and their families. It is in this way that they become more active participants in their own health care.

Taking small steps – one step at a time. Progress usually starts with small but consistent steps in order to reach the targeted health outcomes.

Emphasize follow ups. The follow ups motivate patients and their families to overcome obstacles in health care. Frequent contact with people who care for their health makes them more aware on the status of their health, therefore making them more responsible and motivated in caring.

Overall, health engagement is very crucial nowadays. Health care must use whatever tools are available to keep up with the times in devising ways to maintain health engagement. Proper engagement in health leads to overall positive health outcomes, which is the goal of the health care system (Moore, 2019).

**Caregiver Engagement**

A similar study on informal caregiver engagement has been made by Alloway et al., (2019) entitled Twelve Principles to Support Caregiver Engagement in Health Care Systems and Health Research. The research included a two-day meeting at Canada to share presentations on policy, practice, and research on caregiver engagement. The data was obtained through a two-day conference held by stakeholders and carers at Canada. The discussion was followed by report back

sessions. After the meeting, 16 categories were initially identified; however, these were narrowed down into 12 categories (principles) for a more condensed presentation. The principles that may increase the engagement are:

**A. Policies and structure category**

1. Use Policy Levers, Incentives, and Tools - policies are considered game changers that may help informal caregivers in healthcare. Tools such as questionnaires can be used to gauge factors affecting engagement.

2. Make Blunt Structural Changes - implementing an organizational wide policy for change may take time, due to the different structures in the organization it must pass. Making simple structural changes can simply make a difference (e.g., adding a third chair for a friend to participate in care)

**B. Culture and Mindset**

1. Face fears - try something instead of waiting for it to happen. Sometimes, the little changes make a difference.

2. Recognize caregivers and Increase Engagement Opportunities – simple recognition of the informal caregiver as part of the health care team boosts informal caregiver morale. The approach can start with a formal system to implement.

3. Define what quality means – the definition of quality must be defined not only by a single individual, but by the whole stakeholders. A clear quality policy gives a clear framework to follow.

4. Be mindful of whose experience is being recognized – do recognize who is being represented in the current health situation.

5. Address Language and Power – language has the power to influence; emphasize the need to use the medical terms wisely.

**PROCEDURES**

1. Engage early – it is better to treat and solve problems at the early stage than late.

2. Clarify roles and expectations – re-visit the stakeholders and caregivers because the cycle of engagement continuously changes.

3. Listen and act on what you hear – listen and do interventions after obtaining feedback.

4. Measure - do not just calculate a person always, try to go beyond the cover and understand what is being heard.

5. Create a community of learning – a community of learning helps each individual grow in accordance with his / her need.

The informal caregivers are one of the most overlooked potential workforces in the healthcare system. Despite this, they are the ones who can invisibly make significant contributions to patient care. It is noted that engagement studies are indeed more focused on patients. This study provides categories and principles that are tailored for informal caregiver engagement. Engaging caregivers can give benefits to clinical practice because they see aspects in health care not visible to health care workers' eyes.

At the same time, principles in engagement outline ways to utilize the invisible but significant workforce of caregivers.

A closer focus on the principles by careful analysis can be done in order to develop policies that can be slowly implemented in clinical research. The policies

are also useful for guiding future research involving informal caregivers by serving as a framework for assessment. Principles in caregiver engagement can improve and promote a family centred patient care approach. Although implementation of more engagement procedures and policies may take effort and time, it is still possible to produce small changes. This begins with increasing the perception of healthcare workers towards informal caregivers as vital carers for their patients.

One article of BMC Geriatrics (Bucknall et al., 2019) conducted a systematic review on the engagement of the family members towards the medication administration and care of their older persons patients aged 65 and above. Five databases were included (Cumulative Index to Nursing and Allied Health Literature Complete, Medline, the Cochrane Central Register of Controlled Trials, PsycINFO, and EMBASE). As people become older, managing their health and medications become more complex. Usually, the treatment becomes less simple and families tend to become the people who are most familiar with the patient's usual medications. The study shows that families are the ones who usually know a lot about the patients' medication regimen and care. They are aware of the medications' side effects, interactions, and other interactions to their older persons. In fact, families participate in giving information about the patient and making decisions. Despite this fact, health providers do not acknowledge their participation and no study has been done to engage family members in the patient care at an organizational level. As a result, the interaction between the health care providers and the family members becomes disorganized and is noted to lack formal structure for communication. The study therefore recommends developing a structured communication method that will involve the family as caregivers of the patient to boost patient care for these older persons patients.

Patient care nowadays involves family involvement. The latter involvement in patient care has benefits not only to the patient but to the health care team and health organization as well. The reasons for involving family in patient care are as follows: family members provide additional relevant information and decision making, family members aid in patient care therefore increasing the overall quality of care received by the patient, providing informal caregiver care even at home, and simply because this is also of patient, family, of societal expectation. Since there are different family structures existing in society (different setups), the communication of the health care provider to the family is affected by several family dynamics. These include:

> *"religion, educational, cultural,and legal variables, in addition to the prevailing health-care culture in relation to the family's involvement in a patient's care".*

Even though there is a direct call to increase family involvement, there is still no standardized agreement in its implementation. In some countries, it has been challenging for health care providers to communicate the patient's health information, especially with extended families. Sometimes, different family members may receive the same information but may make different decisions (which may be contrary to the patient's will). To avoid confusion in decision-making, a communication model has been made. This model includes the health care providers, patient, and his / her family members. It has been decided that the most responsible physician relays the information, while the most responsible family members must be selected by the patient to provide care and will help in making decisions. The other family members are still there but only to receive the information. This family communication model still does not replace the usage of family conferences including all concerned families, if needed. This proposed

communication model helps direct efforts in family involvement that may eliminate relaying of health information redundantly to different family members and enable the assigned MRFM to help provide patient care. Overall, family involvement in extended families is more challenging, but should still be considered using such proposed communication models to provide better patient care (Jazieh, Volker, & Taher, 2018).

As older persons patients are usually confined with their family members, health care providers can take this opportunity to involve the family in order to share the knowledge, positive health care practices that may boost overall health of the older persons. It is thus essential that the organization welcomes the family as part of the health care provider team. An engaged family group can also lead to more satisfying patient care results thus reducing prolonged stay in the hospital. In this book, Health Research & Educational Trust (2015) entitled "Patient and Family Engagement Resource Compendium" the methods to increase family and patient engagement is offered entitled “Engaging Health Care Users: A Framework for Healthy Individuals and Communities”. However, this book has not presented a way to measure caregiver engagement for early initial identification of involvement.

Family involvement is also starting to take changes in Iran. A study entitled “How is family involved in clinical care and decision-making in intensive care units? A qualitative study” (Jafarpoor, Manoochehri, & Vasli, 2020) highlights family involvement in the Intensive Care Unit (ICU) setting. This study involves a qualitative research method with conventional content analysis (due to not enough former knowledge on this phenomenon) in 12 ICUs that were affiliated to teaching hospitals in Iran. Nine family members and 15 ICU staff were selected. The inclusion criteria for the family members include patients admitted to ICU for at least

one week, family members must be closely involved in care (e.g., immediate family members), must be 18 years old above, and they must be capable to speak the Persian language. The inclusion criteria for HCP were physicians and nurses for at least 6 months in service in the department. The study was done in Iran to identify the family and health care providers' (HCPs) experiences and perceptions on family involvement. The answers from the interviews had no pre-determined categories, and were thus deduced into themes, subthemes, and eventually into three main themes. The three themes were deduced into "non-agreed involvement in clinical care", "family decision-making on a continuum of paternalistic views", and "barriers to family involvement". The description are follows:

- Non-agreed involvement in clinical care – the family members were willing to participate in providing health care to their admitted loved ones but were not able to get direct permission. On the other hand, some family members were involved in patient care without even the HCPs asking for their willingness to participate.
- Family decision-making on a continuum of paternalistic views- when it comes to invasive and high-risk procedures, family were most likely to be involved in decision-making; however, the HCP were most likely to decide on routine care activities for the patient. To achieve a higher involvement, it would be necessary for family members to receive continuous updates and health information changes.
- Barriers to family involvement – this category focuses on the adverse factors that prevent family involvement. The barriers are discussed below.

The results in general, points out that Iranian ICUs are transitioning to a family centered- care approach (FCC) but is affected by the diversity of how the family responds, policy and structure of the hospital, HCP's beliefs, and views on family

involvement in ICU setups, low ability of the family members, and no consensus in family decision making. Providing an FCC approach has been important for ICU clinicians because it enables them to align care with the family's decision and values. Perhaps, the barrier on HCP's beliefs is affected by the Iranian healthcare system causing the HCP to perceive the FCC differently (FCC is from Western culture). The HCP focuses solely on the biological factors of the patient instead of the overall aspect of the patient. To integrate the FCC model, the hospital organization will have to incorporate it into their vision, mission, and strategic plan. Another barrier in the diversity of family responsiveness noted that while some family members are very eager to take care of their family member, a few families demonstrated answers that portray indifference even on death on the association that death may release family members from the burden of providing care. The third barrier was the policy and structure. Since FCC is gradually being introduced, some family members may not be able to be involved due to the current policy. It is suggested that more family contacts be made regardless of if the patient is in the ICU setting or not. The fourth barrier to family involvement is the low ability of the family to learn. HCP's disregard for the family's learning ability on care affects the overall family involvement. The last barrier was having no consensus among family members, especially in elderly patient care. Since the Iranian family is extended in nature, there is difficulty in reaching the consensus on decision making involving various family members. The study concludes in this study that for now, FCC may not be fully absorbed in the Iranian healthcare system which involves family engagement in decision making and free visitation policy. Since the Iranian culture operates on a paternalistic culture, the study has mostly interviewed family members who are male (fathers, brothers, sons) with very few female respondents for now. The HCPs and family members may utilize the findings on family

engagement to strengthen its implementation in the future (Jafarpoor, Manoochehri, & Vasli, 2020).

One article (Barello et al., 2019) reviewed caregiver engagement and related it to caregiver burden. The objective of the article is to identify the nature and the extent of evidence on engagement of caregivers to their older persons. A scooping review was done to get more information from different studies. According to this study, 1 out of 10 adults are found to be informal caregivers, found to be helping the older persons. They serve as the invisible support system of older persons, which is not yet acknowledged too much until today. Due to little support and prolonged care of their older persons, these informal caregivers were identified to have needs. These include emotional support to decrease the emotional burden, educational support to increase their skills, and organizational support to help them and the patient in mobility upon discharge. Overall, the studies showed that caregivers (informal) experienced a decrease in the quality of life, tiredness, insomnia, depression, weight loss and need for social support. Based on the scoop review, three main categories which need to be addressed to help caregivers increase engagement are (a) overcoming isolation, (b) helping them acquire skills and knowledge and (c) increasing their accessibility to services. Isolation can be overcome by psychological and social support. Educating caregivers overall helps them increase their skills thus lessening their stress in solving patient-related problems during their care. It is also important to let them have a point of contact to reach when they need additional services to help themselves and the patient.

Barello et al., (2019) emphasized the significance of informal caregiver engagement among patients with chronic conditions. It focuses on assessing the informal caregiver engagements' and it focuses on producing a questionnaire related to their assessment. The first phase involves a qualitative study using a

semi-structured interview. A narrative approach was used to analyze the transcripts together with the use of thematic analysis. The second phase involves the development of a quantitative analysis. The answers were obtained from the first phase and a questionnaire was made. Pilot testing was done for the questionnaire using convenience sampling for obtaining caregiver participants. The results were tested with all statistical tests from SPSS in which a $p$ value of $< 0.05$ was obtained in all tests. Since the questionnaire is psychosocial in focus, the caregiver burden inventory and revised scale for caregiving self-efficacy was included.

Thematic analysis was used in the first phase (interview phase).

In the conceptualization of the caregiver health engagement, four phases were identified, namely:

1. Denial
2. Hyperactivation
3. Drowning
4. Balancing

The identified phases are similar to Kubler-Ross theory indicating that there are five stages of grief, namely denial, anger, bargaining, depression, and acceptance. This theory can be compared to the Caregiver Health Engagement (CHE) model for caregivers. Overall, institutions that focus on family-involving care (informal caregivers) may benefit from this study. The CHE model may be used as a guide for the institution in order to better their policies and services so that informal caregivers may be enhanced. The validity of the caregiver engagement scale has been preliminarily verified with the use of statistics. More research using the scale with different samples is needed to generate more data that may efficiently direct clinical practice into identifying overall informal caregivers'

engagement level. More supportive policies can be made in the institution to help support informal caregivers in caring for their loved ones.

In the end, it is indeed a good collaboration of health care workforce and informal caregivers that may improve overall quality of health care.

In another article (Barello, Graffigna, & Savarese, 2015), the caregiver role in caring for the older persons has been assessed and studied. Sick older persons develop long term diseases which require complex medical management and lifestyle changes. Informal caregivers, also known as the family members, play a crucial role in this part. Health care is thus debated to be family-centered instead of being patient-centered. Caregiver engagement is thus an important topic.

Caregivers are the ones who assist in making decisions for the patients. Occasionally, they serve as policymakers and substitute for the patient, thus being co-patients; however, they have difficulty in understanding the terms that are too technical. Caregivers are also the people who experience the most changes in daily routines, roles, division of family responsibilities, and social inclusions in their lives. Eventually, they become prone to depression, anxiety, and poor physical health. Caregivers also serve as surrogate care managers by bridging gaps when there is a lack of multidisciplinary care (Barello, Graffigna, & Savarese, 2015).

**Nursing Homes and the Philippines**

There is a growing population of older people here in the Philippines. With an estimate of 7 million senior citizen in the Philippines, it has been estimated to increase even more. Because of this, retirement, and health care coalition executive director Marc Daubenbuechel states that nursing homes have a big opportunity here in the Philippines. Nevertheless, there is a challenge faced by geriatric care homes in the Philippines. One of these is the family culture. Filipinos

are known to live with their older people even if they already have their own families. It is the social norm that a Filipino family lives with their senior-aged parents, and even closes relatives at times, for overall support and guardianship. It is generally believed that nursing homes are not in the context of the Filipino culture. Despite this culture, there are still several neglected and abandoned older people in the Philippines. There is an institution named Golden Reception and Action Center for the Elderly and Other Special Cases (GRACES) that can be a temporary home for such older people. Sadly, the increasing abandonment of older people occurs which eventually leads to overpopulation in such facilities. In fact, Daisy Caber, social worker from GRACES, says that,

> *"In the Philippines there really are only a few elderly institutions—and there are only a few slots from NGOs [non-governmental organizations] and private institutions, round 30 to 40 slots. Unlike in government [elderly institutions], like GRACES or Golden Acres, which can cater to over 100 people."*

The House Bill 4946, entitled Homes for Abandoned Seniors Act of 2014, recognizes that older people can be neglected due to various circumstances. This Bill aims to thus establish a nursing home in every municipality in the city.

As of now, it is still being pondered on whether Filipinos need to send their older people to nursing homes, especially when dementia or other chronic diseases take place. Nursing homes possess geriatric specific facilities that can be of big help. However, the culture, alongside with the high cost of nursing homes, drives the Filipinos away from the idea of entering their older people in nursing homes. Daubenbuechel still believes that the notion of putting older people in nursing homes as not normal will eventually change, as nursing homes are expected to increase here in the Philippines (Business Mirror, 2022).

Older people who become very ill, regardless of the condition, are usually taken care of by Filipino families, especially since grandparents are considered a standard family member. If the condition progresses, sometimes, Filipino families are challenged to decide on letting them stay in nursing homes, for the safety of the older person and their family as well. More challenging health conditions among older persons sometimes lead to putting older people in nursing homes. Nursing homes are thus gradually increasing in the Philippines. This may be due to the availability of increased geriatric skilled staff who can care for the older person 24 hours a day. Although it may be a sad decision sometimes to bring older people to nursing homes, it is a decision that must indeed also be pondered on when necessary (Lacaba-Bago, 2020).

**Institute on aging**

On January 26, 1996, the National Institutes of Health was approved and alongside it, the Gerontology and Disabilities Programs Cluster, through the Committee on Aging and Degenerative Diseases (COMADD) was established. It is composed of various allied health groups within the University of the Philippines system (Ambe, Garcia, Giron, and Vega, 2021). The COMADD's vision is:

> *"The Filipino elderly enjoying a healthy body, mind, and spirit; being treated with dignity, and valued as a productive member of society; in a dynamic process unique to him/herself and beginning a life of unlimited possibilities."*

The COMADD's mission is as follows:

> *"To create with the aging Filipino, unlimited possibilities for their value-added life through scientific research, training and education, and specialized services."*

The institute has since then started conducting training in gerontology since 1998. It has conducted research forums and training programs to specifically help understand and cater to the needs of older people.

Another project, called the EU RISE PROJECT DREAM, was established also to help older people with lesser cognitive and functional abilities to still grow and contribute to society. This program was put together by Dr. Shelley De La Vega under the Research and Innovation Staff Exchange (funded by the European Commission) (Ambe et al., 2021).

Policies from the government have also been established to promote healthy aging. The Republic Act 9994 (Expanded Senior Citizen's Act derived from RA 9257) is one of them that mandates government hospitals to give free services to older patients.

The Philippine General Hospital also has established the **Geriatric Clinic of the Department of Outpatient Services in the Department of Medicine** in 2004 to cater to different geriatric patients and has catered to 595 per year (2011-2014) (Ambe, Garcia, Giron, and Vega, 2021). The older people are a population receiving increased support from different organizations. Due to the changes associated with aging, they face different challenges holistically. Having a support system from their family and relatives is vital for them. Nevertheless, support from local and national government programs is also a very big help for these older people.

## Synthesis

In the Filipino culture, it is automatic for families to take care of their older persons. This extends even up to the period of hospitalization. Filipino family members are therefore the usual informal caregivers among the hospitalized older persons (Andel & Badana, 2018). Although it is inevitable that some older persons stay at longer periods at the hospital due to their complex health condition, it is vital that the informal caregiver engagement be maintained, thus requiring early identification. Most

studies on nursing focus on nurse involvement to the patient and the relationship of its involvement. Other studies focus on informal caregivers and mostly state that positive informal caregiver engagement significantly improve the older persons' health condition thus preventing the complications associated with prolonged hospital stay and prompting earlier discharge (Heath, 2017). More research is needed on the factors affecting the engagement of informal caregivers to help care more for the older people.

## THEORETICAL FRAMEWORK

### Kristen Swanson Theory of Nursing

One study is done following Kristen Stewart's theory of nursing. The study 'effect of structured nursing care rounds on selected nursing quality indicators' aims to identify the concepts of the theory of Kristen Swanson's theory of caring, to enumerate the effect of the Swanson theory to the nursing performance and patient satisfaction. The study focused on describing Kristen Swanson's theory in a descriptive method. The aspects of the Swanson theory include (a) maintaining belief, (b) knowing, (c) being with, (d) doing for, and (e) enabling, were explained thoroughly.

Maintaining belief –patients are seen by the nurse as individuals who are facing their future and can overcome their challenges. This is the core of nursing care because this is where the nurse accepts the others with high esteem and confidence, believing that this patient is an individual who has a higher being – God.

Knowing – being overall aware is important for the nurse in providing patient care. Identifying the patient in his or her overall state and reality enables the nurse to know more about the patient. The caring style approach makes the nurse become nurturing, more perceptive of his/her situation, thus providing a more humanitarian

approach. The patient's need is addressed holistically. The nursing traits developed in this are:

> *"Attentiveness, commitment, deeper involvement and going beyond routine. While emphasizing a respectful and nonjudgmental attitude towards the uniqueness of persons, knowledge of clinical practice, well developed skills in assessment, data gathering, clinical reporting, documentation, and communication."*

Being with – involves not only being physically there with the patient, but also emotionally.

Doing for – the unique function of the nurse is to assist the patient until he/she regains independence.

Kristen Swanson's theory of nursing provides a theoretical guide for improving overall nursing care delivery. It relates the humanitarian side of nursing which is known to be a required side to nursing. The highly significant qualities were:

> *"Compassion, knowledge, optimism, reflection, concern and commitment, communication skills, focus on the others experience, respect for individual dignity/worth and being present to the other."*

If used well, this theory can surely guide nurses to a more personal approach in patient care. This theory guides other models to a deeper focus on the science of caring. The Carolina Care model was used in Carolina hospitals. This model used the theory of caring as a guide, and over the six years, the hospital experienced an improvement in satisfaction of the patient experience. It is suggested that the Swanson theory of nursing be used more often to guide future nursing practices in hospitals. Further research on the Swanson theory can guide overall nursing practice to render a more personal approach in caring for patients (Lillykutty & Samson, 2018).

Another study was made using Kristen Swanson's Theory of Nursing in relation to critical care nursing personal experiences. The title of the study is Using Data from Critical Care Nurses to Validate Swanson's Phenomenological Derived Middle Range Caring of Theory. The purpose of the study was to identify the patterns of caring based on the personal experiences of the critical care nurses, and the nurses' caring patterns that validate Swanson's theory of caring. The participants were selected from a database named American Association of Critical Care Nurses. Following the principle of confidentiality, all the subjects were mailed regionally.

The information from the participant was obtained using 13 demographic data and two open-ended questions that required personal answers from the participants:

a) Describe in your own words one event in your personal life that made you a more caring nurse.

b) Give specific examples of how that experience has changed your practice.

The data was analyzed using content analysis. A total of 185 mails were sent.84 out of the 185 participants responded. Among the demographic data collected, the following were observed:

- 30 respondents critical care nurses for already 6-10 years
- 50 respondents were female.
- Regarding race, 45% were Caucasian, 18% were African American, 18% were Hispanic, 17% were Asian or Pacific Islander, 3% were American Indian.
- 48% were ages 31-40 years old.
- 48% had at least having a bachelor's degree in nursing.
- 71% of the nurses hold specialty certification (e.g., CCRN, CCNS)
- 79% reported full employment status (>32 hours a week)
- 52 % worked in medical surgical ICU or coronary care units.
- 86% worked with adult patients.

- 75% of the employees worked in a university / teaching hospital.
- 66% worked in units with limited visitation policies.

The personal experiences categorized by themes were as follows:

Personal Situation - the personal experiences enabled the nurses to further provide care to their patients. 4.7% of the respondents had no personal experience to enhance their care.

Unconditional Help - the nurses provided unconditional help especially to patients who were unable to resume their own activities of daily living.

Promoting Self-Care - the nurses promoted self-care by being an advocate, teacher, coach, assistant, and supporter.

In relation to Kristen Swanson's Theory:

Maintaining belief - themes of offering hope and optimism despite the odds is one of the personal experiences among almost half of the nurses.

Knowing - the nurses were willing to listen and know that their personal situation will help them in caring for the patient.

Being there - 60% of the nurses described having done the care of 'being there'. These include a) listening; b) asking patients to ask questions and allowing them to talk; c) doing the little things for patients.

Doing for - the nurses' personal experience of providing unconditional help accounts for Swanson's theory of doing for.

Enabling - the personal experience of being an advocate and coach enables the nurse to promote self-care among patients (self-care is an important aspect in Swanson's theory of nursing).

Studies have shown that personal life care affects the caring of critical nurses to patients. Future research can be focused on identifying if caring can be learned or is instinctual. Further study must also be done on the demographic data and the personal attitudes or attributes of patients.

The study challenges nurses to look further into their life experiences and how it can be further used to care for the patient.

Other nurses describe Swanson theory of care as a guide for connecting with patients in this nursing world where providing comfort and empathy seems to be more often overlooked. Nurse Tiffany Maxton (2014) is a labor and delivery nurse working in a variety of roles. At first, the author nurse Tiffany Maxton had difficulty working with them especially during the demise process. However, using the Swanson theory of caring guides her into providing the needed care for the patient and their families. The article entitled “Swanson’s theory of Caring” aims to identify the role of Swanson’s theory in nursing and the role of theory in the implementation of her care.

Swanson’s theory is a middle range theory that emphasizes the different stages of caring. These include knowing (the nurse attempts to understand the event), being with (emotional presence of the nurse to patient), doing for (caring for patient with empathy), enabling (helping the patient in transitions), and maintaining beliefs (helping the patient see through this life process).

Nurse Maxton cites example of Swanson’s theory by stating an example of her patient - a female patient with a miscarriage and fetal demise. In knowing, she incorporates emotional connectedness through empathy to know more about the patient’s concerns. In being with, she attentively listens to the patient when they are ready to communicate. In doing for, she communicates that she is deeply sorry for

their loss and provides interventions as if they were doing it themselves. These include giving them time and space to mourn, and letting other health care workers know that the patient had a fetal demise. In enabling, she facilitates the transition on fetal demise by letting them grieve privately, letting them write a letter to express their emotions, and letting then hold the baby for closure. In maintaining belief, the nurse lets them know that there are also other support groups that can help the patient and her family face the future better despite their fetal demise. Using the Swanson Theory of Caring is useful for gaining emotional connectedness to patients (Maxton, 2014).

**Patient Health Engagement Model.**

The article discussed the importance of the Patient Health Engagement Model (PHE model) as a basis for caregiver engagement among older people. There are four phases of the PHE model. The first one is the blackout phase, characterized by the blockage of the ability to think, act, and feel towards the condition. The second one is the arousal phase characterized by the hyper-attention to the critical signs and information given to the patient. The third one is adhesion, a phase in which the patient can confidently comply with the prescribed regimens. The fourth phase is eudemonics, a state wherein the patient can live an independent and meaningful life with his or her condition.

The caregiving health engagement, on the other hand, focuses on the roles of the caregiver in each phase of the patient's health engagement. It has four roles as well, in response to the PHE model. These include:

a) **Blackout phase** - caregiver serves as a **consoler** wherein the caregiver provides emotional scaffolding. During this phase, the caregiver needs information

from healthcare providers and support in order to help the patient overcome the blockage cognitively and emotionally.

b) **Arousal phase** - the caregiver serves as a **nurse** in this phase. In this phase, the caregiver takes the reins in the care (since patient is in a hyperactive state towards the critical information given to him). The caregiver may even replace the patient in making clinical decisions.

c) **Adherence phase** - the caregiver serves as a **security guard** in the adhesion phase. In here, the caregiver becomes more committed to helping the patient become more autonomous despite the condition.

d) **Eudaimonic Phase** - the caregiver serves as a **life buddy**. In here, the caregiver has learned to accept the consequences and conditions of the condition of the patient, thus successfully living with it in a harmonious manner.

By re-examining the role of the PHE model in caregiver engagement, it is emphasized that the caregivers cognitive, emotional, and behavioral pattern change over time. The overall state of the caregiver changes in accordance with the PHE phase of the patient, thus requiring continuous support from the healthcare professionals. For older persons patients, these caregivers need supportive actions such as providing emotional support, cognitive support (health information), and skill support in caring for the older persons. (Barello, Graffigna, &Savarese, 2015).

Lastly, these caregivers also pass through a journey while caring chronically for the older persons. They pass through the blackout phase, arousal phase, adherence phase, and eudaimonic phase too. Eventually, they reach the eudaimonic phase to aim for a harmonious and balanced life despite the presence of chronic conditions.

In conclusion, the healthcare system grows to be a complex system catering mostly to its patients; however, more improvement must be given in caring for the patients' families -- the informal caregivers who care for older persons patient's complex health conditions.

**Patient and Family Centered Care Theory**

This theory is grounded on promoting collaboration between the healthcare workers, patients, and families. This theory collaborates with people of all ages in all types of healthcare settings which makes it adaptable for involving informal caregivers caring for older persons patients. The core concept of patient and family centered care include:

(a) dignity and respect - the patient and family's knowledge, values, culture, and decisions are honored by the health care professional and the organization.

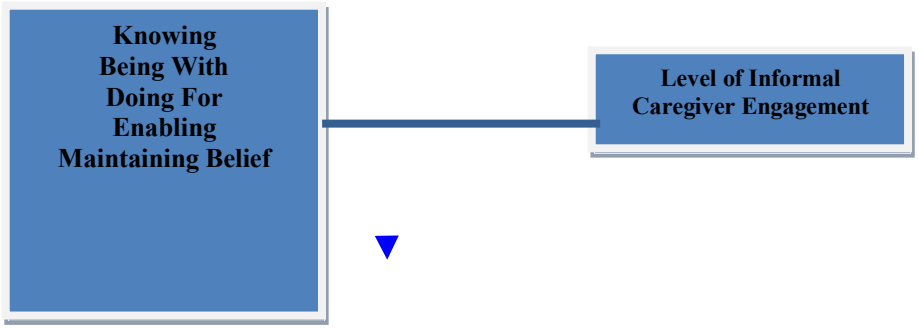
(b) information sharing - patients and family receive accurate, affirmative, and timely information for them to participate and make decisions as a family.

(c) participation and collaboration - families and patients are included in the decision-making process involving the patient and policy development (Institute for Patient- and Family-Centered Care, 2019).

## CONCEPTUAL FRAMEWORK

Figure 1.

*The framework shows the relationship of the dependent variables (Concepts under Kristen Swanson's Theory of Nursing) to the independent variable (level of informal caregiver engagement)*




The study involved focusing on the factors of knowing, being with, doing for, enabling, and maintaining belief as independent variables that are factors to be considered in care, and their relationship to the level of informal caregiver engagement.

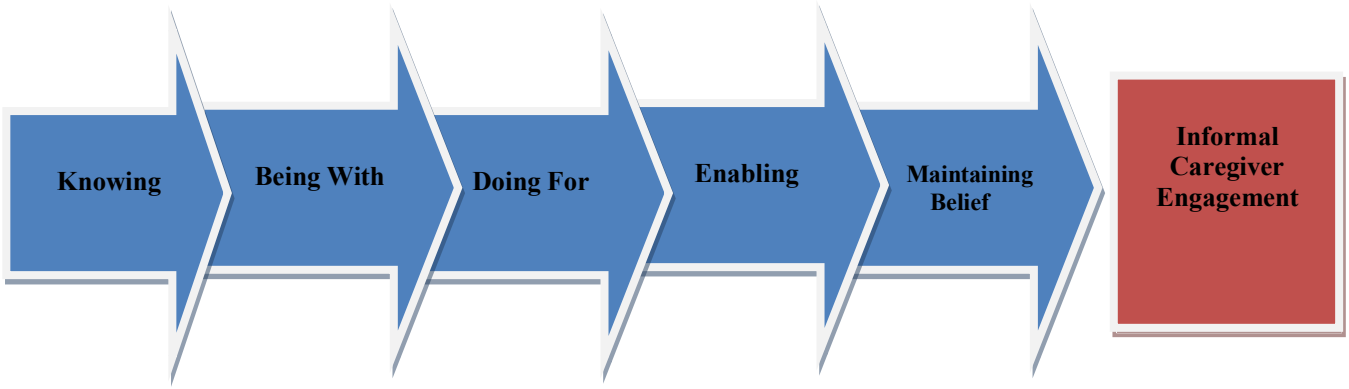
Swanson's theory focuses on nurturing caring as a method of nurturing in which one values an individual. The care can be the valued other (the one cared for), toward one who feels (personal and intimate), and a sense of commitment (accountability and duty) (Kalfoss & Owe, 2015).

It is composed of an overlapping set of caring values that is composed of Knowing, Being With, Doing For, Enabling, and Maintaining belief.

Each process contains different levels of engagement, that when combined form an increased humanitarian and dignity centered engagement to the patient.

Figure 2.

*Sequential illustration of identifying the state of care among informal caregivers using Swanson's theory of care and its relationship to informal caregiver engagement.*




Using Kristen Swanson's theory is consistent for guiding the care given to the older persons patients (Ketterlin, 2020). Each of the sequences from Kristen Swanson's theory of caring is being identified through a questionnaire in the form of a Likert scale questionnaire. The nurse's role in the Kristen Swanson theory is transferred to studying the informal caregiver's care in relation to the Kristen Swanson Theory because more study tends to be focused on nurse care only. Expanding the relationship on the informal caregiver's care to their hospitalized loved is focused on this study using the Swanson Theory.

*Knowing* is the awareness of the informal caregiver on their loved one's condition. It is about being informed about their loved one. *Being with* pertains to the emotional presence of the informal caregiver to their hospitalized loved one. It means they offer their shoulder to cry on, and making their hospitalized loved one feel that they are being someone they can depend on. *Doing for* pertains to the informal caregiver being an advocate for his/her hospitalized loved one, which involves engaging in the loved one's needs until they are met. *Enabling* pertains to the informal caregiver and the hospitalized loved one being informed on their situation to successfully make their own decision. *Maintaining belief* pertains to the informal

caregiver having hope for his/her hospitalized loved one so that he/she will get well. The Swanson theory is useful for generating more knowledge among informal caregivers and its relationship to the level of informal caregiver engagement.

## OPERATIONAL DEFINITION OF TERMS

*1) Older persons* - pertains to the aging population that is 60 years old and over (HelpAge Global Network, 2019). This definition will follow the findings in Philippine research in which being an older person is 60 years old and above (Binay 2017); however, due to the increasing health condition accompanied with aging, the study will include only participants 60 – 74 years old since the is the 1st age group range classified by the work of Akishita et al., (2017). The level of measurement is ordinal.

*2) Informal Caregiver* - informal caregiver pertains to the family and relatives who provide care to the older persons (Alloway et al., 2019). They are the participants of this study with a nominal level of measurement.

3) *Kristen Swanson Theory of Care* – a theory used by this study that guides nursing care to promote a more personal approach to patient care. Its sequential care process includes knowing, being with, doing for, enabling, and maintaining of belief.

*4) Knowing* – knowing pertains to the nurse's awareness and knowledge about the patient (Lillykutty, and Samson, 2018).

*5) Being with* –pertains to the nurse being emotionally present when caring for the patient (Lillykutty, and Samson, 2018).

*6) Doing for* – pertains to the nurse being an advocate, and caretaker for the patient. The nurse does things on behalf of the patient (Lillykutty, and Samson, 2018).

*7) Enabling* – the nurse must empower the patient by providing necessary health information so that the patient may make sound decisions (Lillykutty, and Samson, 2018).

*8) Maintaining belief* – pertains to maintaining hope in the patient's condition that he may recover (Lillykutty, and Samson, 2018).

## RESEARCH HYPOTHESIS

Ho1: There is no significant relationship between the caring processes and the level of informal caregiver engagement.

Ha1: There is a significant relationship between the caring processes and the level of informal caregiver engagement.

# Chapter III

# RESEARCH METHODOLOGY

## Research Design

The study utilized the descriptive correlational research design to identify the relationship between the caring processes theories from Kristen Swanson's theory of caring and the level of informal caregiver engagement. The study did not control any of the variables and focused on describing the existing significant relationship among the variables. No inference was made from the data that will be obtained. Correlational research is used to study two variables that are quantitative and it is used to predict if they are related to one another, hence this design will help identify if the caring process has a relationship with the level of engagement. This research design identifies only the relationship whose results can be used to draw further studies on informal caregiver engagement in the future (e.g., whether a cause-and-effect relationship is needed, whether it needs a deeper quantitative study,) (Sumeracki n.d.)

## SAMPLING TECHNIQUE

The study used the purposive sampling technique because the researcher selected only respondents who fit the set criteria. The informal caregiver participants of a selected tertiary hospital in Las Piñas City among medical surgical wards must be caring for their loved one who is aged 60-74 years old only.

The hospital has a 300-bed capacity, composed of non-COVID and COVID wards, and is composed of wards and special areas. Due to the ongoing changes in pandemic, there are times that the wards are converted to COVID wards, vice-versa. Hence, the researcher for now chose to represent 15% of the population to meet the statistical constraints, with a confidence level of 95% and margin of error of 5%. The sample size was thus 119 which was eventually rounded off to 121 for certainty of compiled data.

The informal caregiver must also be able to meet the following criteria:

2.1. The informal caregiver can read and write.

2.2. The informal caregiver is 18 years old and above.

2.3. The informal caregiver participant can be a family member, relative or friend who has cared for the older person for at least 1 month.

2.4. The informal caregiver participant must be caring for the older person must not be hired or paid.

The exclusion criteria for the informal caregiver are:

2.5. The study did not include informal caregivers who are sick in any manner or are not feeling well.

2.6. This study did not include informal caregivers who did not want to participate in this study for any reason whatsoever in the meantime.

2.7. This study also did not include informal caregivers who verbalize that they are not cognitively prepared to answer the questionnaire.

The study obtained participants from the JONELTA ward, third main, and fourth floor of the selected tertiary hospital in Metro Manila, Las Pinas. The estimated population among all the mentioned wards is around 25-40, depending on the present census held while the study is being done. The study, however, collected a sample of 121 participants, in which the data collection will be done in 1-6 months.

Since the ethical board of Perpetual Help Medical Center required the researcher to have a waiver of consent, the researcher did not obtain any written consent from the participants. The researcher visited each of the qualified informal caregivers' rooms and verbally read the waiver of consent to them. The participants then answered a printed version of the Likert style questionnaire on the caring processes determinants (knowing, being with, doing for, enabling, and maintaining belief) and the level of informal caregiver engagement.

For JONELTA Ward, the researcher made a separate letter for commencement in research in non-covid wards and submitted a letter on data privacy, which was eventually approved (please see appendix C for letter).

## RESEARCH SETTING

The study was done in Perpetual Help Medical Center Las Pinas. The hospital has a 300-bed capacity and can cater to different medical cases due to its wide specialization in services.

Due to the COVID-19 pandemic, the medical surgical ward setup has changed. The second floor has a hope wing for cancer patients admitted. A charity area is also available on this floor named JONELTA ward. The third floor has become a step down for post COVID-19 patients who are now negative. The fourth floor has been an admission floor for covid negative patients. The fifth and sixth floor has been changed to a covid ward. The fifth floor, however, becomes a non-COVID ward during times of low covid census. Since each general ward has different medical-surgical cases of different ages, the study will include all general ward floors and then will identify which among them have eligible informal caregivers. The qualified participants are visited by the researcher for the answering of the questionnaires; however, in order to avoid complications in this research study, the researcher limited the visit to only non-COVID floors.

## DATA COLLECTION

In Phase I, the researcher asked permission from the Ethical Research Board from the University of Perpetual Help Medical Center Las Pinas or University of the Philippines Open University. The permission was obtained by sending a letter of request for review. Afterwards, the researcher informed the Director of Nursing of the University of Perpetual Help Medical Center Las Pinas through a formal letter. The letter aims to inform the commencement on the conduction of the study in the said institution. The

researcher also asked permission from the head nurses to conduct the research in each of their respective wards through e-mail. The non-COVID wards were chosen only for safety reasons of the researcher. The COVID wards were not included in the study as COVID-19 patients may have complications which can affect their informal caregivers' overall well-being.

In Phase 2, the researcher made a courtesy visit directly to the director of nursing and the head nurses of the selected wards. The pre-made questionnaire was tested among other informal caregivers of patients aged 30-59 years old and the data was collected and assessed for consistency. The pilot testing was done on 10 participants. The researcher counterchecked this with the research adviser prior to actual conduction of the pre-made questionnaires.

In Phase 3, the researcher went to the nurses' stations of each selected wards in order to obtain initial data on the charts and screened for patients who are aged 60-74 years old. The qualified candidates were screened and then visited by the researcher to establish rapport with the family and patient. A waiver of informed consent is applied in this study, because the research results in no more than minimal risk to the participant; Nevertheless, the researcher reads a verbal consent to the eligible participants to indicate the number of participants who are willing to join.

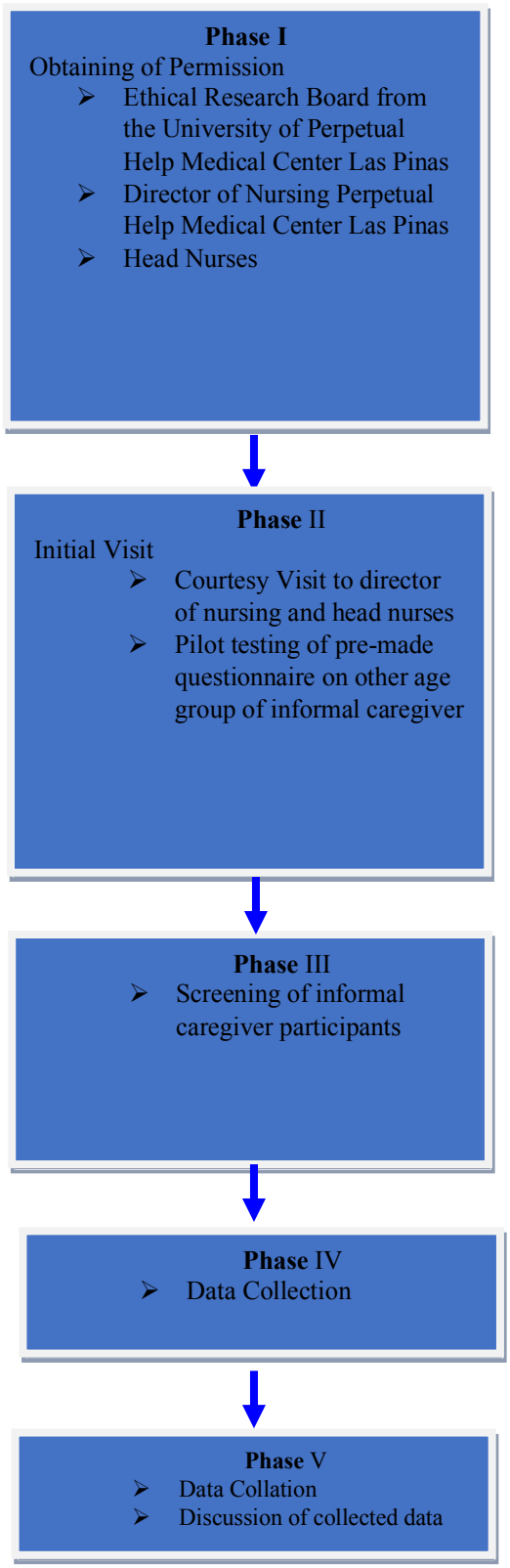
In Phase 4, the researcher, together with the research assistant, performed data collection on the qualified informal caregivers who are taking care of older persons patients aged 60 – 74 years following the ethical considerations. The data is collected by distributing the printed version of the questionnaires to each patients' room and will be collected after 30 minutes for each participant. The questions are presented in a Likert type questionnaire, and participants will only have to tick the checkbox that contains their answer. The time limit is a maximum of 30 minutes.

If any participants dropped out or left the questionnaire unanswered this became immediately noted by the researcher.

In phase 5, the data collation was done by the researcher. The data obtained will be organized, presented, and analyzed using the following steps:

1. The researcher will identify the levels of measurement of the variables. The researcher used statistical software of MATLAB / SPSS / STATGRAPHICS. The data are checked as to what statistical treatment is suitable.
2. The researcher selected a topic based on the objectives of the study. The researcher presented the following data for correlation:
    a. The caring processes using Kristen Swanson's theory of care is identified.
    b. The level of informal caregiver engagement of the informal caregiver participants is identified.
    c. The relationship of Swanson theory's caring processes and the level of informal caregivers are identified. The (a) knowing, (b) being with, (c) doing for, (d) enabling, and (e) maintaining belief is selected and correlated for its relation to the level of informal caregiver engagement.
3. The correlation was done with the statistical software of choice.
4. The results were discussed with the faculty adviser through pre-set zoom meetings.

Figure 3. Data Collection Process

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## RESEARCH INSTRUMENT

The study used the following instruments for data collection:

**Table 1.**

*Swanson's Theory of Caring Questionnaire.*

**Background**

**Informal Caregiver Age**

**Informal Caregiver Gender**

**Relationship with patient**

*Items obtained from Bjork, M., Brostrom, A., Hjelm, C., Hodges, E., Knuttson, S., Mårtensson, S., and Swanson, K. (2020)*

| CATEGORY | Item | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| KNOWING | I am aware on the situation of my loved one. | | | | | |
| | I seek ways for taking care of my loved one by listening to my health care providers and asking questions when needed. | | | | | |
| | I am able to clearly address to the nurses and doctors my inquiries and concerns about my loved one when the need arises. | | | | | |
| BEING WITH | I make sure I am available for my loved one when the need arises. | | | | | |
| | I sometimes see the pain of my loved one and choose to endure it with him / her. | | | | | |
| | I choose to be with my loved one and listen with empathy and compassion. | | | | | |
| DOING FOR | I care for my loved one like how patient should do for himself/herself. | | | | | |
| | I find ways to attend to the needs of my loved one in such a way that it increases his / her sense of dignity. | | | | | |
| | I attend to the needs of my loved ones with empathy and compassion. | | | | | |
| | I anticipate the needs of my loved one before any problem arises. | | | | | |
| ENABLING | I find ways to make my loved one feel empowered during his/ her hospital confinement. | | | | | |
| | I enhance my loved ones healing by promoting a therapeutic environment inside his or her hospital room. | | | | | |
| MAINTAINING BELIEF | I keep my loved one feel hopeful by listening and doing his or her requests that boost his or her morale. | | | | | |
| | I do my best to let my loved one maintain a hope filled attitude in whatever way possible (e.g. praying together, sharing problems, letting my loved one connect with others) | | | | | |

**Table 2.**

*Caregiver Engagement Scale (Alloway, C., Goldhar, J., Kokorelias, K., Kuluski, K., Peckham, A., Petrie, J 2019*

| Category | Question | 1 | 2 | 3 | 4 | 5 | I don't know |
|---|---|---|---|---|---|---|---|
| | | Low to High | | | | | |
| **INFORMAL CAREGIVER POLICY AND STRUCTURE** | The tools and resources I need to support my loved one are provided in this institution (e.g. contact information to my loved ones health care providers are readily available, I can easily reach my nurses when I need something) | | | | | | |
| | I am able to communicate my loved ones needs to his/her health care providers because of a conducive health care set-up. (e.g. adding third chair for informal caregiver during consultations, making open space for caregiver to also listen during nursing and doctor rounds). | | | | | | |
| | I know when to find time to privately care for my loved ones in the institution because of an organized set of rounds among doctors and nurses. | | | | | | |
| **CULTURE AND MINDSET** | The health care team is able to recognize barriers (language, health literacy, physical and financial limits, perceptions on engagement) in preventing informal caregiver engagement | | | | | | |
| | The health care staff reach out to me and are willing to discuss the different aspects of informal caregiver engagement | | | | | | |
| | I feel that there is a clear quality policy in caring for my loved one, thus letting me focus on being with my loved one holistically | | | | | | |
| | Whenever I make mistakes in doing my informal caregiver care, I do not feel a culture of blame and is instead seen as a learning opportunity to share. | | | | | | |
| | The quality of care helps me focus in rendering a more personal approach of care to my loved one | | | | | | |
| | The health care providers at times help me identify what I need (health care needs that are difficult to verbalize or tell) | | | | | | |
| **PROCEDURES** | I am flexible and open minded to identify problems early in order to address it to the health care providers | | | | | | |
| | I engage early in talking with my loved one before procedures are done to him / her. | | | | | | |
| | I feel engaged overall in caring for my family / relative | | | | | | |
| | I am able to give feedback on the status of my family / relative's health to the healthcare team. | | | | | | |
| | I am able to share my views on the procedures done to my loved one. | | | | | | |

## PLAN FOR DATA ANALYSIS AND INTERPRETATION

This described the data analysis plan based on each research question to be answered including demographic data to be gathered. Start with demographics then go through each objective. Sample dummy tables are usually included to show how such data was presented.

### Demographic data

| | |
|---|---|
| **Name (Initials Only)** | **Gender** |
| **Age** | **Relationship with patient** |
| **Civil Status** | |

**Table 3**

*Plan for data analysis and interpretation table*

| Specific Research Questions | Independent variable/s and level of measurement | Dependent variable/ and level of measurement | Level of analysis: Identify if univariate, bivariate or multivariate | Statistical Test or Technique to be used (Descriptive or Inferential analysis; specify the type) | Explain the appropriateness of statistical treatment to be used |
|---|---|---|---|---|---|
| What are the current caring processes among informal caregivers | n/a | Ordinal | Univariate | | The spearman Rho is the appropriate statistical treatment for ordinal variables. |
| What is the level of informal caregiver engagement? | Level of informal caregiver engagement | Ordinal | n/a | | The spearman Rho is the appropriate statistical treatment for ordinal variables. |
| Is there a relationship on the caring processes and level of informal caregiver engagement, namely:<br>(For the caring processes)<br>a) Knowing<br>b) Being with<br>c) Doing for<br>d) Enabling<br>e) Maintaining belief<br><br>(For the level of engagement)<br>a. Policy and structures | n/a | Pearson's | Bivariate | | The Pearson is used for correlation studies. |

| | | | | | |
|---|---|---|---|---|---|
| b. Culture and mindset<br>c. Procedures | | | | | |
| Specific Research Questions | Independent variable/s and level of measurement | Dependent variable/ and level of measurement | Level of analysis: Identify if univariate, bivariate or multivariate | Statistical Test or Technique to be used (Descriptive or Inferential analysis; specify the type) | Explain the appropriateness of statistical treatment to be used |
| What are the current caring processes among informal caregivers | n/a | Ordinal | Univariate | | The spearman Rho is the appropriate statistical treatment for ordinal variables. |
| What is the level of informal caregiver engagement? | Level of informal caregiver engagement | Ordinal | n/a | | The spearman Rho is the appropriate statistical treatment for ordinal variables. |
| Is there a relationship on the caring processes and level of informal caregiver engagement, namely:<br>(For the caring processes)<br>a) Knowing<br>b) Being with<br>c) Doing for<br>d) Enabling<br>e) Maintaining belief<br><br>(For the level of engagement)<br>a. Policy and structures<br>b. Culture and mindset<br>c. Procedures | n/a | Pearson's | Bivariate | | The Pearson is used for correlation studies. |

## DATA MANAGEMENT

The data obtained was analyzed using the SPSS (Statistical Package for the Social Sciences). The study focused on descriptive statistics to obtain the frequency in each category in the questionnaire.

The data was tested using the Spearman's Rho test to test the relationship for association of the independent variable (Swanson's theory caring processes) and the dependent variable (level of informal caregiver engagement).

### *Data Privacy and Management*

In accordance with Department of Health, Department of Science and Technology, Philippine Health Insurance Corporation, the Joint Administrative Order 2016-0002 states that (2016) health information from patients and their families can be obtained and stored electronically to allow IT-enabled health services which can allow exchange of data from different health centers and institutions. This allows easier data access for faster decision-making among health care providers for patients. The data security of these sensitive health information is essential to prevent information leakage and breaches of confidentiality.

### *Consent*

This study will implement the waiver of informed consent throughout the study.

### *Data gathering and storage*

The data was gathered with the help of a research assistant. After screening and identification of willing participants, the researcher and research assistant visited each room and oriented the participants to the questionnaires. The participants were given a maximum of 30 minutes to answer. After 30 minutes, the research assistant collected the papers and gave it to the researcher.

***Data usage***

The electronic, recorded, and paperwork data must only be used within the research confidentiality measures that was disclosed by the study (in the research objectives) clearly stated to the informal caregiver.

***Data retention***

For storage and research purposes, the research retained the study for 3 years at maximum.

***Data disposal***

The data shall be deleted from the laptop of the researcher and the USB after finishing its set period for data retention.

***Tokens***

Each participant who has successfully completed the study was rewarded with a token of appreciation, containing a set of sanitizing kit (alcohol and facial tissue).

## ETHICAL CONSIDERATIONS

***Nonmaleficence***

Nonmaleficence means that it must not also harm the institution or participants by avoiding confidentiality breach. The participant (informal caregiver) should not be harmed. The researcher observed confidentiality in all data collection methods and observed sensitivity when asking the interview and questionnaire questions. The researcher always observed courtesy.

***Justice***

This is to make sure that the participants are treated fairly and must not be disturbed in any form while engaging with their family member / relative. The informal caregivers are allowed to focus on their patient in certain cases (in case of deterioration,

emergencies) and may not answer the questions (even if previously agreed on a certain schedule) to attend to the patient and to avoid risks of complications.

***Beneficence***

The study, since the results are obtained and association between variables are made, the researcher must impart the knowledge to the institution and if allowed, especially if it helps improve their knowledge on their engagement to the patient.

***Autonomy***

The researcher respected the decisions of the participants because they must voluntarily participate. They were given the option to freely give the most convenient time in the study. The participants also have the right to withdraw or refuse from the study, regardless of their reason.

To obtain bioethical consideration, the researcher made a letter addressed to the ethical committee of the university of the institution. The risks were assessed by the head. After being approved, the researcher informed the medical director, nursing services director, and the data privacy officer. After the approval, the researcher provided a copy of the approved letters to the head nurses per ward, and then the study was done.

***Conflict of Interest***

The researcher is currently working as a nurse in Philippine General Hospital. The researcher previously worked at Perpetual Help Medical Center from 2017-2020 as a staff nurse.

## Chapter IV

## RESULTS AND DISCUSSIONS

This chapter presents and discusses the results in the study. The data presented are arranged according to the objectives of the study.

***Table 4.***

*Sociodemographic Profile of the Respondents (n = 121)*

| **Characteristics** | | |
|---|---|---|
| | *Mean(M)* | *Standard Deviation* (*SD*) |
| **Age** | 46.74 | 16.34 |
| **Gender** | *n* | *%* |
| Male | 29 | 24 |
| Female | 92 | 76 |
| **Relationship with patient** | *n* | % |
| **1** | **39** | **32.2** |
| **2** | **10** | **8.3** |
| **3** | **1** | **.8** |
| **4** | **3** | **2.5** |
| **5** | **42** | **34.7** |
| **6** | **6** | **5.0** |
| **7** | **10** | **8.3** |
| **8** | **5** | **4.1** |
| **9** | **5** | **4.1** |
| **Total** | **121** | **100.0** |

The total numbers of respondents were 121, wherein the ages of the respondents ranged from 18 – 76 years old. The average age of the respondents was in the middle adult age group (*M=46.74, SD=16.34*).

Most of the informal caregivers were females (92 or 76%). Among the informal caregivers, most were spouses of either husband or wife (39 or 32.2%). The least was sister-in-law or brother-in-law (1 or 0.8%).

According to the World Health Organization, the revision of age are as follows: young age for the people below 44 years old, middle age is 44-60 years old, elderly age is 60-75 years old, senile age is 75-90 years old, long-livers are those living after age 90 years old (Dyussenbayev, 2017). It has been noted among research that mostly female informal caregivers are dominant compared to the males (Blazeviciene et al., 2021) with the interquartile range age of 48-58 years old. Aside from the caregiving tasks, women also play a series of roles – they also work as hand-on provider, care manager, a friend or companion and a partner in decision making. Many studies have noted a generalized dominant gender of women for informal caregiving. Even though men provide caregiving as well, women render as much as 50% more time in caregiving compared to their male counterparts. (Family Caregiver Alliance, 2022). According to Centers Disease Control and Prevention (2019), 1 out of 4 women (25.4%) are informal caregivers compared to 1 out of 5 in men (18,9%). The more dominant population of women among informal caregivers is prevalent probably because of societal expectations of women as informal caregivers and because when the need for care arises, women usually are the ones who step up to take the role (Centers for Disease Control and Prevention, 2019).

In caregiver-recipient relationships, 42% are composed of children who look after their parents. 31% care for their mother while 11% care for their father. 15% look after their non-relative patient (e.g., friend, loved one) (Caregiver Connection Team, 2018).

***Table 5.***

*Descriptive Statistics of Knowing (N= 121)*

| Caring Process of Knowing (3 items) | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| I am aware on the situation of my loved one. | 4.72 | .73 |
| I seek ways for taking care of my loved one by listening to my health care providers and asking questions when needed. | 4.69 | .68 |
| I am able to clearly address to the nurses and doctors my inquiries and concerns about my loved one when the need arises. | 4.74 | .62 |
| Total | 4.71 | .63 |

Knowing pertains to full awareness on the patient's situation. It involves family caregivers being involved in the health information of the patient. The 121 participants of this study gave a high score for item 3 *(M=4.74, SD=.62).* Filipino families are closely knit, even living with older persons as they age for guidance and guardianship. The family members are thus familiar with their older persons health needs. The former also becomes the next person to become familiar with the therapeutic regimen of the older person at home. Whenever their older person is hospitalized, the families or relatives are almost fully aware on what concern to ask the health care provider when the need arises (Kashiwagi 2017). The lowest mean is item 2 (*M=4.69, SD=.68)* but is still close to the highest score of 5. Sometimes, relaying health information to families with low ability may not be beneficial. The families or relatives may be eager for involvement, but due to difficulties or challenges faced by families such as new chronic illnesses, learning new health information may initially be a barrier for family involvement. Low ability of family learning can impact quality patient care (Jafarpoor, Vaslii, & Manoochehri, 2020).

Family involvement among clinicians is a major step towards helping achieve better patient care. One of the possible barriers in knowing about the families' or relatives admitted loved one may be their ability to learn about the condition. According to the Patient and Family-Centered Care (PFCC), one of its core areas is information sharing. In this core, the family must receive not only accurate but easily understood health information that can help the family make decisions. Better information may lead to better involvement, leading to safer patient care.

***Table 6.***

*Descriptive Statistics of Being With (N= 121)*

| Caring Process of Being With (3 items) | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| I make sure I am available for my loved one when the need arises. | 4.79 | .55 |
| I sometimes see the pain of my loved one and choose to endure it with him / her. | 4.59 | .77 |
| I choose to be with my loved one and listen with empathy and compassion. | 4.76 | .67 |
| Total | 4.71 | .58 |

Table 7 demonstrates the scores of the determinants of Swanson's Caring Process. The findings of being with for item 1 *(M=4.79*, *S=.55),* item 2 (*M=4.59, SD=.77)*, and item 3 (*M=4.76, SD=.67)* are relatively high. The informal caregivers indicate their superior effort (near a score of 5=highest) in Item 1. This indicates that they are willing to be with their admitted loved one even if they are within the hospital. These informal caregivers have the advantage of having lived with their older persons longer, therefore forming an invisible bond with them. Living with them gives them the 'telepathic' ability to know when their loved one is in pain, even if it is not being said. Therefore, being with the patient increases the informal caregiver's care to the patient

(Boyle, 2015). The lowest score obtained is in item 2. Aging may cause some families to place their older people in nursing homes, but family members mostly choose to stay and be with their older people even during hospitalization. Hence, some progressive countries continue to look up unto the Filipino culture because of their loving and caring attitude towards the older people.

Despite the Filipino culture of having an older person as a standard family member, there are still noted cases of increasing abandonment and neglect. Some older people are abandoned in the streets due to various circumstances. Although there are several institutions for cases like these such as the Golden Reception and Action Center for the Elderly and Other special Cases (GRACES), the numbers continue to rise (Business Mirror 2022). The house bill 4946, entitled Homes for Abandoned Seniors Act of 2014, recognizes that older people can be neglected due to various circumstances. This bill aims to thus establish a nursing home in every municipality in the city.

**Table 7**

*Descriptive Statistics of Doing For (N=121)*

| Caring Process of Doing For (4 items) | | |
|---|---|---|
| | *Mean* (*M*) | *Standard Deviation* (*SD*) |
| I care for my loved one like how patient should do for himself/herself. | 4.65 | .72 |
| I find ways to attend to the needs of my loved one in such a way that it increases his / her sense of dignity. | 4.69 | .75 |
| I attend to the needs of my loved ones with empathy and compassion. | 4.75 | .65 |
| I anticipate the needs of my loved one before any problem arises. | 4.70 | .60 |
| Total | 4.70 | 0.61 |

Table 8 demonstrates the scores of the determinants of Swanson's Caring Process, Doing For. The findings of being with for item 1 *(M=4.65, SD=.72),* item 2 (*M=4.69, SD=.75)*, item 3 (*M=4.75, SD=.65)* and item 4 *(M4.70, SD=.60)* are relatively high and indicate participation and care among informal caregivers.

Even if a person is ill or has health problems, unless that person has cognitive problems or issues, it is important to let him/her make decisions. Important actions involve allowing them to choose even if they are hospitalized. The freedom to make decisions lets the patients feel that they are still in control of their lives (Moore, 2019). A high score in "doing for" indicates that they are cared for with dignity, in which they are empowered to feel care as if they were caring for themselves. Examples of activities that increase dignity include asking the patient for opinions and involving the patient in decisions as much as possible. Caring with dignity means upholding the individual's beliefs and values to let them feel their individual choices are still being followed (Institute for Patient- and Family-Centered Care, 2019). Older people who have family connections feel more self-fulfilled and loved, enabling better mental health. They are thus able to make better decisions for themselves when it comes to health care (Superior Senior Care, 2021).

Even though Filipinos are able to care for their older person with dignity, it has been noted in Filipinos that culture shift is taking place. In a study in Chicago, it has been noted that the children of Filipino older people become more westernized and must live busy on-the-go lives. Because of this, they become less involved with their older people. Eventually, some Filipinos as starting to turn to nursing homes for care of their older people. Caring for older people nowadays pitches in the challenge to balance ones current life (due to the current economy and hardships) with trying to attend to the

needs of their older people. Because of this, some may look into the option of letting their older parents stay in the nursing home. This trend is seen as a potential to cause culture shift among Filipinos in the future (Immigrant Connect Chicago, n.d.)

**Table 8.**

*Descriptive Statistics of Enabling (N= 121)*

| Caring Process of Enabling (2 items) | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| I find ways to make my loved one feel empowered during his/ her hospital confinement. | 4.72 | .612 |
| I enhance my loved ones healing by promoting a therapeutic environment inside his or her hospital room. | 4.50 | .73 |
| Total | 4.6 | .62 |

Table 9 demonstrates the scores of the determinants of Swanson's Caring Process, Enabling. The findings of enabling for item 1*(M=4.72, SD.61),* is superior and indicates participation and care among informal caregivers. It manifests that informal caregivers are committed to render compassionate care and patient empowerment to their loved ones. The simple act of empowerment among older people uplifts them, eventually improving their overall being.

Patient empowerment is established globally. Empowerment helps older people have better clinical outcomes and lets them live a better quality of life. Proper empowerment is exhibited by older people making their own decisions and allowing them to engage in their health decisions. It allows older people to make decisions in accordance with their beliefs and values (Daveson et al., 2017).

Item number 2 (*M=4.50, SD=.73)* is slightly lower than item 1. Since the informal caregiver and older person are confined in hospital, they are limited to fully manipulating the environment in order to have a therapeutic environment for themselves, especially since the rooms are pre-arranged already. Yet, the score of 4.50 is still high, which indicates a positive finding on the current environment. A therapeutic environment pertains to any location in which it makes the client feel comfortable, or at least distracted from something unpleasant, while the care provider renders the care to the individual (Liden, 2022).

**Table 9.**

*Descriptive Statistics of Maintaining Belief (N=121)*

| Caring Process of Maintaining Belief (2 items) | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| I keep my loved one feel hopeful by listening and doing his or her requests that boost his or her morale. | 4.68 | .67 |
| I do my best to let my loved one maintain a hope filled attitude in whatever way possible (e.g., praying together, sharing problems, letting my loved one connect with others) | 4.69 | .72 |
| Total | 4.69 | .66 |

Table 10 demonstrates the scores of the determinants of Swanson's Caring Process, Maintaining Belief. The findings of item 1 (*M=4.68, SD=.67)* and item 2 (*M=4.69, SD=.72)* are high. Maintaining belief is about maintaining social support and finding hope amidst uncertainties (Lillykutty & Samson,2018). Communication is so important because it helps families and patients prepare for uncertainties ahead. The presence of communication provides comfort to the patient and the family. Once the patient recovers, this is only the beginning not only for the patient but also for the family.

A strong foundation of trust and friendship among family and health care workers, helps the patient feel supported as they move forward (Boyle, 2015).

**Table 10.**

*Descriptive Statistics of Caring Process (n=121)*

| *Subscales* | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| Knowing | 4.71 | .63 |
| Being With | 4.71 | .58 |
| Doing For | 4.70 | .61 |
| Enabling | 4.61 | .62 |
| Maintaining Belief | 4.69 | .66 |

The 121 respondents mostly rated their caring processes on their loved as high. Knowing is being aware about their loved one (*M=4.71, SD=.63)*. Being with is staying with their loved one while caring for them with empathy and compassion (*M= =4.71, SD.58).* Doing for pertains to caring for their loved one with dignity as if their loved one were caring for themselves (*M=4.70, SD=.61).* Enabling pertains to elating the humanitarian side through compassion and commitment (*M=4.61, SD=.62).* Maintaining belief pertains to helping their loved one maintain a hope-filled attitude in life despite the changes in their health condition (*M=4.69, SD=.66).* A mean score near the Likert scale of 5 is high. The informal caregivers perceive their caring process as being able to render the required care to their older person. This indicates that the family relatives or friends are those who take care of the older person and are the vital backbone of the older person in their care (Alloway et al., 2019). Informal caregivers can provide complex care even after discharge. They serve as the second set of eyes and hands for their older people as they continue with life despite their illnesses.

**Table 11.**

*Descriptive Statistics of Informal Caregiver Engagement- Policy Structure*

| Policy Structure (3 items) | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| The tools and resources I need to support my loved one are provided in this institution (e.g., contact information to my loved one's health care providers are readily available, I can easily reach my nurses when I need something) | 4.53 | .85 |
| I am able to communicate my loved ones needs to his/her health care providers because of a conducive health care set-up. (e.g., adding third chair for informal caregiver during consultations, making open space for caregiver to also listen during nursing and doctor rounds). | 4.54 | .77 |
| I know when to find time to privately care for my loved ones in the institution because of an organized set of rounds among doctors and nurses. | 4.59 | .76 |
| Total | 4.43 | 1.01 |

Table 12 demonstrates the level of informal caregiver engagement among informal caregivers. They have a high score policy and structure (*M=4.43, SD=1.01*) wherein the scores of Item 1 (*M=4.53, SD=0.85)*, Item 2 (*M=4.54, SD=.77)*, and Item 3 (*M=4.59, SD=.076)* are closely connected.

Having an organized set of health care provider rounds in the hospital is helpful for both the informal caregiver and the older person. It is during this time that communication becomes important, especially for informal caregivers. It is the time when the latter knows what to ask and when to ask. Clear communication enables the informal caregiver to care for their loved one more efficiently. Proper communication enables the informal caregiver to give their best support to their loved one as family (Boyle, 2015).

Utilizing the policies serves as ‘game changers’ for the informal caregivers. Hospital policies can give resources to informal caregivers through a network of services supporting caregiver engagement. The hospital policy must allot time to involve informal caregivers so as to eventually enable them to increase their knowledge and allow them to become more engaged care providers for their loved ones. Simple changes such as including a chair for the family member in consultation and providing a series of hotline numbers to reach in case of questions allow the informal caregiver to be more engaged. (Alloway et al., 2019).

**Table 12.**

*Descriptive Statistics of Informal Caregiver Engagement- Culture and Mindset*

| Culture and Mindset (6 items) | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| The health care team is able to recognize barriers (language, health literacy, physical and financial limits, perceptions on engagement) in preventing informal caregiver engagement | 4.50 | .83 |
| The health care staff reach out to me and are willing to discuss the different aspects of informal caregiver engagement | 4.36 | .98 |
| I feel that there is a clear quality policy in caring for my loved one, thus letting me focus on being with my loved one holistically. | 4.58 | .77 |
| Whenever I make mistakes in doing my informal caregiver care, I do not feel a culture of blame and is instead seen as a learning opportunity to share. | 4.50 | .78 |
| The quality of care helps me focus in rendering a more personal approach of care to my loved one. | 4.63 | .68 |
| The health care providers at times help me identify what I need (health care needs that are difficult to verbalize or tell) | 4.50 | .80 |
| Total | 4.48 | .78 |

The culture and mindset (*M=4.48, SD=.78*) shows a high score. The highest score is Item 5 (*M=4.63, SD=0.68).* This indicates that superior care is being provided to the informal caregiver and their older person. This in turn allows the informal caregiver to

personally attend to the needs of their loved one. Older people have difficulty in following their therapeutic regimen. The family members are the ones who support them in medication compliance. It is thus important to focus on the culture by promoting a culture of learning among informal caregivers and enabling them to face their fears, letting them become more engaged caregivers (Alloway et al., 2019).

One of the challenges nowadays though is the high workload among nurses and doctors. This sometimes results in less frequent rounds to ask the informal caregivers on the needs of the family (Jafarpoor, Vasli, & Manoochehri, 2020).

**Table 13.**

*Descriptive Statistics of Informal Caregiver Engagement- Procedures*

| Procedures (5 items) | | |
|---|---|---|
| | *Mean* (*M*) | *Standard Deviation* (*SD*) |
| I am flexible and open minded to identify problems early in order to address it to the health care providers | 4.70 | .65 |
| I engage early in talking with my loved one before procedures are done to him / her. | 4.67 | .67 |
| I feel engaged overall in caring for my family / relative | 4.74 | .62 |
| I am able to give feedback on the status of my family / relative's health to the healthcare team. | 4.67 | .72 |
| I am able to share my views on the procedures done to my loved one. | 4.62 | .69 |
| Total | 4.61 | .84 |

The procedures *(M=4.6, SD=.84*) outcome is also high. As older people age and care becomes more complex, the families become more familiar with the older person's routine of care. Informal caregivers immersed in a culture of learning instead of a culture of blame learn a lot during the implementation of procedures of their loved ones, making them engaged caregivers. It is thus important to identify their learning needs because

these informal caregivers will have the care responsibilities once the patient is discharged. Some studies mention that informal caregivers eventually become capable of providing complex care when the patients are discharged (Heath, 2017), especially when complex lifestyle changes take place (Barello, Graffigna,& Savarese, 2015). Since the score in item 4 (*M=4.74, SD=0.62)* is highest, it appears that the informal caregiver will be able to also remain engaged in care even after the patient becomes discharged. The lowest score among the questions is item 5 (*M=4.62, SD=0.69)* but is nevertheless near the highest score of 5. It is noted in some studies that some families get to be really involved in the procedures being done to their loved one; however, some families portray otherwise. There are some families that show non-involvement on the patient's condition. There are situations also where they may become indifferent, depending on the circumstances. An example is portrayed below (this is however in an ICU setup in Iran) (Jafarpoor, Vasli, & Manoochehri, 2020):

> "*The first question raised by few families is about the time their patient is going to die. I always say that a case with CVA should be Tracheostomy, but they are no longer satisfied with it, that is, they are waiting for their patient to die. About ten percent of families behave like this. They just ask us to tell them about the time of their patient's death.*

**Table 14.**

*Means and Standard Deviations of Informal Engagement*

| Subscales | *Mean* (*M*) | *Standard Deviation* (*SD*) |
|---|---|---|
| Policy and Structure | 4.43 | 1.01 |
| Culture and Mindset | 4.48 | .78 |
| Procedures | 4.6 | .84 |

Table 11 shows the mean and standard deviation of all the subscales of informal caregiver engagement, namely Policy and Structure *(M=4.43, SD=1.01)*, Culture and Mindset (*M=4.48, SD=.78)*, and Procedures *(M=4.6, SD=.84).* All of the mean are near the highest possible score

of 5. The lowest standard deviation is .78 while the highest standard deviation is 1.01, which means they do not deviate too much from the mean.

A high procedures checklist indicates that the informal caregivers have clear roles and expectations on their part. A high culture and mindset score indicates that caregivers are recognized as part of the culture. They are incorporated during patient care, giving the caregivers the opportunity to learn more. The respondents show that they are highly engaged in caring for their loved one. They can utilize the policies and structures of the hospital to be able to learn more about their loved one's condition. Examples of these include adding a third chair in consultation and giving the caregivers a prescription pad that contains all the information on whom to contact in case the patient gets discharged (Alloway et al., 2019). Supporting caregiver engagement is essential yet needs more research in order to help promote informal caregiver engagement.

**Table 15.**

*Correlation between Informal Caregiver Engagement and Determinants of Swanson's Caring Processes*

| Caring Processes | Policy and Structure | | Culture | | Procedures | |
|---|---|---|---|---|---|---|
| | *r* | *p-value* | *r* | *p-value* | *r* | *p* value |
| Knowing | 0.44 | 0.00 | 0.49 | .00 | 0.50 | .00 |
| Being With | .35 | 0.00 | .494 | .00 | .48 | .00 |
| Doing For | .43 | .00 | .58 | . 00 | .56 | .00 |
| Enabling | .40 | .00 | .51 | .00 | .50 | .00 |
| Maintaining Belief | .37 | .00 | .49 | .00 | .47 | .00 |

The Determinants of Swanson's Caring Processes are significantly related to the subscales of policy and structure, culture, and procedure of level of informal caregiver engagement. Knowing (r=0.44, p=.00), Being With (*r=0.35, p=.00),* Doing for *(r=.43, p=.00*), Enabling (*r=.40, .00),* and maintaining belief (*r=0.37, p=0)* are positively

correlated to the policy and structure, with Knowing being the highest. Informal caregivers who stay with their older persons are people who become familiar even with their health regimen. Sometimes, even looking at their loved one provides the informal caregivers with a 'telepathic ability' to know their holistic state. Introducing family centered care in the hospital (simple and gradual structural changes) may enable informal caregivers to be more involved in caring for their loved one. A high level of Knowing is thus correlated to the level of engagement on the policy and structure with a moderate level of correlation. None among the Pearson r results between knowing and policy and structure showed a weak correlation.

The five determinants of the Caring Process, namely Knowing (*r=0.49, p=.00),* Being With (*r=0.494, p=.00)*, Doing For (*r=0.58, p=.00)*, Enabling (*r=0.0.51, p=.00)* and Maintaining Belief (*r=0.49, p=.00)*, in relation to the culture and mindset also demonstrated positive correlation. It indicates that each caring process is correlated to the current Culture and Mindset that is currently existing in the hospital. A culture of non-blaming amidst the closely knit family ties among the Filipinos enables the informal caregivers to be engaged in care of their loved ones.

The five determinants of the Caring Process demonstrated the following results in relation to the Procedures; these include Knowing (*r=0.50, p=.00)*, Being With (*r=0.48, p=.00)*, Doing for (*r=0.56, p=.00)*, Enabling (*r=0.50, p=.00)*, and Maintaining Belief (*r=0.47, p=.00)*. All of these have a positive correlation as well. This indicates the engagement of the informal caregivers in each process whenever a procedure is being done to their loved one.

Any increase in the caring process of Kristen Swanson's theory directly increases the overall informal caregiver engagement (Lillykutty and Samson, 2018). This is because Swanson's theory focuses on nurturing and healing relationships that will be received by the patient. To do this, this will need personal engagement from the

informal caregiver. Therefore, a direct correlation exists between the caring process and informal caregiver engagement (McKelvey, 2018).

# Chapter V

# SUMMARY, CONCLUSION AND RECOMMENDATIONS

## Summary and Conclusion

The total number of respondents was 121 informal caregivers. The age range of the respondents were 18-76 years old, mostly near the middle adult age group (M=46.74, SD=16.34). Majority of the respondents were female (92 or 76%).

The majority of the respondents were spouses (39 or 32.2%) and the least were sister-in-law (1 or 0.8%, daughter in law (1 or 0.8%), and nephew (1 or 0.8%).

The study first identifies the caring processes among informal caregivers. The findings of knowing *(M=4.71, SD=.63),* being with *(M=4.71, SD=.58),* doing for *(M=4.70, SD=.61*), enabling *(M=4.61, SD=.62*), and maintaining belief (*M=4.69, SD=.66*) are relatively high. This indicates that the informal caregivers have a direct participation in the caring process.

Kristen's Swanson's theory incorporates a care approach that is more personal, humanistic, and dignified that is usually more readily rendered by informal caregivers (Lillykutty & Samson, 2018). Since the informal caregivers are the 'backbones' of the older persons it is important to identify the involvement of informal caregivers in the caring process.

The study secondly identified the current level of informal caregiver engagement. Studies on informal caregiver engagement are gradually starting to emerge. Informal caregivers serve as a second set of eyes who are aware of the older person's therapeutic regimen. They are loved ones who have started to be assigned more complex care tasks (e.g., wound care) that can be continued even upon discharge, thus helping the older person. Meetings on informal caregiver engagement have also

emerged which indicates that informal caregiver engagement must be more focused on, as this improves overall patient safety and prevents readmission (Heath, 2017). Lastly, the correlation between the Caring Processes and the level of Informal Caregiver Engagement shows a positive correlation. Because of the existing correlation, it would be better to take note that Caring Processes and Informal Caregiver Engagement affect each other.

Since any increase in the caring process of Kristen Swanson's theory directly increases the overall informal caregiver engagement, the engagement rendered by informal caregivers to their loved ones must not be treated as extensions and but as something to improve on (Alloway et al., 2019). Because of this, the level of engagement must be studied on, especially since this is something that boosts health care for older people.

The Determinants of Swanson's Caring Processes are significantly correlated to the subscales of policy and structure, culture, and procedure of level of informal caregiver engagement.

## RECOMMENDATIONS

**Research Design –** the study was done in a descriptive correlational design. However, it is suggested that a deeper quantitative study be also done on different aspects about informal caregivers, since little study is done on topics about informal caregivers. Using a cross-sectional survey design can be used to study other topics revolving around informal caregiver involvement. Examples of these topics include motivations of informal caregivers, or possible factors that can cause informal caregivers to be involved in research as well, thus leaving the notion of simple being backbones of the older people (Andersson et al., 2021).

**Research Setting –** it is recommended for researchers to also correlate the Caring

Process and Level of informal caregiver engagement in special care areas so as to identify if there is also an existing correlation between the caring processes and level of informal caregiver engagement.

**Nurses –** This study helped emphasize that family involvement is critical in-patient care. The family members are part of the health care system who are also engaged in caring for their older people. It is therefore important to include the family members in delivering patient care, as they are seen as also part of the team to help the patient recover sooner.

**Older Persons and Informal Caregivers –** the aging population is increasing rapidly in the Philippines (Philippine Statistics Association, 2019). By 2050, the older persons are projected to be around 16.5% of the population. Although studies on older persons are being done, empirical studies on older people and family caregiving issues need to be highlighted (Andel & Badana, 2018). The descriptive data on caring process and informal caregiver engagement may help provide initial data about its positive correlation. The study provides the caring process determinants with questions that families may use to increase their overall care rendered to older people. The informal caregivers may use this study to see the strength of correlation of each caring process to their level of caregiver engagement.

**Researchers –** Currently, most studies emphasize patient health engagement and nursing engagement. Similar studies are present on informal caregiver engagement, however, direct studies on the factors affecting levels of engagement still needs more research. This study provides baseline data on the level of informal caregiver engagement (Alloway et al., 2019). Since the vital role of informal caregivers is emphasized in this study, the researchers may use this research to further enhance the lack of knowledge about levels of informal caregiver engagement. Another aspect that is

essential to investigate is also the motivation behind informal caregivers in caring. Little study has only been done in studying the motivating factors behind informal caregivers and the effect of caregiving on their lives (Andersson et al., 2021).

**Administrative authorities –** Caregiver engagement is important, especially because they can contribute holistically to the wellbeing of the older person. This study may recommend encouraging hospitals to begin shifting health care from patient- centered to family-centered (Barello, Graffigna, & Savarese, 2015). After all, informal caregivers are the invisible yet significant backbone for health care of older persons. After proper identification of the level of informal caregiver engagement, the administrative authorities may use the findings on the policy and structure, culture and mindset, and procedures as cues for generating more knowledge on informal caregiver engagement.

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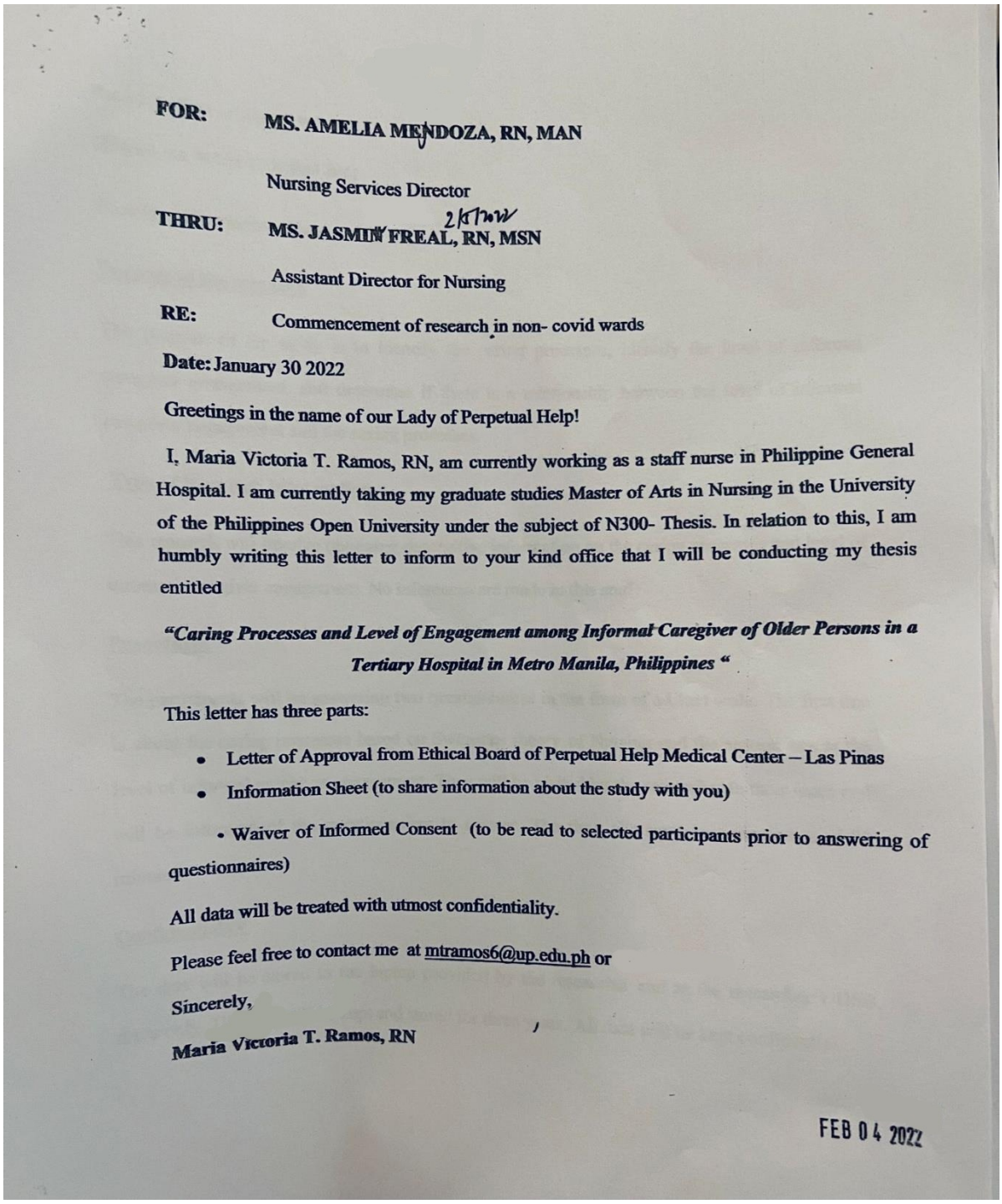
## Appendices

## APPENDIX A

Letter (To be obtained from Perpetual Help Medical Center)



**FOR:** **MS. AMELIA MENDOZA, RN, MAN**

Nursing Services Director

**THRU:** **MS. JASMIN FREAL, RN, MSN**

Assistant Director for Nursing

**RE:** Commencement of research in non- covid wards

**Date:** January 30 2022

Greetings in the name of our Lady of Perpetual Help!

I, Maria Victoria T. Ramos, RN, am currently working as a staff nurse in Philippine General Hospital. I am currently taking my graduate studies Master of Arts in Nursing in the University of the Philippines Open University under the subject of N300- Thesis. In relation to this, I am humbly writing this letter to inform to your kind office that I will be conducting my thesis entitled

***"Caring Processes and Level of Engagement among Informal Caregiver of Older Persons in a Tertiary Hospital in Metro Manila, Philippines "***

This letter has three parts:

- Letter of Approval from Ethical Board of Perpetual Help Medical Center – Las Pinas
- Information Sheet (to share information about the study with you)
- Waiver of Informed Consent (to be read to selected participants prior to answering of questionnaires)

All data will be treated with utmost confidentiality.

Please feel free to contact me at mtramos6@up.edu.ph or

Sincerely,

**Maria Victoria T. Ramos, RN**

FEB 04 2022

**Purpose of the research**

The purpose of the study is to identify the caring processes, identify the level of informal caregiver engagement, and determine if there is a relationship between the

level of informal caregiver engagement and the caring processes.

**Type of Research Intervention**

This research will involve obtaining descriptive information on the caring processes and level of informal caregiver engagement. No inferences are made in this study.

**Procedures**

The participants will be answering two questionnaires in the form of a likert scale. The first one is about the caring processes based on Swansons theory of Nursing and the second one is the level of informal caregiver engagement. They will be visited by the researcher in their room and will be informed of the questionnaires to answer. The time allotment is a maximum of 30 minutes.

**Confidentiality**

The data will be stored in the laptop provided by the researcher and in the researcher's USB drive only. The data will be kept and stored for three years. All data will be kept confidential.

**Part III. Waiver Of Informed Consent**

**IERB CODE:** UPHS-IERB SP 2021-001

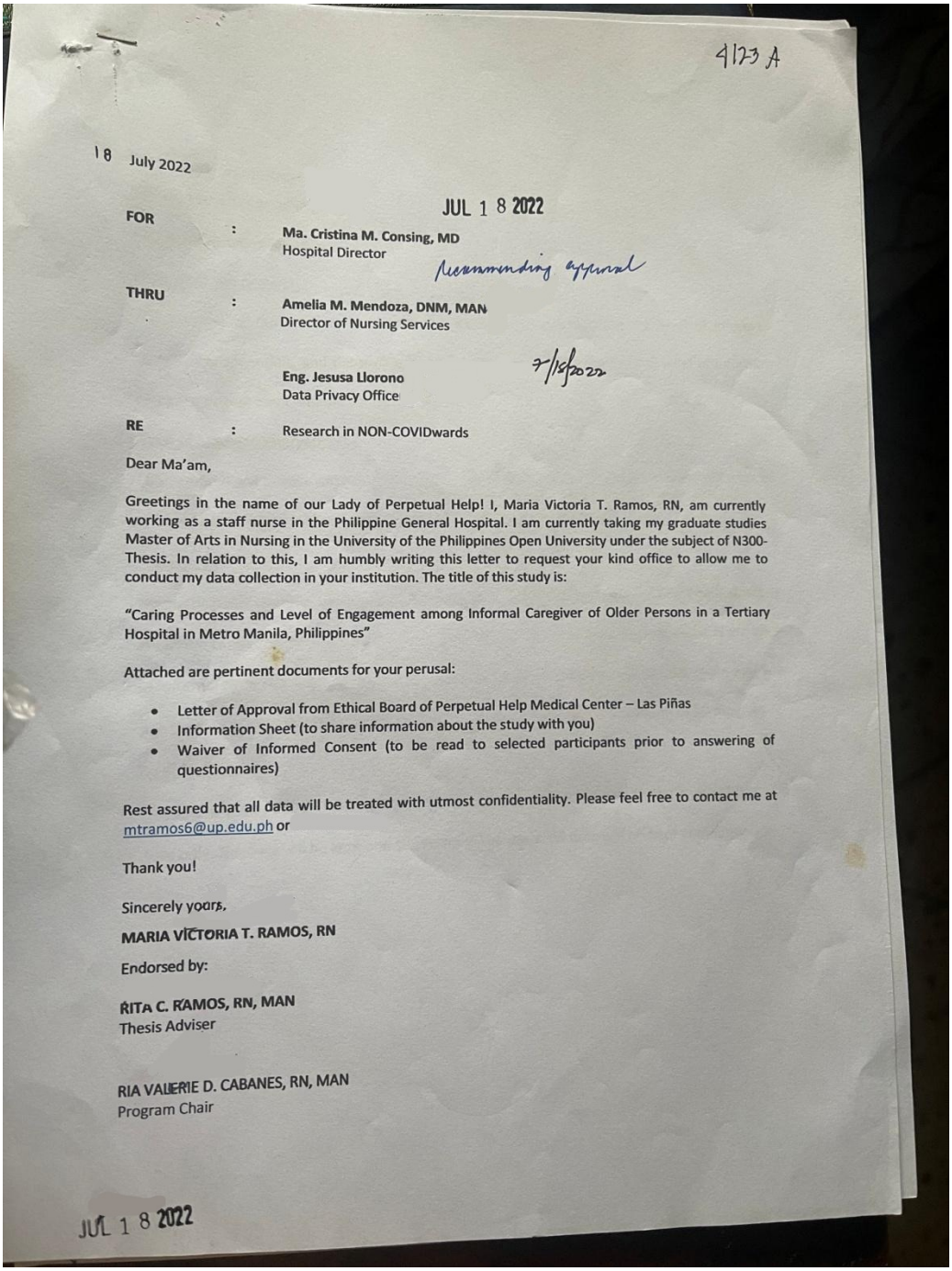
**PROTOCOL TITLE:** Caring Processes and Level of Engagement among Informal Caregiver of Older Persons in a Tertiary Hospital in Metro Manila

This is a waiver of informed consent for the reasons as stated below:
The study puts participants only on a subject minimal risk (involves answering questionnaires).
The study does not involve any procedures or specimen collections in which a written informed consent is usually required.
Thank you.

Researcher:
Maria Victoria T. Ramos, RN
University of the Philippines – Open University

## APPENDIX B

Letter to Perpetual Help Medical Center for Commencement of Research in Non-COVID Awards



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18 July 2022

JUL 18 2022

FOR : Ma. Cristina M. Consing, MD
Hospital Director
Recommending approval

THRU : Amelia M. Mendoza, DNM, MAN
Director of Nursing Services

7/15/2022
Eng. Jesusa Llorono
Data Privacy Office

RE : Research in NON-COVIDwards

Dear Ma'am,

Greetings in the name of our Lady of Perpetual Help! I, Maria Victoria T. Ramos, RN, am currently working as a staff nurse in the Philippine General Hospital. I am currently taking my graduate studies Master of Arts in Nursing in the University of the Philippines Open University under the subject of N300-Thesis. In relation to this, I am humbly writing this letter to request your kind office to allow me to conduct my data collection in your institution. The title of this study is:

"Caring Processes and Level of Engagement among Informal Caregiver of Older Persons in a Tertiary Hospital in Metro Manila, Philippines"

Attached are pertinent documents for your perusal:

- Letter of Approval from Ethical Board of Perpetual Help Medical Center – Las Piñas
- Information Sheet (to share information about the study with you)
- Waiver of Informed Consent (to be read to selected participants prior to answering of questionnaires)

Rest assured that all data will be treated with utmost confidentiality. Please feel free to contact me at mtramos6@up.edu.ph or

Thank you!

Sincerely yours,

MARIA VICTORIA T. RAMOS, RN

Endorsed by:

RITA C. RAMOS, RN, MAN
Thesis Adviser

RIA VALERIE D. CABANES, RN, MAN
Program Chair

JUL 18 2022

**Part I. Letter of Approval**

**(Please see other attached file)**

**Part II: Information Sheet**

**Purpose of the research**

The purpose of the study is to identify the caring processes, identify the level of informal caregiver engagement, and determine if there is a relationship between the level of informal caregiver engagement and the caring processes.

**Type of Research Intervention**

This research will involve obtaining descriptive information on the caring processes and level of informal caregiver engagement. No inferences are made in this study.

**Procedures**

The participants will be answering two questionnaires in the form of a likert scale. The first one is about the caring processes based on Swansons theory of Nursing and the second one is the level of informal caregiver engagement. They will be visited by the researcher in their room and will be informed of the questionnaires to answer. The time allotment is a maximum of 30 minutes.

**Confidentiality**

The data will be stored in the laptop provided by the researcher and in the researcher's USB drive only. The data will be kept and stored for three years. All data will be kept confidential.

**Part III. Waiver Of Informed Consent**

**IERB CODE:** UPHS-IERB SP 2021-001

**PROTOCOL TITLE:** Caring Processes and Level of Engagement among Informal Caregiver of Older Persons in a Tertiary Hospital in Metro Manila

This is a waiver of informed consent for the reasons as stated below:

The study puts participants only on a subject minimal risk (involves answering questionnaires). The study does not involve any procedures or specimen collections in

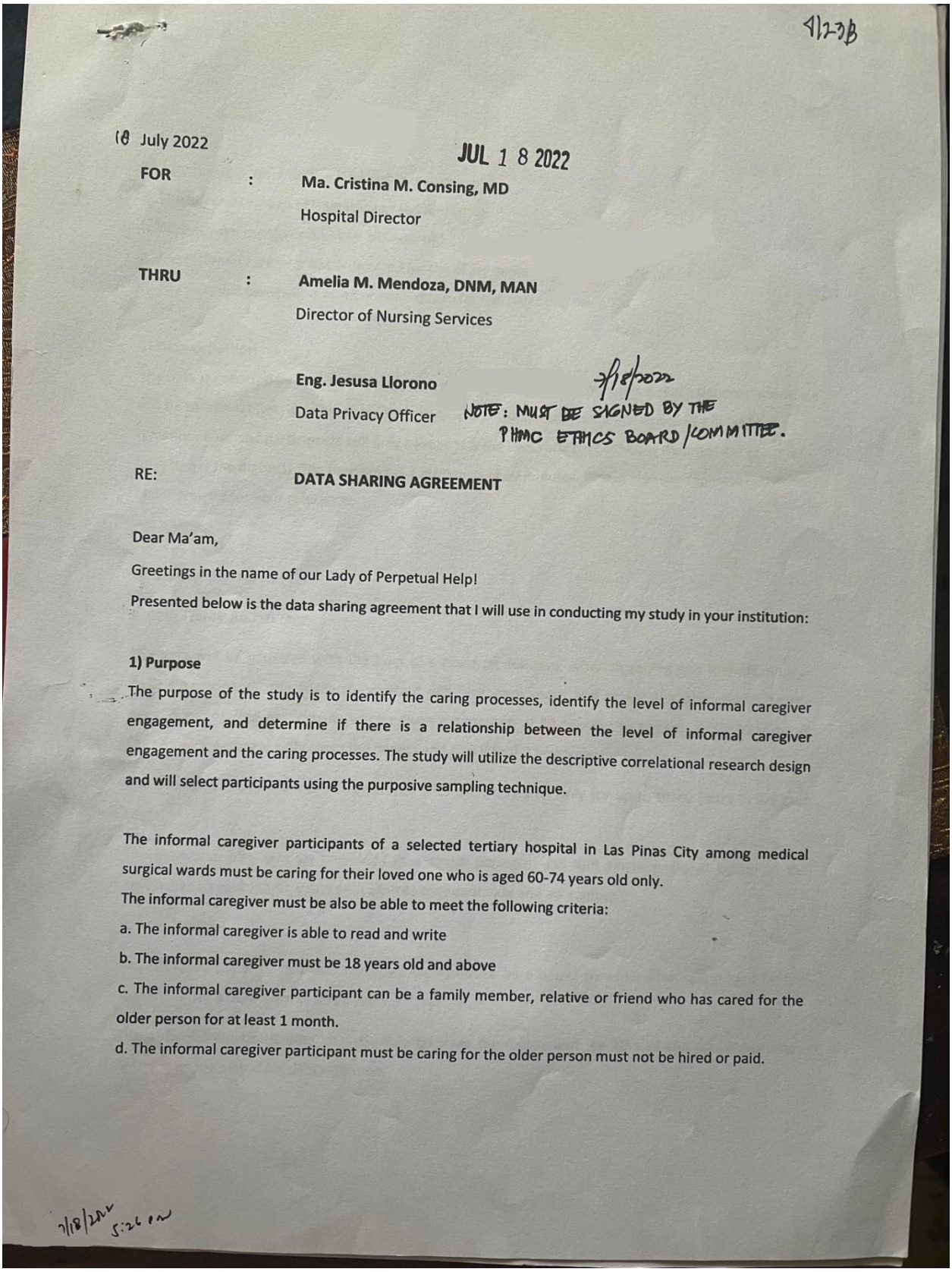
which a written informed consent is usually required.

Thank you.

Researcher:
Maria Victoria T. Ramos, RN
University of the Philippines – Open University

## Appendix C

Data Privacy Letter



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18 July 2022

JUL 18 2022

FOR : **Ma. Cristina M. Consing, MD**
Hospital Director

THRU : **Amelia M. Mendoza, DNM, MAN**
Director of Nursing Services

**Eng. Jesusa Llorono** 7/18/2022
Data Privacy Officer NOTE: MUST BE SIGNED BY THE PHMC ETHICS BOARD/COMMITTEE.

RE: **DATA SHARING AGREEMENT**

Dear Ma'am,

Greetings in the name of our Lady of Perpetual Help!

Presented below is the data sharing agreement that I will use in conducting my study in your institution:

**1) Purpose**

The purpose of the study is to identify the caring processes, identify the level of informal caregiver engagement, and determine if there is a relationship between the level of informal caregiver engagement and the caring processes. The study will utilize the descriptive correlational research design and will select participants using the purposive sampling technique.

The informal caregiver participants of a selected tertiary hospital in Las Pinas City among medical surgical wards must be caring for their loved one who is aged 60-74 years old only.

The informal caregiver must be also be able to meet the following criteria:

a. The informal caregiver is able to read and write

b. The informal caregiver must be 18 years old and above

c. The informal caregiver participant can be a family member, relative or friend who has cared for the older person for at least 1 month.

d. The informal caregiver participant must be caring for the older person must not be hired or paid.

7/18/2022 5:26 PM

The exclusion criteria for the informal caregiver are:

e. The informal caregiver is unable to read and write.

f. The informal caregiver is below 18 years old.

g. The informal caregiver has only cared for the older person for less than one month.

h. The informal caregiver is hired or paid to care for the older person.

**2) Data collection**

The data is collected by distributing the printed version of the questionnaires to each patients' room and will be collected after 30 minutes for each participant. The questions are presented in a likert type questionnaire, and participants will only have to tick the checkbox that contains their answer (1 is the lowest, 5 is the highest). The time limit is a maximum of 30 minutes. Please also see separate questionnaire for your reference.

**3). Control measures**

a. Data Transit and storage

The data will be gathered with the help of a research assistant. After screening and identification of willing participants, the research assistant will visit each room and orient the participants to the questionnaires. The participants will be given a maximum of 30 minutes to answer. After 30 minutes, the research assistant will collect the papers and give it to the researcher.

The collected questionnaires will be stored with the researcher only for up to three years in her own room.

The electronic data will be only kept in a single personal USB and single personal laptop of the researcher for up to three years with utmost confidentiality and anonymity.

b. Data Disposal

The collected paper of questionnaires will be shredded by a paper shredder after being kept by the researcher for a maximum of three years.

The obtained electronic data shall be deleted from the laptop and the USB of the researcher after finishing its set period for data retention.

Rest assured that confidentiality and anonymity of the participants is observed. Please feel free to contact me at mtramos6@up.edu.ph or for any clarifications of inquiries.

Thank you!

Sincerely yours,

**MARIA VICTORIA T. RAMOS, RN**

**Endorsed by:**

**RITA C. RAMOS, RN, MAN**

Thesis Adviser

**RIA VALERIE D. CABANES, RN, MAN**

Program Chair

## Appendix D

Research Instrument for Caring Process

| **Background** | |
|---|---|
| **Informal Caregiver Age** | |
| **Informal Caregiver Gender** | |
| **Relationship with patient** | |

**Swanson's Theory of Caring Questionnaire. Items obtained from Bjork, M., Brostrom, A., Hjelm, C., Hodges, E., Knuttson, S., Mårtensson, S., and Swanson, K. (2020)**

| CATEGORY | Item | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| KNOWING | I am aware on the situation of my loved one. | | | | | |
| | I seek ways for taking care of my loved one by listening to my health care providers and asking questions when needed. | | | | | |
| | I am able to clearly address to the nurses and doctors my inquiries and concerns about my loved one when the need arises. | | | | | |
| BEING WITH | I make sure I am available for my loved one when the need arises. | | | | | |
| | I sometimes see the pain of my loved one and choose to endure it with him / her. | | | | | |
| | I choose to be with my loved one and listen with empathy and compassion. | | | | | |
| DOING FOR | I care for my loved one like how patient should do for himself/herself. | | | | | |
| | I find ways to attend to the needs of my loved one in such a way that it increases his / her sense of dignity. | | | | | |
| | I attend to the needs of my loved ones with empathy and compassion. | | | | | |
| | I anticipate the needs of my loved one before any problem arises. | | | | | |
| ENABLING | I find ways to make my loved one feel empowered during his/ her hospital confinement. | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | **I enhance my loved ones healing by promoting a therapeutic environment inside his or her hospital room.** | | | | | |
| **MAINTAINING BELIEF** | **I keep my loved one feel hopeful by listening and doing his or her requests that boost his or her morale.** | | | | | |
| | **I do my best to let my loved one maintain a hope filled attitude in whatever way possible (e.g. praying together, sharing problems, letting my loved one connect with others)** | | | | | |

## APPENDIX E

## Questionnaire for informal caregiver engagement

**Caregiver Engagement Scale (Alloway, C., Goldhar, J., Kokorelias, K., Kuluski, K., Peckham, A., Petrie, J 2019)**

| Category | Question | 1 | 2 | 3 | 4 | 5 | I don't know |
|---|---|---|---|---|---|---|---|
| | | Low to High | | | | | |
| **INFORMAL CAREGIVER** | | | | | | | |
| **POLICY AND STRUCTURE** | The tools and resources I need to support my loved one are provided in this institution (e.g. contact information to my loved ones health care providers are readily available, I can easily reach my nurses when I need something) | | | | | | |
| | I am able to communicate my loved ones needs to his/her health care providers because of a conducive health care set-up. (e.g. adding third chair for informal caregiver during consultations, making open space for caregiver to also listen during nursing and doctor rounds). | | | | | | |
| | I know when to find time to privately care for my loved in the institution because of an organized set of rounds among doctors and nurses. | | | | | | |
| | | | | | | | |
| **CULTURE AND MINDSET** | The health care team is able to recognize barriers (language, health literacy, physical and financial limits, perceptions on engagement) in preventing informal caregiver engagement | | | | | | |
| | The health care staff reach out to me and are willing to discuss the different aspects of informal caregiver engagement | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | I feel that there is a clear quality policy in caring for my loved one, thus letting me focus on being with my loved one holistically | | | | | | |
| | Whenever I make mistakes in doing my informal caregiver care, I do not feel a culture of blame and is instead seen as a learning opportunity to share. | | | | | | |
| | The quality of care helps me focus in rendering a more personal approach of care to my loved one | | | | | | |
| | The health care providers at times help me identify what I need (health care needs that are difficult to verbalize or tell) | | | | | | |
| | | | | | | | |
| **PROCEDURES** | I am flexible and open minded to identify problems early in order to address it to the health care providers | | | | | | |
| | I engage early in talking with my loved one before procedures are done to him / her. | | | | | | |
| | I feel engaged overall in caring for my family / relative | | | | | | |
| | I am able to give feedback on the status of my family / relative's health to the healthcare team. | | | | | | |
| | I am able to share my views on the procedures done to my loved one. | | | | | | |

## CURRICULUM VITAE

**MARIA VICTORIA T. RAMOS, RN**
**Place of Birth:** San Juan, Greenhills, National Capital Region
**Civil Status:** Single
**Institutional Affiliation:**
Philippine General Hospital
**Company Name and Address:**
Philippine General Hospital Ermita, Manila
**Company Contact Number**: 85548400
**E-Mail Address:** mtramos6@up,.edu.ph

**Educational Background:**

University of the Philippines Open University — June 2012- present
Saint Paul University Manila – Bachelor of Science in Nursing — 2006- 2010
- Dean's Lister 2nd semester SY 2006-2007

Bloomfield Academy — 2002-2006
- High School Salutatorian

**Work Experience**

**1) Philippine General Hospital** — **January 2020-present**

Nurse II
- Assesses needs of the patient based on vital signs, physical examinations and nursing history.
- Ensures implementation of the nursing care plan based on nursing standards.
- Prioritizes the patient's health needs and problems accordingly.
- Administers prescribed medication to patients.
- Monitors patient's response to the prescribed medication, therapeutic order and dietary regimen.
- Evaluates effectiveness of nursing care rendered through patient's response.
- Attends resuscitative measures as needed.
- Documents relevant information pertinent to patient care.
- Ensures implementation of HICU standards.
- Receives handovers of patients.
- Orients the patients and significant others to hospital policies and procedures.
- Carries out health care management orders.
- Refers significant findings of patient appropriately in collaboration with other members of the health team.
- Ensures availability of request and results for laboratory, diagnostic, and therapeutic procedures.
- Operates life-saving monitors and equipment.
- Assists the physicians in performing procedures for patients.
- Maintains safety and comfort measures of patients.
- Correlates normal and abnormal findings to determine plan of care.
- Provides psychosocial support to patients.
- Ensures proper safe keeping of medical records.
- Documents completeness and availability of medical equipment, narcotics and E-cart stocks.
- Practices safe and economical use as well as implements control measures for the proper utilization of resources.
- Reports leaks and wastage in utilities to the Nurse IV / Nurse III.

- Complies with hospital policies, procedures, objectives and quality control.
- Maintained clean, orderly and safe environment conducive to patient's recovery.
- Assists the head nurse in providing learning activities for new nurses, non-nursing personnel and students.
- Complies with Regulatory and Institutional requirements.
- Attends to at least 8 – 16 hours seminars and other training related activities.
- Participates in hospital approved research studies.
- Maintains collaborative relationship with colleagues and other members of the healthcare team.
- Establishes professional and therapeutic relationship to patient and family.
- Provides relevant teachings / educational activities of the patient's families and significant others.
-

**2) Perpetual Help Medical Center – Las Pinas** **November 2017-December 2019**
Staff Nurse

- Renders holistic care to patients
- Professionally applies insights obtained from clinical experiences and implements in nursing care
- Provides individualized patient care and collaborates with other health team members for delivering excellent patient care
- Provides support to new nurses in helping provide quality nursing care
- Attends seminars as required for professional growth and development

**3) Cebu Pacific Air** **July 2014-October 2017**
Ticketing Agent and Health Safety Officer

**Additional Skills:**

- **Excellent oral and written communication skills in English and Tagalog**
- **Highly efficient in Microsoft Office, Excel and Powerpoint**
- **Capable of Working under pressure while delivering best results in patient care**

**Lanugages:**
**English : Fluent**
**Tagalog: Fluent**

**Honors and Awards:**
**Dean's List (2nd semester, SY 2006-2007)**
**High School Salutatorian Sy 2005-2006**
**High School awards on Graduation - Best In Mathematics, Best in English, Best in Science, Best in Social Studies**