

**IGBINEDION UNIVERSITY, OKADA,
EDO STATE, NIGERIA**

INAUGURAL LECTURE SERIES - 4th

**THE CHALLENGES OF BEST
PRACTICES AND STANDARDS IN
NURSING IN NIGERIA**

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IGBINEDION UNIVERSITY PRESS LTD



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Florence Nightingale (Lady with the Lamp)

NURSES CARE, GOD HEALS



A section of the Igbinedion University Nursing Laboratory I



A section of the Igbinedion University Nursing Laboratory II

THE CHALLENGES OF BEST PRACTICES AND STANDARDS IN NURSING IN NIGERIA

**Inaugural Lecture Delivered at the
Igbinedion University, Okada, Edo State, Nigeria
on April 15, 2010**

By

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Inaugural Lecture Series – 4th

Igbinedion University Press Ltd. Okada, Nigeria

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ISSN -----

Printed by Igbinedion University Press Limited
Okada, Edo State, Nigeria

INTRODUCTION

Mr Vice-Chancellor Sir, Provost and Deans of Colleges, Distinguished invited ladies and gentlemen, all staff and students of the great Igbinedion University here present, it gives me great pleasure to be called upon to give the fourth in the series of inaugural lectures of this University. I am aware that the original purpose of an occasion like this is meant to mark the inauguration or installation of a new professor to the chair of the subject he/she professes. Given our acceptance of multiple professorships, an additional purpose currently is to present to the academic community at large, some idea of the progress of activities going on in each discipline and the manner in which such represent real contribution to the world of learning in particular and to society in general.

I was humbled when this great University invited me to give my inaugural lecture more so about what it connotes. When I prayed about it, the Holy Spirit drew my attention to what the Bible says in I Corinthians 1:20 & 24c:

“Where is the wise man?
Where is the scholar?
Where is the philosopher
of this age? Has God not
made foolish the wisdom
of the world? . . . Christ is
the power of God and the
wisdom of God” (NIV).

I then became empowered and assured of my source of ready help.

My pleasure in having to present, as it were, the state of the discipline of Nursing, is heightened by the realization that this is the fourth inaugural lecture in the discipline in this country and the FIRST coming from the Premier Private University in Nigeria. I give high regard to my predecessors – Prof. E.O. Adebo, University of Ibadan (of

blessed memory), Prof. M. K. Jinadu and Prof. R. B. Fajemilehun both of Obafemi Awolowo University Ile-Ife, who gave the first three.

Society and Poor Quality Services

My topic today will examine very critical elements which form the foundation of what society expects from all service providing professions, groups or vocations anywhere in the world – “HIGH QUALITY SERVICE”. Why are some buildings under construction in different parts of Nigeria collapsing? Why did Kano state government in Nigeria take Pfizer to court over the death of 11 children who died as a result of polio immunization which the pharmaceutical company manufactured? Why did the management of Lagos University Teaching Hospital sack its Chief Medical Director and Chief Laboratory Scientist over injecting a baby with the Human Immunodeficiency Virus? Why do bedridden patients develop bedsores during hospitalization when nurses fail to regularly change their positions and care for their pressure areas? Such list is endless in society’s experiences of poor quality services it receives. Quality service in health care delivery system is crucial as it impacts directly on human health and illness management which is the purpose of seeking the service in the first instance.

The health care delivery system is changing rapidly globally as the population and its health care needs and expectations change. The shifting demographics of the population (e.g. early maturation, living longer, etc), the increase in chronic illnesses and disabilities (such as increase in incidence of diabetes, hypertension, renal diseases, cancer etc), the greater emphasis on health care costs (such as higher cost of drugs, surgical procedures, hospitalization etc) and technological advances (such as death of distance in spread of illness, new diagnostic and treatment modalities, rapid storage, retrieval and dissemination of information) have all resulted in changing emphases in health and nursing care delivery.

Family Caring Roles

At creation God designed that human procreation, growth and development processes should require meticulous and long period of caring and mothering from pregnancy through birth to attainment of independent living. The inherent positive characteristics of such traditional role relationships in all cultures which involve caring, loving, helping, supporting, nurturing and enabling/empowering form the bedrock of nursing profession. In health and illness, nursing care is universally required and is respectful of and unrestricted by consideration of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.

WHO IS NOT A NURSE?

Permit me to rhetorically ask these questions. Is a 13 year old girl nursing a baby a nurse? Or a housewife caring for her children? or a man attending to his sick wife, or a house keeper making a bed a nurse? If you nurse an idea or nurse a grudge, are you a nurse? If a lady wears a white gown, puts on a cap and walks on the street or in a market place, is she a nurse? Of course NOT. If I can change the plugs of my car engine, am I a mechanic? No! As we have naturally endowed roles or learnt skills through experiences or just by trial and error, human beings undertake many seamless roles that do not automatically make them professional practitioners.

Who then is a nurse?

*“ A person who has received authorized education, acquired specialized skills and attitudes and is registered and licensed by a regulatory body (in Nigeria, NMCN), to provide promotive, preventive, restorative and rehabilitative **CARE** to individuals, families and communities **INDEPENDENTLY** and in collaboration with other members of the health team” (NMCN, 2009).*

NURSING

Probably the most widely known definition of nursing came from Virginia Henderson:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him regain independence as soon as possible (Henderson, 1961).”

While this definition is valid in a wide range of circumstances it does not describe the important roles of nurses in working with families and communities, in education, public health, and health promotion activities. Nursing is uniquely involved in providing a wide range of curative and preventive services in primary health care. In fact, it has been argued that “primary health care is an objective that has always been a fundamental driving force for nurses, a natural extension of nursing practice especially in community health (WHO, 1987).

Other nursing theorists have also defined nursing thus:

“The goal of nursing is that individuals achieve their maximum health potential through maintenance and promotion of health, prevention of disease, nursing diagnosis, intervention and rehabilitation” (Rogers, 1970).

“Nursing is the science that observes, classifies and relates the processes by which persons positively affect their health status, and the practice discipline that uses this particular scientific knowledge in providing a service to people” (Roy, 1984).

“Nursing is deliberate action to bring about humanely desirable conditions in persons and their environments” (Orem, 1985).

Nursing is functionally defined as helping individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. This requires nurses to develop and perform functions that promote and maintain health as well as prevent ill health. Nursing also includes the planning and giving of care during illness and rehabilitation, and encompasses the physical, mental and social aspects of life as they affect health, illness, disability and dying (Salvage, 1993).

These definitions are progressively encompassing the total scope of the vision and mission of nursing. The Salvage (1993) definition has therefore captured a more satisfactory description of nursing mandate.

THE ROOT OF NURSING

The detailed history of a profession that combines scientific principles, technical skills and personal compassion can't be precisely relayed. Nursing in the early days before Nightingale era was primarily a family matter with mothers caring for their own families or neighbours assisting each other. However, records revealed that nursing came to limelight in 1854 when the mother of professional nursing, Florence Nightingale, started the battle field record with other 38 nurses and cared for the sick and injured men during the Crimean war in England. Her persistence, dedicated service, day and night experiences paid off by making her famous and recognized by "Lady with the Lamp". Her unique service resulted in complete change in nursing profession and led to the beginning of professional nursing (Adelowo, 1988).

By 1880, the status of nursing was greatly improved with the establishment of hospital-based schools of nursing throughout Europe. In 1882, the first movement for recognition and registration of nurses began and the International Council of Nurses (ICN) was established with headquarters in Geneva, Switzerland. The ICN has undergone

phenomenal developments and has brought great and positive changes to the improvement of nursing practice globally. The professional associations of nurses in every member country belong to the ICN. Its code of ethics (ICN, 1993), as reviewed in 2005, has four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. It believes that the need for nursing is universal and inherent in Nursing is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. The Constitution of the Federal Republic of Nigeria (1999) supports this position of ICN in its chapter IV: Fundamental Human rights 33 (i) and 34 (i).

How then should nursing care be rendered to ensure that quality care is available, accessible and affordable to care receivers? What are the indicators that guide nursing practice to ensure that best practices are adopted by practitioners to yield quality care? How are minimum benchmarks set, maintained and upgraded to ensure that high quality nursing care is given?

International Council of Nurses (ICN) Position Statements

The International Council of Nurses Position Statement (1993) sets the standard for nursing education and practice internationally and Nigeria is a member. ICN believes that:

- i. Nursing profession must reaffirm the scope of nursing role and be responsible for standards of nursing care given to the public.
- ii. The skills and competencies of well-prepared nurse managers make them appropriate personnel for general management positions within health care systems.
- iii. Nursing authority must be affirmed as a profession in its right although it is allied with its colleagues in all other health profession in providing health care. Nurses are responsible and accountable for the nursing services they provide for both the sick and the well.

- iv. Nursing has a body of knowledge and practices which are distinct and different from other non-nursing courses as medicine, pharmacy, etc. Teaching of nursing courses, theory and practice must be done by nurses who are qualified to teach.
- v. Nurses are accountable for defining nursing roles because it has been observed with great concern in many countries worldwide that undue emphasis is put on cure rather than care and this limits the potential of nurses to provide health care to total population and also undermine the quality of nursing care.
- vi. National Nurses' Associations should advocate and participate in the process of establishment of standards for nursing education and practice and suggesting strategies for implementation and sustainability.
- vii. Nursing research is important for evidenced-based practice and quality for the health and welfare needs of the people.
- viii. A system of governance for the profession must provide for:
 - a. High standards for personal and professional growth and performance of nurses at general and advanced level practices.
 - b. Public sanction for nurses to perform to the extent of their capabilities.
 - c. Participation of the profession in the development of public policy.
 - d. Accountability of the profession to the public for the conduct of its affairs in their behalf.
 - e. Proper recognition and remuneration for the contribution of the profession and opportunity for the self-actualization of its members.

NURSING IN NIGERIA: ITS PRACTICE AND EDUCATION

The development of nursing practice and education in Nigeria was examined by Ojo (2002) and described in four chronological periods as follows: Early past – 1850s–1950s; Immediate past – 1960s–1970s; Present – 1980s–1990s; Immediate future – 2000 and beyond.

Nursing came to Nigeria through the British colonial masters. Health care services were provided mainly for wounded soldiers and government officials by government and later missionaries came to supplement government efforts by setting up mission homes, dispensaries and medical centres etc for the health care of civilian populations.

Among the major factors that accounted for the underdevelopment of nursing during most of the period under review by Ojo (2002) included:

- a) Peculiarly low status of women in the West African sub-region with culture and religion perpetuating disadvantaged gender inequality of women who constitute the large majority of nurses.
- b) Inability of nurses to get and utilize latest knowledge and technology about nursing practice.
- c) Societal perception of nursing as an occupation dependent on medicine thereby get marginalized
- d) Entrants to the hospital-based training institutions were of very low education
- e) Even early nurses who got exposed to the developed world came back to discriminate against those trained and practising in Nigeria. The dichotomy had negative effects on development of nursing.

Nursing Education in Nigeria

Schools of nursing were started by regional governments from 1949 to produce home grown practitioners. In the same year (1949) the Nursing

Council of Nigeria was established to coordinate the schools and create standards for nursing education and practice (Adelowo, 1988). However, the training emphasized on-the-job manipulative skill acquisition, strict obedience to institutional rules and regulations of practice and ethical conduct but with minimal opportunity for creativity, accountability, independent clinical decision making or professional development (Ojo *et al.*, 2002). As the need for more trained nurses arose, state governments and missionary organisations opened nursing schools. By 1965, a department of nursing to produce the first set of graduate nurses in Nigeria was established at the University of Ibadan. The current situation of existing institutions for training of nurses/midwives etc at diploma and university levels is presented in Table 1.

The present Nursing and Midwifery Council of Nigeria (NMCN) was established by decree No. 89 of 1979 of the Federal Republic of Nigeria, now known as Nursing & Midwifery (Registration etc) Act. Cap. 143, Laws of the Federation of Nigeria, (2004). The NMCN is the only legal, administrative, corporate and statutory professional regulatory body for all cadres of nurses and midwives in Nigeria whose function is to ensure the delivery of safe and effective nursing and midwifery care to the public through quality education and best practices (NMCN, 2009).

The roles of the NMCN as highlighted by the council in Adejumo and Adejumo (2009, Eds) include:

- a) Determining who are nurses and midwives for the purposes of the act setting up the council.
- b) Determining standards of knowledge and skill to be attained by persons seeking to become nurses and midwives.
- c) Establishment of a register of persons entitled to practise the profession.
- d) Regulating and controlling the practice.
- e) Maintaining high degree of discipline within the profession.
- f) Performing other functions conferred upon the council by the act.

Table 1: List of Approved Nursing Educational Institutions in Nigeria & Number of Registered Practitioners with NMCN, as at October 2009

S/N	TYPE OF SCHOOL	No.	REGISTERED	REMARKS
1	Diploma General Nursing	76	137,023	
2	Diploma Midwifery (Basic)	24		
3	Diploma Midwifery (Post Basic)	47	93,542	Admissible into university for 4-year Direct programme
4	Diploma Psychiatric Nsg.	9	6,287	
5	Post Basic Diploma Peroperative Nsg.	5	2,022	
6	Post Basic Diploma Ophthalmic Nsg.	5	567	
7	Post Basic Diploma A & E Nsg.	4	850	
8	Post Basic Diploma Orthopaedic Nsg.	3	809	
9	Post Basic Diploma Nurse Anaesthetist	1	756	
10	Post Basic Diploma E.N.T. Nsg.	1	042	
11	Post Basic Diploma Intensive Care Nsg.	2	055	
12	Post Basic Diploma cardiothoracic Nsg.	1	090	
13	Post Basic Diploma Burns & Plastic Nsg.	2	088	
14	Post Basic Diploma Paediatric Nsg.	4	412	
15	Post Basic Diploma Occupational Health Nsg.	1	049	
16	Advanced Diploma Nurse Educators	-	3,105	
17	Advanced Diploma Midwife Educators	-	751	
18	Advanced Diploma Public Health Nurse Educators	-	167	Mop-up programmes to become graduates
19	Advanced Diploma Nurse Admin.	-	1,262	
20	B.N.S.C degree in Universities	10	-	All undergraduates must qualify as RN with the degree certificate
21	Postgraduate Nursing Programmes	3	-	More Universities starting
22	New Departments awaiting NUC and NMCN accreditation	17	-	<ul style="list-style-type: none"> ▪ Some might have now been approved ▪ Rest still awaiting

The council has remained committed to the fulfilment of these functions as current trends in nursing and midwifery education and practice in Nigeria have revealed. The NMCN has over the years incorporated new concepts in nursing care into the nursing and midwifery curricula to ensure that they are dynamic, current, relevant and of very high standard (NMCN, 2009). The council has collaborated with World Health Organisation (WHO) on Integrated Management of Childhood Diseases and Life Saving Skills. Manual Vacuum Aspiration in collaboration with Ipas; Management of Tuberculosis and Leprosy in partnership with Netherlands Leprosy Relief Organisation and National Tuberculosis and Leprosy Control Programme (NTBLCP), among others.

NURSING EDUCATION STANDARDS

Standards are agreed upon rules for the measurement of quantity, extent, value and quality of any service, educational unit, programme, product, object or instrument. Bennett (1989) defined standards as being desirable and achievable levels of performance consistent with quality. When applied to nursing care, quality has three dimensions which are identified as structure, process and outcome. These dimensions are central to definition of quality assurance developed by the Royal Australian Nursing Federation (RANF) (1985) as “A planned systematic use of selected evaluation tools designed to measure and assess the structure, process and/or outcome of practice against an established standard, and institution of appropriate action to achieve and maintain quality.

The College of Registered Nurses of Manitoba (2007) developed standards for nursing education programmes and established four components of standards for nursing education programme. They are:

1. Programme Plan

This identifies health needs of the people, philosophical foundations, organisation and roles of programme personnel and students, criteria and methods for running the programme, etc.

2. The Curriculum

Its congruency with philosophy of programme, standard of practice for registered nurses, code of ethics, and entry level competences.

3. Resources

There should be sufficient human, clinical, physical, fiscal and support resources to sustain the programme.

4. Programme Effectiveness

Graduates of the programme should meet the entry level competencies and the standard of practice for registered nurses and there are formal systems and processes in place to measure programme effectiveness. Similarly, the National League for Nursing Accreditation Commission (NLNAC) (2005) developed an accreditation manual with interpretive guidelines for degree programmes.

The WHO and Sigma Theta Tau in 2006 developed a global standards document for initial nursing and midwifery education in Bangkok, Thailand. Commonalities in both documents revealed the following components:

1. Mission/governance
2. Faculty qualification
3. Students/admissions criteria
4. Curriculum and instruction/programme component
5. Resources
6. Integrity
7. Educational effectiveness/graduate qualification

The purpose of assessing nursing educational programme using the standards variables is to ensure high levels of opportunity for student learning and achievement. When this is done, assuring quality of education is achieved for the future of nursing education.

Nursing Education for Standard Practice

A directly expected outcome of standards of nursing education is standards of nursing practice. Previously, the health care industry was considered above being questioned about quality of care, but nowadays, healthcare is a major industry and each hospital and care provider is accountable to its consumers. The availability and quality of health care are determined by the values and expectations of the consumers. Health care consumers now demand for quality care. College and Association of Registered Nurses of Alberta (2003) developed nursing practice standards which became effective in November 30, 2005. The document articulated the following:

1. That nursing is a self-regulating profession
2. Formulated four indicators of meeting the standards which are: professional responsibility; knowledge based-practice; ethical practice and provision of service to the public

Alexander (1978) said that an important function of professional nurses at the first level of nursing service is to organize the activities of the staff into a workable pattern to meet patients' needs and that the pattern usually follows the structured design adopted by the health institution/organization to meet defined objectives. According to her, this structured design can enhance or constrain the staff in providing quality nursing services. Since nursing is all about interaction of nurse and patient, the interaction should be uniquely humane with a quality of relationship that is acceptable to the patient and maintaining his/her biological and social integrity.

Nursing care approaches which nurses have used to organise their activities include:

1. Case nursing: Whereby practitioner provides total nursing care to one or more patients with health problems which require intensive care or seclusion from other patients.

2. Functional nursing: In this method, tasks are allocated as assignments strictly on division of labour and procedural description. It is task oriented e.g. medication nurse, wound dressing nurse etc.
3. Primary care nursing: Defined as a comprehensive, continuous and coordinated nursing process for meeting the total needs of each patient.
4. Team nursing: Described as a method of care in which a group of people led by a qualified nurse provides for the health needs of an individual or group of clients through collaborative and cooperative effort.

Of these four models of nursing care delivery, the most prevalent in use in most health institutions in Nigeria is the functional approach. Although it does not individualize care, robs the nurse of developing skills in planning, implementing and evaluating care given to individual patients, lacks continuity and holistic approach to care, it is the most preferred. Because, few nurses can manage many patients (10 –15 clients per nurse) in deviance to standard nurse: patient ratio of 1:1 to 1:5 depending on the type of ward (NMCN Nursing Education and Practice standards, 2009). This approach will cut cost but will lower care standards, stress nurses and frustrate care receivers.

In such a situation as this, even if nurses become experts in the procedures they repeat over time, the tendency of cutting corners when they are short staffed will negatively impact on best practices, standards and quality of care rendered. The need for nurse managers in health care institutions to adopt other care approaches has therefore become more compelling so that the care rendered can be of quality.

The Patient and His illness: A brief Sociological Analysis

The social dimension of the patient and his illness can be described as a highly important relationship which merits proper examination. This is a one-person relationship, a situation in which there is no partner to whom emotions can be transferred. The relation

is by no means one sided as it occurs between a person and a situation.

No matter whether illness is a severe shock or withdrawal syndrome, it is always a form of life. No form of life can be maintained without some gratification. To examine illness as a source of direct gratification we must emphasize that in any illness pain, limitation, apprehension, and so on are always present. To change any form of life, one must either use compelling force or offer more acceptable gratification in place of those to be made impossible by the change (Balint, 1964). In effect, to change illness form of life to healthy form requires either a compelling force e.g. invasive surgery, shock therapy, etc or tender loving care, encouragement, support, helping relationship, advocacy and empowerment by a caregiver such as a nurse.

NURSING AND CARING

These are two concepts that are interwoven and interrelated but analytically different. Caring has been considered as a nursing concept and has also been conceptualized as relational expression of human concern and as a collection of human activities that assist others (Kapborg and Bertero, 2003). Caring is a universal phenomenon that influences the way people think, feel and behave towards one another. It is central to human expertise, to curing and to healing. The Relationship of caring is based on whole being, concerns and projections for the individual which in turn provides motivation and direction, involves a moral commitment towards protecting human dignity and preserving humanity.

Theoretical Perspectives of Caring

Caring has been explained from the following theoretical perspectives (Kapborg and Bertero, 2003):

- a) Dual component of attitudes/values and activities. Whatever activities the nurse performs have attitudinal and value orientation components.

- b) Process and integration which includes motivation and behaviour.
- c) Relational expression of human concerns in interrelationships of both being and doing.
- d) Intentional intervention interaction whereby the nurse purposively carries out helping actions in the relationship.

In all these, the care-giver and receiver perceive someone as unwell, unsafe, at risk or in need. The interaction is encapsulated in shared/mutual attitudes and feelings of concern for each other. Caring according to Kapborg and Bertero (2003) refers to level of emotional involvement between the care giver – formal or informal – and the client through seeking the client out, spending quality time with providing emotional support, paying attention to needs or ensuring manipulative therapeutic actions. Caring therefore is not only the BEDROCK but the SOUL of nursing.

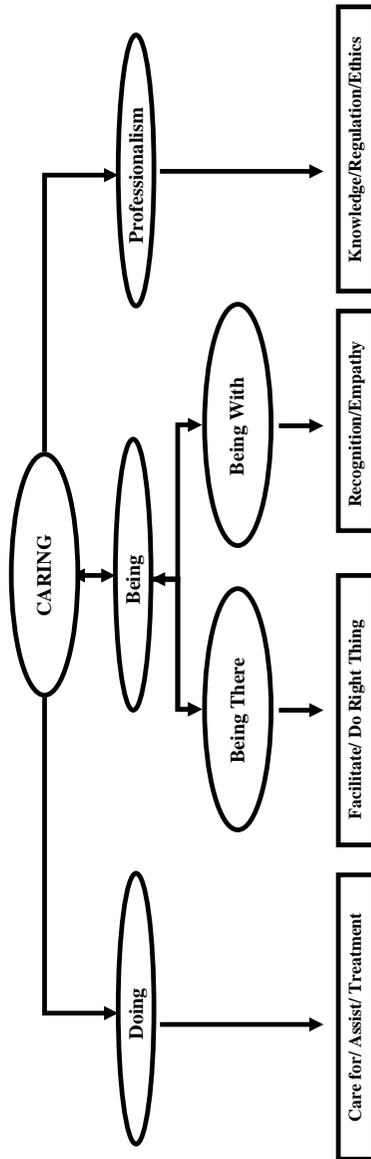


Figure 1: Schematic Illustration of Caring (Kapborg and Bertero, 2003)



Igbinedion University Nursing Students in the Ward



Igbinedion University Nursing Students on Community Health Nursing Posting

Nursing Roles to Improve Patient/Client Care

Nursing is a service profession whose focus is the patient/client. An attempt at explaining its roles for improved patient care forms an analysis of the theoretical underpinnings of change for quality care. Chin (1974) offers five guidelines for developing a model of change using best practices. He states that the model should:

- 1) Explain how stability and continuity can exist in a system along with change and how change processes can develop within a network of factors that maintain stability
- 2) Place the source of change somewhere in the system and describe how the conscious efforts of the change agent and client are a source of change.
- 3) Explain or imply how goals are determined.
- 4) Indicate what means are available to the change agent for changing the change process itself.
- 5) Explain how the change agent fits into the scheme of things and what the agent's relationship is to patient and to others in the system.

Using this theoretical model to explain the innovation or the positive change which best practices will bring to nursing practice in terms of quality care can be clearly put as convincing. Three propositions offered by Jacox (1974) about this model are enumerated as follows:

- a) The first relates to the situation or system in which the nursing practice occurs with regard to type of health institution, roles performed and range of functions.
The second proposition relates to persons or roles of others found in the practice setting (patients, physicians, etc) and the relationships among them. Both medicine and nursing (Jolley, 1989) share a mutual and collective core of knowledge and

skills. Educating these students together increases common cognition based on knowledge of people rather than stereotypes. Cordial inter-professional relationship is a strong precursor of quality patient care in health care delivery institutions anywhere in the world.

- b) The final proposition relates to the situational, attitudinal and behavioural factors that determine the extent to which the nurse can function effectively as a leader and innovator of nursing practice. Within this context, the effectiveness of the nurse as a change agent in improving the quality of nursing care is influenced by his/her level of clinical knowledge and practice which can be analysed as follows:
 - i. Amount of knowledge in the nursing field is so great and diverse that expertise can be cultivated only in specific areas e.g. Medical-Surgical Nursing, Maternal and Child Health Nursing, Community Health Nursing etc.
 - ii. An expert nurse is one who through graduate education and extensive on-the-job experience in a specialized field has mastered the theoretical basis and technical skills necessary to practice nursing in the specialty.
 - iii. The effort to improve nursing practice should also come from the nurse as change agent who has appropriate professional, attitudinal, ethical, and behavioural qualifications.

Nurse–Patient Negotiation

Patient is from a Latin word meaning ‘to suffer’ connoting dependence while client is from a Latin word meaning ‘to learn’ connoting alliance and interdependence. Both are relevant and related to experiences of health care receivers.

The traditional paternalistic approach to health care which espoused that “the professional knows best” started to die out in the

United Kingdom since the early eighties when the general socio-political trends started to promote the beliefs that consumers of health care should exercise choice and express opinion about the care they receive (Timobranski, 1994). The nursing literature widely promotes the importance of a nurse-patient/client relationship which fosters the involvement of the patient in negotiation and decision-making regarding his/her care. It is therefore important for nurses to always advocate individualized, holistic care and must hold such ideology as a central tenet to their philosophy. It is however questionable whether this philosophy is widely expressed in reality in clinical practice. There is also the problem of lack of adequate empirical evidence to support the assumption that patients wish to participate in clinical decision making about their care.

Whatever the situation, Peplau (1952) proposed inductive, partial theory of interpersonal relations in nursing and laid the foundation for other theories developed concerning nurse-patient relationship (Ramos, 1992; Salvage, 1992). Current Nursing philosophy assumes that negotiation and patient choice are pivotal concepts to the provision of high quality nursing care. Wright (1990) advocated the involvement of patients and significant others in decision-making regarding nursing care. He states that the patient has the right to:

- have choice in his/her care and be given enough knowledge so that he/she can make rational decisions.
- skilled nursing care to meet his/her needs, working in partnership with him/her, family and friends to achieve health and happiness.

Nursing Culture and Nurse-Patient Negotiation

Even as evidences point to the desirability of nurse-patient negotiation in nursing practice, some aspects of nursing culture negatively impinch on nurse-patient interaction. May (1990) concluded that nurse-patient interaction is task-oriented, superficial and routinized. In addition, Macleod (1983) in her review of literature

asserted that nurses use a range of tactics to avoid communication with patient and that they attempt to control all interactions in order to limit the quality and depth of verbal communication with patients.

Nevertheless, the shortcomings identified in nurse-patient interaction should be viewed within social and organizational context in which they occur. Traditionally, physical nursing tasks are viewed as work while verbal communication with patients is viewed as non-work or idleness and these influence nurses' behaviour with regard to relations and interactions with patients and their significant others. It is therefore crucial that nurses should be empowered to adopt flexible approaches to planning and implementing nursing care to accommodate patients who wish to negotiate and those who are not willing. An organizational culture that encourages autonomy should also be encouraged.

AN OVERVIEW OF NURSING CARE CHALLENGES IN NIGERIA

1. A critical mass of nurse practitioners in Nigeria hold the registered nurse certificates which has been equated to higher national diploma for employment purposes but need academic quantification for wider academic career progression.
2. The educational level affects proper understanding and utilization of the most current concepts in nursing such as nursing process, evidence- based practice, best practices, advanced nursing practice and reflective practice etc. which are designed to improve quality of care rendered by nurses globally.
3. Nurses themselves were slow in embracing university education like other health practitioners, thereby, limiting their opportunities for progress and slow down the rate of improvement of quality of care they render.

4. Problem of gender marginalization is very pronounced in nursing because a large majority of nurses are females.
5. Low voice of nursing at management levels of health care delivery system thereby making introduction and implementation of new and beneficial ideas, methods, strategies in nursing care difficult to get support and as a result impeding nursing development and quality of care rendered.
6. The professional association of nurses – National Association of Nigerian Nurses and Midwives (NANNM) focuses more on the welfare of its members at the expense of development, maintenance and monitoring of nursing education and practice standards.
7. Governments’ cost saving practice of minimum staff for maximum work which in health care delivery system endangers the health of the citizens as standards and quality are lowered.
8. International organizations and agencies support for health and nursing education and practice development has been dwindling over the years for various political, economic and financial absurdities in governance in Nigeria as well as global economic melt down in recent years.

All these factors are negatively impacting on the quality of care rendered by nurses. In view of these challenges, the adoption of universally established approaches for delivery of quality care is the panacea.

EVOLUTION OF BEST PRACTICES

A best practice is a technique, method, process, activity, incentive or reward that is believed to be more effective at delivering a particular outcome than any other one when applied to a particular condition or

circumstance (Wikipedia, 2009). The concept of best practice is that with proper processes, checks and testing, a desired outcome can be delivered with fewer problems and unforeseen complications. It can also be described as the most efficient (least amount of effort) effective (best results) way of accomplishing a task based on repeatable procedures that have proven themselves overtime for large numbers of people.

The concept originated in the private sector as a tool to benchmark performance against competitors and thereby stimulate improvement (Brannan *et al.*, 2006). Best practices have been applied in various domains of human endeavours which include Teaching/Education; Incremental/ Interactive development; Quality assurance; Performance engineering; Risk management; Change processes, Change management; Evidence-based medicine, Nursing, physical planning and land use management, local governance and even home care, among others.

Development of Best Practice Guidelines

These are systematically developed statements to assist practitioner and client decisions about appropriate nursing care for specific clinical circumstances (Field & Lohr, 1990). These statements are a way for nurses to share the most current, reliable, information about how to handle specific problems e.g. Catheter in situ, pain. Or illnesses e.g. cancer of the prostate, psychosis.

Best practice guidelines (also called clinical practice guidelines) use has been reported in studies to lead to better catheter care (Estabrooks, 1999), increased symptoms relief to pain and reduced length of hospital stay (Thomas, McCall, Cullum, Rouseau and Soutter, 1999). The following are the qualities of effective best practice guidelines:

- Representative of existing knowledge and practices.
- Developed by a team
- Valid leading to predictable outcome

- Cost effective
- Reproducible
- Reliable
- Clinically Applicable
- Flexible
- Clear, Precise, Transparent and User friendly
- Reviewed frequently on a scheduled or unscheduled basis
- Accompanied by an evaluation

Steps for Developing a Best Practice Guideline

- i. Perform a systematic review of literature
- ii. Use an instrument to assess the strength of the evidence e.g. appraisal of guidelines, Research and evaluation
- iii. Develop a shortlist of guidelines for review by an expert panel
- iv. Extract recommendations and categorize them
- v. Review short listed guidelines and recent literature by external stakeholders
- vi. Revise according to feedback received
- vii. Pilot test
- viii. Revise again as needed
- ix. Release and disseminate the guidelines
- x. Evaluate how the guidelines is circulated and used

Barriers to Implementing Best Practices Guidelines

Implementing best practices in clinical settings by professional nurses report the following as barriers:

- Insufficient organisational support form administration and physicians
- Lack of time
- Lack of resources
- Lack of authority and change practice
- Lack of incentive for use of best practice guidelines
- Lack of relevance

Ways to make best practice guidelines attractive to nurses include:

- Present strong evidence that is consistent with what nurses know from clinical experience and clinical preferences
- Support the newly introduced guidelines with supportive leadership and a work environment that embraces change
- Introduce change(s) appropriately with responsibility for success shared equally by guidelines developers, implementers, users and evaluators.

Best Practice Guidelines successes in Nursing Practice

Measuring the impact of nursing interventions on client outcome can be challenging. There are at least five key ways in which nurses affect client response. Clinical practice guidelines can therefore be considered successful when they satisfy the following criteria.

- a. Prevent complications by ensuring clients are safe and free from injury, infection and complications.
- b. Advancement of nursing interventions that affect client clinical outcomes such as system control.
- c. Enhance client knowledge of disease and treatment such as Illness process, medication, health attitudes, adherence to treatment instructions which are influenced by education provided by nurses.
- d. Improve the functional health outcomes of clients (physical, social, cognitive, mental, continence, mobility, self-care, home) and quality of life – all as a direct result of nurses' actions.
- e. Improve clients' satisfaction or how clients perceive care provided and their interaction with nurses.
- f. The guidelines are implemented and continue to be used.

When best practice guidelines are developed, implemented, evaluated and continued to be used, the positive impact on client/patient outcomes are evident, measurable and significant enough for quantification and qualification of the value of nursing care in health care delivery services

Critique of Best Practice Guidelines

It is important to state that no practice is completely perfect. The protocols/ guidelines that exist and are in use in training institutions for preparation of nurse practitioners in Nigeria and globally are used to guide practice. They have continued to be used for training and provision of some degree of quality care. That in itself does not foreclose the need for change so that the most current approaches can be adopted to improve the quality of care provided by nurses.

Secondly, technological developments, challenges of increased consumer education and resultant increase in the degree, frequency and scope which consumers challenge/question professionals about the care they receive, call for constant review of nursing practice guidelines. It is therefore appropriate to adopt new or modified guidelines for practice. In fact, the International Council of Nurses (ICN) recently developed a practical manual as benchmark for best practices globally. Each country is expected to adopt it for its use in nursing practice. A copy of this is currently available and being adapted in the department of Nursing, Igbinedion University, Okada.

Best practice guidelines have been criticised and found to have the following weaknesses:

- It has been observed that strict obedience to protocols may impede critical thinking on the part of nurse practitioners
- It may also interfere with reflective thinking on, in, during and after any nursing activity by the nurse
- It may also limit the chances of flexibility in practice when specific situations require such adjustments

The principle of responsibility and accountability on the part of the nurse practitioner may be endangered if the practitioner can not use his/her initiative in taking clinical decisions in the clients best interest legally, fairly, and socially.

Weighing all evidences for and against best practices in nursing, its adoption in nursing practice in Nigeria will be beneficial in all clinical setting for individuals, families and communities as it has been reported in other parts of the world. However, the critical factor that will make best practices protocols beneficial in Nigeria is higher education for nurses beyond the hospital based diploma programme.

The Link between Best Practice and Innovation

These two concepts are conceptually distinct. While Innovation is the adoption of new practice/policy that is new to an organisation, best practice is the adoption of a new practice/policy through following some tried and tested, generally accepted method, process or view, among practitioners of what is a state of the art approach (Brannan *et al.*, 2006). Best practice can however be employed as a means of innovation.

Best Practice in Nursing

Traditionally, nursing has not based practice on evidence even as the body of nursing knowledge has increased. Most practising nurses are not familiar with the process of research analysis, gathering evidence and applying it to their practice situations (Kowalak *et al.*, 2003). Evidence based practice represents what can be described as best practice which in turn will yield an outcome of practice standards.

In a service and helping profession like nursing, the components and characteristics of best practices are comprehensively relevant and appropriate for its practice. It can therefore be inferred that best practices in nursing care will involve:

- a) Techniques, methods, and activities in manipulative dexterity of clinical skills repeatable in various situations.
- b) Such activities are tried, tested and proven to produce desired outcomes.

- c) Process of assessment of clients/patients' condition, making nursing diagnosis, planning care, implementing and evaluating care.
- d) It also involves the process of coordinating care efficiently with positive ethical and professionally competent nurse-patient negotiated relationships.
- e) Delivering effective outcome (best results) with fewer problems or complication for the care receiver.

Whenever or in whatever nursing care situation these components are present, standards of nursing care will be of high quality and client/patient satisfaction with care becomes an expected expression.

In an effort to ascertain whether or not practising nurses adopt best practices in caring for hospitalized patients, Ojo and Oyewole (1999) examined the efficacy of nursing measures for pressure sore prevention among bed-ridden patients in selected hospitals in Osun State, Nigeria. The study revealed poor proficiency in changing patients' position (poorly = 76.7%) and offering bedpans/urinals (poorly = 73.3%) as well as irregularity in performing care of pressure areas (once 8 hourly) and bed making (once weekly). Development of pressure sores was found among majority of the bed-ridden hospitalized patients (56.7%). It was also found that advance in age and prolonged hospitalization highly predisposed patients to pressure sores. The study corroborated the work of Thomas and Chilmen (1978), Parish (1975), Wood (1966) and Bergston and Braden (1987).

Table 2: Frequency of performance of pressure sore preventive procedures

Procedures Frequency	Morning Shift		Afternoon Shift		Night Shift		Total	
	No of Nurses Observed	%	No of Nurses Observed	%	No of Nurses Observed	%	No of Nurses Observed	%
1. Care of Pressure Sores								
2 Hourly	-	0	-	0	-	0	0	0
4 Hourly	5	20.8	2	11.0	1	5.5	8	13.3
*Once per 8 Hours								
Shift	19	79.2	10	55.6	14	77.8*	48	71.7*
None	-	0	6	33.3	3	16.7	9	15.0
Total	24	100	18	100	18	100	60	100
2. Changing of Patients Position								
2 Hourly	-	0	-	0	-	0	-	0
4 Hourly	16	66.7	3	16.7	-	-	25	41.7
Once per 8 Hours								
Shift	3	33.3	12	66.6	9	50.1	29	48.3
None	-	0	3	16.7	3	16.6	6	10
Total	24	100	18	100	18	100	60	100
3. Bed Making								
Once in a week	19	79.2	18	100	17	94.5	54	90*
Twice in a week	4	16.6	-	-	1	5.5	5	8.3
Thrice in a week	1	4.2	-	-	-	0	1	1.7
Everyday of the week	-	0	-	-	-	0	-	0
Total	24	100	18	100	18	100	60	100
4. Offering of Bedpans/Urinals								
2 Hourly	-	0	-	-	-	0	-	0
4 Hourly	10	41.7	6	33.3	2	11.1	18	72.7
Once per 8 Hours	14	58.3	12	66.7	16	88.9*	42	100*
Total	24	100	18	100	18	100	60	100

Table 3: Proficiency rating of pressure sore preventive nursing measures

Procedures	Well Done	%	Not Well Done	%
Care of Pressure Areas	50	83.3	10	16.7
Bed Making	43	71.7	17	28.3
Changing Patients Position	14	23.3	46	76.7*
Offering Bedpans/Urinals	16	26.7	44	73.3*

Therapeutic Touch (TT) as a Caring Strategy in the Context of Best Practice in Nursing

Nurses and physicians have much more to do with touching patients in their daily clinical activities more than any other health care service provider (Ojo *et al.*, 2002). How much of this touch is really therapeutic even when they occur during procedures and treatments? The origin of therapeutic touch (TT) dates far back into history and its use in nursing is recognised to have been developed by Krieger and Kunz at New York University in the early 1970s (Krieger, 1975).

The technique of therapeutic touch (TT) is a derivative of the laying-on of hands which is neither related to religion or culture. It was practised as contact (touch) or non-contact such as through the voice, eye contact or just being there with a person or a combination of both. TT is core to caring since it combines doing with being there with the patient with professional skill as described by Kapborg and Bertero (2003) in their schematic illustration of caring.

Nurses have always touched patients, an extension of professional skill. Carter and Sanderson (1995) reported that in the past nurses touch patients spontaneously as a natural response without knowing why they do. TT within the context of best practice expects the nurse of today to recognise the principle of intentionality which means to deliberately set out to help the patient in order to facilitate healing. Secondly, the nurse should understand Roger's (1986, 1987) proposition that human beings are open energy systems that they are more than and different from the sum of their parts. This implies that the transfer of energy between people is a natural and continuous

event. Human beings are known to have natural abilities to transform and transcend their condition of living. These functions are the necessary pre-requisites for healing to occur (Krieger, 1993, cited in Mackereth and Wright, 1997). TT application is therefore a facilitator of the healing process and has the following processes (Hayes and Cox, 1999):

- a) Stage 1 – Centring – when the practitioner focuses entirely on the recipient of TT for self understanding, quietness and calm.
- b) Stage 2 – Employment of tactile sensitivity to assess the human energy fields, being out of balance, mobilize them through practitioner’s hands to help and facilitate healing.
- c) Stage 3 – Using hands to rebalance the energy field to help and facilitate healing.
- d) Stage 4 – A full reassessment of the recipient’s energy field.

McCann and McKenna (1993) cited in Roper *et al.* (1986) classified TT into Instrumental touch and Expressive touch. Engelhardt (2000) in using TT as a caring measure recommended a simple approach as follows:

- Tell patient you understand his/her distress/experience/pain/discomfort etc.
- Encourage to be calm.
- Hold patient’s hand for reassurance.
- Stroke the patient’s arm and keep reassuring.
- Keep your voice as calm as possible.
- Tell patient to squeeze your hand if that will make him/her feel better.

Several studies were reviewed on the effectiveness of TT and in almost all cases TT was found to be very effective (Ojo *et al.*, 2002). Such studies revealed reductions in anxiety levels among hospitalized patients (Heidt, 1981; Green, 1998); reduction of tension, headache and pain (Weller and Bzedek, 1986). Induce relaxation, decrease anxiety

and speed healing (Dalglish, 1999). Reduction in the perceived experience of post operative pain (Meehan, 1991). Reduction in the preoperative anxiety experienced by open heart surgery patients (Quinn, 1984). The study concluded that since TT has been established as an evidence-based and effective best practice nursing care method, it is recommended for adoption in nursing practice in Nigeria and other African countries (Ojo *et al.*, 2002).

Bridging Theory-Practice Gap for Standards

Investigative efforts to identify the theory-practice gap among Nigerian nurses covered the following aspects in my research activities.

- (a) Examining trends of nursing research among undergraduate nurses in Obafemi Awolowo University, Ile-Ife (Ojo, Irinoye and Mukoro, 2002).
- (b) Nurses knowledge and attitude towards implementation of nursing process (Ojo and Irinoye, 2002)
- (c) Nurses attitude towards Part-time degree in Nursing (Ojo, 1996)
- (d) Presenting oneself as a nurse: A social and professional reality construction (Ojo, Wambui, Mutea and Chelagat 2002)

For nurses to be able to perform as company of equals in their work place encounters with physicians, pharmacists, medical rehabilitation therapists etc and be recognized and accepted as professional practitioners, competent to give high quality nursing care that they will be responsible and accountable for, nursing education needed to shift to higher grounds. That was the motivating force for focusing some of my researches and publications on nursing care of adult hospitalized patients, nurses' perception of the care they give; their health promotion roles, and investigating their attitude to higher education. The need to create opportunities for a progressive professional education that will enable nurses to render evidence-based, best practice and high standard nursing care to consumers became imperative.

Experiencing Quality Nursing Care

Many of us here must have had personal experiences of care as patients/client and also must have shared the health care experiences of friends or relatives. All clients/patients want to be treated well, and know that the nurse is knowledgeable, skilled and competent. They want to have high quality care always and want nurses to have a caring and humane attitude, make them feel safe and comfortable.

The attitude of the nurse and his/her approach is the most important factor in securing this experience which patient/client expect. They want to be treated as human beings, not “a case” but with compassion, respect, empathy and by nurses who are “interested in them”.

Six core elements have been identified for a good nursing experience for patients (Maben and Griffiths, 2008). These are:

1. A holistic approach to physical, mental and emotional needs and a patient-centred and continuous care.
2. Efficiency and effectiveness combined with humanity and compassion.
3. Professional, high quality evidence-based practice.
4. Safe, effective and prompt nursing intervention
5. Patient empowerment, support and advocacy.
6. Seamless care through effective teamwork with other professions.

In a reciprocal desire for high quality care, nurses too have identified five main aspects they value most about nursing (Maben and Griffiths, 2008)

1. Making a difference to patients’ lives
2. Close contact with patients
3. Delivering excellent care
4. Working in a team and being a role model
5. Continuous development – learning and improving

In effect, both recipients of care and nurses set their expected standards of the relationship which should be met to ensure delivery of quality nursing care.

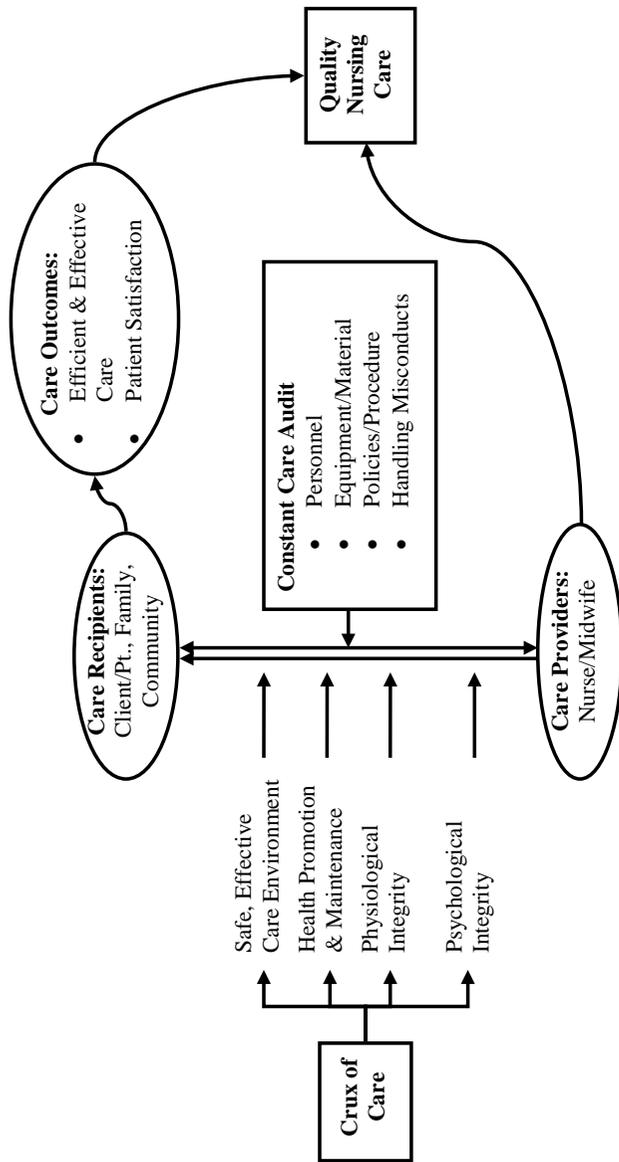


Figure 2: Model for Providing Quality and Satisfactory Nursing Care (Ojo, 2006)

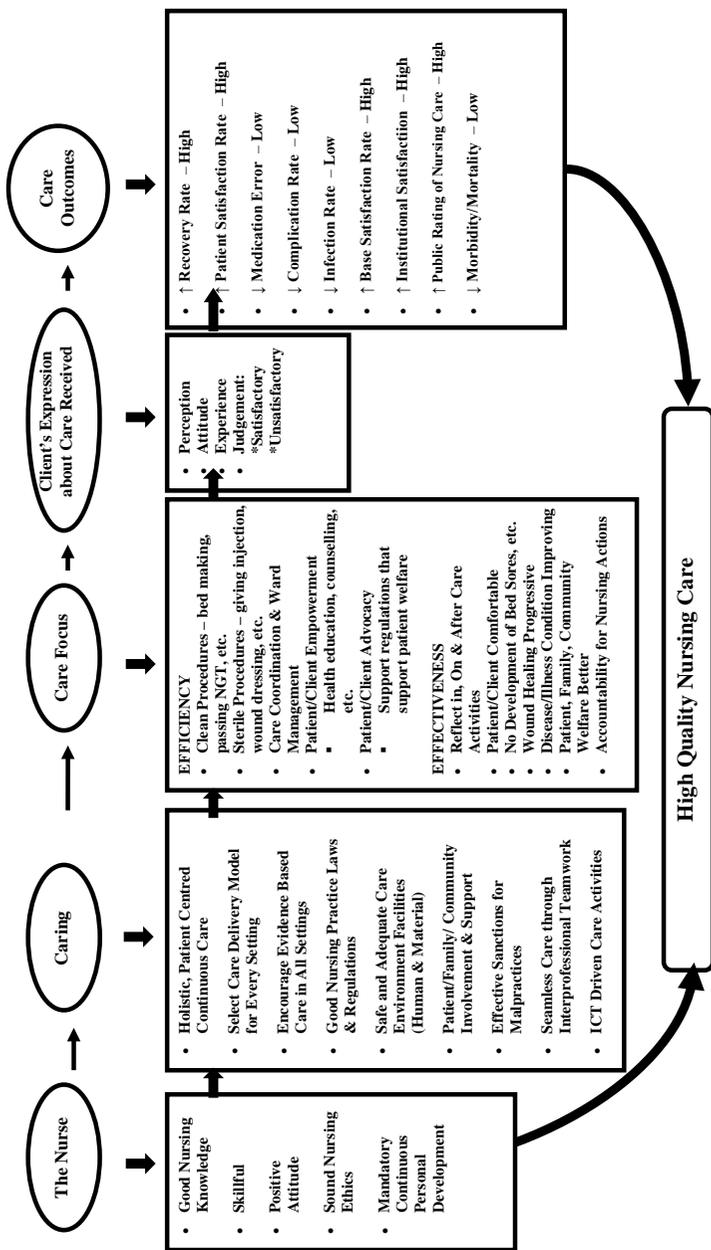


Figure 3: Best Practices Nursing Care Model (Ojo, 2010)

ASSESSING STANDARDS OF CARE

According to Doughty and Marsh (1984) nurses need to assure themselves and their patients that they are delivering a high standard of quality nursing care. History of quality assurance activities in nursing is traceable to Florence Nightingale's attempt to improve the care received by soldiers during the Crimean war in 1858. Subsequently, nursing developed into a profession with an emerging body of knowledge which resulted in a growing interest in the improvement of quality of nursing care.

Eli (1990) opined that nurses do not ask patients enough for their perception of care received. The methods suggested for identifying problems about quality of care include the use of such tools as questionnaires, interviews, surveys and observations of care whilst it is being delivered. According to Pawsey (1990) patient satisfaction surveys are commonly used in quality assurance surveys. These positions form the basis for research and publication on patients and nurses perception that span my years of academic and professional endeavours.

My work on compliance among hospitalized hypertensive patients in selected hospitals in Oyo State Nigeria (Ojo, 1985) essentially examined the relationship between patient's attitude to doctors and nurses and compliance with prescribed drugs, diet and rest. It also assessed their perception of the seriousness of their illness as well as duration of hospitalization and the relationship with compliance with prescribed drugs, diet and rest. The tools used were patient questionnaire and observational check list. The study revealed among others findings that:

1. Hospitalized patients who perceived the ward setting, regulations and routines favourably complied with their medical regime.
2. That patients who perceive nurses as sympathetic complied with medical regime while those with negative perception refused to comply.

3. The overall rate of non compliance was 2.9%. This agrees with the finding by Lunt and Austin (1960) who found a default rate of 2% among hospitalized patients on anti-tuberculosis drug.

The implication is that patients are motivated to either comply or not. Nurses and other health care providers should provide a therapeutic hospital environment for the client in order to facilitate compliance and recovery. Care should also be individualized so that routinization of hospital activities can be minimized if not eliminated. These are findings that remain valid for providing quality nursing care.

In another study on compliance with medical regimen among patients with chronic renal failure in a teaching hospital in Nigeria, Ayadiran, Ojo, Fajemilehin and Akinsola (2003) found no significant relationship between religion and compliance, and health belief and compliance. However a negative relationship was found between literacy level and compliance with medical regimen and vice-versa ($r = 0.33$). Another important finding is the significance of the patients' perception of their condition and compliance which revealed that the better the patients' perception of their condition the higher their compliance ($p < 0.05$)

Nurses Perception about care given

Considerable attention was given to investigating how nurses perceive the care they give to special groups of patients. Such groups include AIDS patients (Ojo, Irinoye and Akinboro, 1996); HIV positive renal patients (Ojo, Akoma, Osunwusi and Ayandiran, 1999); Counselling needs of mothers for healthy Puerperium (Irinoye, Ojo and Ogunbode, 2000); Constraints to bedside teaching of hypertensive patients (Ojo, Rasheed and Oyeleye, 1998). Nurses' perceptions were generally negative due essentially to such factors as inadequate information about the condition and unnecessary fear about contracting the disease among others. The need for nurses to always update their knowledge about certain disease conditions they will have to attend to in their practice was emphasized.

Patients' education is one of the cardinal responsibilities of the nurse. The study found that nurses offered such reasons as inadequate staffing, too busy performing nursing procedures for their failure while patients' related constraints include uncooperativeness. Institutional excuses reported were lack of teaching aids and lack of periodic training programmes for nurses.

The study concluded with recommendations for nurses to see patient education as a compulsory component of their role to empower clients/ patients for healthy living. Management responsibility in providing enabling environment was also advocated to improve the quality of nursing care rendered to patients.

My research search light was also beamed towards the health promotion roles of the Nigerian nurses. Investigations jointly conducted include: Irinoye, Ogungbemi and Ojo (2003); Irinoye, Ogunbode and Ojo (2000); Ojo, Osayande, Irinoye and Mukoro (2001); Ajayi, Garba, Ngoran and Ojo (2004); Jinadu, Adegbenro, Esmal, Ojo and Oyeleye (2007). These studies provide verifiable data to support the need for nurses to be actively involved in health promotion and disease prevention activities aimed at improving the welfare of Nigerian people.

Ojo (2006) at a National Nurses Training Workshop on Optimising Quality Care in Nursing Practice in Nigeria presented the highlights of what constitutes best practices in nursing care interaction with clients. They include: Treat the client well, provide client/patient with preferred care, provide individualized care, aim for dynamic interaction, avoid under or over information, and use and provide opportunities for learning.

CHALLENGES OF BEST PRACTICES FOR STANDARDS IN NURSING IN NIGERIA

The trend that has emerged from the adoption of evidence-based practice and employing best practice protocols in performance of nursing responsibilities all over the world and to some extent in Nigeria is that:

1. Nursing practice which was traditionally based on intuitions and old practices passed on, gradually started to respond to change.
2. The change was necessitated by rapid improvement in the trends of nursing education, practice and research.
3. Other health care professions are embracing evidence-based practices, so nursing has no option but to respond positively.
4. Other factors include: Technological explosion; globalisation of the world economy and society including death of distance in disease spread; shift of population-based care and the increasing complexity of patient care; impact of health policy and regulations and era of the educated consumers.

A personal experience in 1974 when I resigned from Adeoyo State Hospital, Ibadan to pursue a Bachelor of Science degree in Nursing at the University of Ibadan summarizes Nigerian nurses' initial perception of university education for nurses. My registered nurse colleagues mocked and queried "Do you need a degree to serve and remove bedpans?" About 35 years after, university based nursing education in Nigeria can still be described as abysmally low in terms of the number of universities offering nursing, population of students who enrol, the total number of graduates so far produced in nursing departments etc. It is even worse when one considers the number of departments offering postgraduate programmes and the total number of such products available to teach in the departments.

In effect, nursing research and researchers are few and senior academic staffs in nursing are in very short supply. Only 3 departments of nursing have postgraduate programmes and have produced a total of 104 graduates.

The scenario presented aptly reveals a daunting challenge to development and utilization of evidence-based and best practices in nursing in Nigeria. Tables 1 and 4 can be summarized that all the 3,595 graduate nurses are primarily registered general nurses just like all post

basic nurses. Of a total of 137,023 registered nurses in Nigeria, 3,595 are university graduates, which forms 2.6%. If between 1969 and 2009 all regular universities produced 3,595 graduates the need for alternative routes for university nursing education becomes imperative.

We, at the department of nursing at Obafemi Awolowo University, Ile-Ife rose to the challenge and developed a part-time degree programme in 1994. It took the department 10 years to get it approved in 2004. Currently, 520 registered nurses are undergoing part-time degree programme in the department. In addition, the National Open University of Nigeria (NOUN) also has 4,360 nurses on its enrolment. Mr Vice Chancellor Sir, my consolation is that we are making progress.

Table 4: Total number of nurse graduates produced from Nigerian Universities (1995 – 2009)

S/No.	Universities	Duration	Undergraduates	Post-graduates
1	University of Ibadan	1968/69 – 2008/09	1179	76
2	Obafemi Awolowo University, Ile-Ife	1977/78 – 2008/09	176	25
3	University of Nigeria, Nsukka, Enugu Campus	1985/86 – 2006/07	1024	3
4	Ahmadu Bello University, Zaria	2002 – 2009	276	–
5	University of Calabar	1996/97 – 2007/08	391	–
6	Ladoke Akintola University of Technology, Ogbomosho	2006/07 – 2008/09	238	–
7	Babcock University, Ilishan, Remo	2003/04 – 2008/09	208	–
8	Niger Delta University, Bayelsa State	2006/07 – 2008/09	31	–
9	Maddona University, Elele	2007/08 – 2008/09	72	–
Total			3,595	104

Source: All departments of Nursing reflected. 2009.

Recent studies have confirmed that a higher prevalence of degree nurses at the bedside positively impact patient outcomes. Swindells and Willmott (2003) found that graduates perform better than diplomates in the following domains (Table 5):

Table 5: Domains graduates performed better than diplomates

Cognitive Ability	Reflective Ability	Practice	Professional Practice
Analyses issues	Reflect in and on action		Change agent
Think critically	Rationale for thoughts and behaviour		Enhances capabilities of others
Evaluates care approaches	Identifies future learning needs		Team working and leadership
Problem solving approach			Accountability
Think through current issues			Networking and collaboration
Identifies gaps in information			Adaptability, flexibility
Informed decision making			Extended level of competence
Applies specialist knowledge			Evaluation of concept and strategies
			Relevant policies and impact on practice
			Confidence to challenge

Source: Swindells and Willmott (2003).

APPLICATION OF BEST PRACTICES IN COMMUNITY PROJECT

My community health intervention endeavours made some significant contribution to the promotion of health and prevention and control of HIV/AIDS in Osun and Ekiti states of Nigeria. The National Action Committee on Aids (NACA), now National Agency for Control of HIV/Aids (NACA) sponsored a 12 month project which was executed by Health Promotion and Care Resources Development Foundation (HECAREF) in the 2 states between 2004 and 2005 for which I served as the project director. The intervention project on Participatory STI/HIV/AIDS Education project was in 12 selected Rural Communities of Osun and Ekiti States. This effort is in support of Millennium Development Goal 6 on Combating HIV/AIDS, Malaria and Other Diseases (FGN, 2004).

There is the need to highlight certain best practices in the processes and steps adopted in the implementation of the community project which include:

- (a) Proper understanding of the project goals and expected output.
- (b) A systematic arrangement of project into phrases
- (c) Implementing each phrase paying thorough attention to correct performance of every step involved in each activity.
- (d) Reflecting in and on every activity and phase of the project to identify any errors and make amends.
- (e) Monitoring and evaluation to ensure set goals are achieved.

Major Achievements of the Project include:

1. Trained 23 master trainers and 357 peer promoters
2. Reached a total of 157,815 people in 6 communities in Osun and 331,885 in Ekiti State with current reproductive health information about HIV/AIDS control strategies.

3. Local government, traditional rulers and community development associations in some communities donated funds, promised support and gave recognition to the peer promoters' continued activities after the project time has ended thus assuring sustainability and ownership by the communities.
4. An end of project assessment questionnaire administered to community leader, Local government health officials, political office holders and policy makers to express their views, opinions and levels of satisfaction with the project revealed that:
 - (a) 99.4% was aware of the activities of the project towards STI/HIV/AIDS prevention and control.
 - (b) All (100%) confirmed that the project was beneficial in the fight against STI/HIV/AIDS through such community empowerment
 - (c) 96.5% reported that the peer promoters were very useful, efficient and effective in the health education project.
 - (d) 90.1% agreed to take over the ownership of the project at the expiration of 12 month period.

The success of this project in Osun State motivated the Osun State Action Committee on HIV/AIDS (OSACA) to sponsor HECAREF for a 12 month project on HIV/AIDS prevention and control in another six rural communities in 2007/2008. The outcome was equally satisfactory to both the sponsors, communities and the organisation.

It must be highlighted that in all phases of the activities, the communities experienced that the nurse-led team is knowledgeable, skilled and competent and with a caring and humane attitude in providing a seamless service through effective team work with other professionals in the health care industry.



Plate I: Project Director, Dr. A.A. Ojo (Standing) reporting the project activities, achievements and challenges



Plate II: Peer promoters presenting a drama sketch on prevention of HIV/AIDS and care and support for AIDS victims

NATIONAL STANDARDS PROGRAMMES FOR HEALTH CARE ADOPTING BEST PRACTICES PROTOCOLS

The federal ministry of health in collaboration with WHO and DFID has developed a best practices programme for universal precautions and health care waste management practices. Its focus is on administration of injections.

Administration of injections is one of the most common health care procedures. According to WHO (2005), a safe injection is one that is given using appropriate equipment that does not harm the recipient, does not expose the provider to any avoidable risks and does not result in waste that is dangerous to other people.

Other best practices programme to ensure standards both in health care and in nursing and midwifery practice in Nigeria include:

- 1. Use of Midwifery Kit in Community Midwifery**
- 2. Use of Objective Structured Clinical Examination (OSCE) for midwifery examination.**
- 3. Use of Directly Observed Therapy (DOT) in the Management of Tuberculosis**
- 4. Use of Post Abortion Care (PAC) developed and promoted by IPAS for nurses/midwives to improve the reproductive health of Nigerian women.**

Prevailing Situation of Nursing in Nigeria

Nursing has a unique, pervading and significantly important role in health care delivery throughout the life span of everybody everywhere in the world. While this role has been articulated, documented, and appreciated in the health industry by all stakeholders in the developed world, the Nigerian experience poses a lot of challenges. The challenges are attributable mainly to very slow development of nursing, gender marginalization, and underdevelopment of Nigeria herself in various aspects of what constitutes national development indices that are progressive and based

on sound policies and strategies, implemented, monitored and evaluated for public welfare.

Nevertheless, the current state of nursing education and practice in Nigeria is that it is being effectively situated appropriately in the global trends of the profession. The professional Association (NANNM) is an active member of the ICN, more universities are starting nursing programmes while the NMCN is pursuing vigorously a nursing education reform agenda within the Health Sector Reform Programme of the Federal Ministry of Health. The council has also developed a national document of nursing education and practice standards. The council in addition has taken a pragmatic step to correct the negative public perception of practising nurses by the initial take off of a National and Mandatory Continuing Profession Development Programme (MCPDP) in Medical-Surgical Nursing (my specialty). It is designed to update nurses' knowledge and clinical skills and rebrand their attitudes and behaviours in their relationships with clients/patients. In all these pursuits, I have been opportuned to make my modest contributions. The Nigerian Association of University Nursing Programmes (NAUNP) is also coordinating and supporting university nursing education programmes for quality education and practice. Nigeria is now the centre for the African sub-region for the development and refinement of nursing diagnosis in collaboration with North American Nursing Diagnosis Association International (NANDA-I). Best practices and standards are benchmarks to be complied with for quality practice and are expected to guide every nursing activity. Nursing in Nigeria is currently engaged in efforts to further improve the quality of care Nigerians are receiving.

Mr Vice-Chancellor Sir, I have come, seen, but have not conquered the challenges of change in nursing because it is a continuous process in any profession or life endeavour, so the struggle continues.

CONCLUSION

Mr. Vice- Chancellor Sir, permit me to conclude this lecture on this note that nursing is the power of caring. The extent to which the nurse demonstrates strict obedience to protocols of best practice determines the standard of care rendered. These standards expect the nurse to use specialized knowledge and skill to act reasonably and prudently as persons who possess similar knowledge and skill would under similar circumstances. Best practices produce standards and standards produce quality care. Standards are the bench marks of achievement based on desired level of excellence. Standards of care developed and implemented determine the quality of care provided. These standards hold nurses, both new graduates and experienced, responsible and accountable for their actions and therefore liable for any negligence in practice. Nursing is universally acknowledged as a noble profession and Nigerian nurses should nurse Nigerian society efficiently and effectively. I have tried to provide a template for us to do this. We must be more committed to doing it, and we can.

RECOMMENDATIONS:

- Today's practicing nurses must be aware of nursing standards, adopt best practices protocols in their nursing activities, be conversant with legal issues in nursing, legal limits of nursing and legal liabilities.
- The nursing process should become a compulsory tool for delivering of nursing care in all setting in Nigeria.
- Best practices guidelines should be constantly developed, reviewed and adopted in health care institutions nationally to facilitate scientific quantification of nursing practice in patient clinical outcomes.

- For nursing quality to improve in Nigeria, it is important to use both the patient's view and nurse's conception of good nursing care to utilize frameworks for evaluation of care. Such framework will also form basis for determining that "good nursing care" makes a difference to patient outcomes.
- Cutting health care costs by using unqualified health workers instead of qualified nurses in private health institutions erode standards of care, so such institutions should be monitored to ensure adequate nurse- ratio for ensuring public good.
- Governments at all levels, Nigerian nurses, the public and other stakeholders should devote attention and commitment to address the three key programmes which ICN recommended as crucial to the betterment of nursing and health, that is professional practice, regulation and socio-economic welfare.
- Governments at all levels in Nigeria are urged to set machinery in motion to access the world health assembly mandate to WHO (2009) to strengthen the capacity of nursing and midwifery workforce through the provision of support to member states on workforce development particularly for senior academic staff in nursing and midwifery for our new departments of nursing in Nigerian universities.
- There is increasing need for interdisciplinary team work and multi professional care approach to health care delivery system in Nigeria rather than energy dissipation on inter-professional competition and power play to the detriment of public welfare. Nursing is leading the way.

- Nursing should recast or re-brand its role as practitioners, partners and caring leaders and re-establish and reset its values, behaviours and relationships with patients/clients for public acceptability, satisfaction, and respect.
- The scope of nursing practice of individual nurses at unit level should be differentiated according to educational level and performance competencies and remunerated accordingly.
- Nursing practice at unit level should be self managed rather than managed by traditional supervisors i.e. clinical team, or supervisory team for different specialties of nursing practice.
- Team nursing should be encouraged in all hospitals and structured along nursing specialties in practice.
- For nurses to deliver best practice nursing care, staff shortages and cutting cost should stop being the major motivation for selecting models of care delivery by health institutions.
- Nursing education should move completely into university so that graduate registered nursing workforce will be developed for providing quality evidence-based care for a rapidly changing society.
- Nursing profession should identify robust funding streams for nursing education at undergraduate and postgraduate levels and create structured career pathways and appropriate remunerations for higher education and status.

- Nurse specialist with relevant and adequate academic and professional qualifications and experience should be employed as nurse consultants to teaching/specialist hospitals attached to the institution where they work. They will participate in health and nursing policy formulation and decision making, initiate and encourage clinical nursing research to improve quality of nursing care as well as serve in staff recruitment, training and development programmes of the health institutions.

- Finally, governments at all levels in Nigeria, managements of health care institutions, policy makers and other stakeholders should reverse the current under representation of nursing at all levels of management and policy making by including nurses at policy and decision making levels for the common good of the society we all serve. Nurses should also develop interest in politics.

ACKNOWLEDGEMENTS

Praise, honour and adoration unto God for His mercies on me and my family which by His covenant will endure for ever, Amen. I express appreciation to my late farmer parents who sent me to school and did so with commitment. Special thanks are due to my dear wife Mrs Rebecca Bolanle Ojo and our dear Children, Engr & Mrs Babawale and Dr Modupeola Ojo. They have added tremendous value, joy and contentment to my life. I appreciate you all.

For my educational, professional, spiritual, personality and social development, I appreciate the roles of all my teachers and mentors. Late Prof. Mrs Adebode and Dr (Mrs) Adebimpe Okunade to mention a few. His Royal Highness, Oba M.A. Olabode, the Omola of Imala Land of Ogun state, first Executive Secretary of NANNM, my pastors, brothers and sisters in Christian fellowships and very close friends, professional and academic senior and junior colleagues with whom I have worked closely in my career progression, I thank you all.

I appreciate the opportunities I have been given to serve the Nursing and Midwifery Council of Nigeria by past and present chairpersons and registrars. My experiences in various capacities had been quite fulfilling and positively impacted on my professional development and I believe so it has been on the Council.

I particularly want to mention with appreciation the role played by Mr Vive-Chancellor who did know that God was using him to perform a divine role of bringing me to my professional roots to conclude my professional and academic career. Having trained as a nurse in Bendel State, I am today giving this inaugural lecture in Edo State.

I thank all staff and students of the Department of Nursing, School of Clinical Medicine, College of Health Sciences and of Igbinedion University for your support and presence at this occasion. Thank you for listening and God bless you all, amen.

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