



**CONCORSO PUBBLICO, PER TITOLI ED ESAMI, PER LA COPERTURA A TEMPO
INDETERMINATO DI N. 40 POSTI DI INFERMIERE – RUOLO SANITARIO
(AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI)**

PROVE D'ESAME

PROVA SCRITTA

PROVA SCRITTA N. 1 (VEDI ALLEGATO)

PROVA SCRITTA N. 2 (VEDI ALLEGATO)

PROVA SCRITTA N. 3 (VEDI ALLEGATO)

Prova Estratta: la prova scritta **n. 2, (VEDI ALLEGATO)**.

PROVA PRATICA

PROVA PRATICA N. 1 (VEDI ALLEGATO)

PROVA PRATICA N. 2 (VEDI ALLEGATO)

PROVA PRATICA N. 3 (VEDI ALLEGATO)

Prova Estratta: la prova pratica **n. 1, (VEDI ALLEGATO)**.

PROVA ORALE

PROVA ORALE N. 1 – DOMANDE DEL GIORNO 7.1.2025 (VEDI ALLEGATO)

PROVA ORALE N. 2 – DOMANDE DEL GIORNO 8.1.2025 (VEDI ALLEGATO)

PROVA ORALE N. 3 – DOMANDE DEL GIORNO 10.1.2025 (VEDI ALLEGATO)

Domande Estratte: **VEDI ALLEGATI**.

OM TERU di VALUTAZIONE TITOLI

ALL.8

Info procedura

Id procedura: 20240000107

Numero: 75

Titolo: CONCORSO PUBBLICO, PER TITOLI ED ESAMI, PER N.40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

Tot. candidature: 121 di cui completate: 106

Tabella 1 - Titoli di carriera

Indietro

Nuovo Codice

		Codice	Descrizione	Punteggio unitario	Unità di misura	Rapportato PT	Rapportato anno	% punteggio	Periodi doppi	Verifica data requisiti	Verifica corrispondenza
☒	Collega	1d	Servizio prestato alle dipendenze Università/PA nel profilo a concorso	1,00000	Numero mesi	N	S	0,00	N		
☒	Collega	1e	Servizio militare	1,20000	Numero mesi	S	S	0,00	N		
☒	Collega	1f	Servizi presso ASL/PA come dipendente ex c	0,60000	Numero mesi	S	S	0,00	N	N	N
☒	Collega	1g	Servizi presso ASL/PA come dipendente D / Area Professionisti della Salute e dei Funzionari	1,20000	Numero mesi	S	S	0,00	N	N	N
☒	Collega	1h	Servizi presso ASL/PA come dipendente DS	1,20000	Numero mesi	S	S	0,00	N	N	N
☒	Collega	1i	INFERMIERE (AREA DEI PROFESSIONISTI DELLA SALUTE)	1,20000	Numero mesi	S	S	0,00	N	N	N
☒	Collega	1z	Aspettative	0,00000		S		0,00			



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Tabella 2 – Titoli accademici e di studio

[Indietro](#) [Nuovo Codice](#)

		Codice	Descrizione	Punteggio unitario	Unità di misura	Rapportato PT	Rapportato anno	% punteggio	Periodi doppi	Verifica data requisiti	Verifica corrispondenza
 x	Collega	2a	Diploma di laurea triennale diverso dal titolo richiesto per accesso al concorso	0,30000	Attribuzione punteggio singola info	N		0,00	N		
 x	Collega	2b	Laurea specialistica o magistrale oltre al titolo richiesto per accesso al concorso	0,50000	Attribuzione punteggio singola info	N		0,00	N		
 x	Collega	2c	Laurea specialistica o magistrale del titolo richiesto per accesso al concorso	1,00000	Attribuzione punteggio singola info	N		0,00	N		
 x	Collega	2d	Corso di Perfezionamento	0,20000	Attribuzione punteggio singola info	N		0,00	N		
 x	Collega	2e	Master 1o Livello	0,30000	Attribuzione punteggio singola info	N		0,00	N		
 x	Collega	2f	Master 2o Livello	0,30000	Attribuzione punteggio singola info	N		0,00	N		
 x	Collega	2g	Dottorato di Ricerca	1,00000	Attribuzione punteggio singola info	N		0,00	N		



AL.N.8

CRITERI DI VALUTAZIONE

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Tabella 3 – Pubblicazione e titoli scientifici

[Indietro](#)

[Nuovo Codice](#)

		<u>Codice</u>	<u>Descrizione</u>	<u>Punteggio unitario</u>	<u>Unità di misura</u>	<u>Rapportato PT</u>	<u>Rapportato anno</u>	<u>% punteggio</u>	<u>Periodi doppi</u>	<u>Verifica data requisiti</u>	<u>Verifica corrispondenza</u>
		Collega	3a Pubblicazioni/Articoli attinenti alle materie del concorso	0,04000	Attribuzione punteggio singola info	N		0,00	N		
		Collega	3b Abstract attinenti alle materie del concorso	0,01000	Attribuzione punteggio singola info	N		0,00	N		



ALL. 8

Id procedura:

20240000107

Numero:

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Titolo:

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Tabella 4 – Curriculum formativo e professionale

Indietro

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		Codice	Descrizione	Punteggio unitario	Unità di misura	Rapportato PT	Rapportato anno	% punteggio	Periodi doppi	Verifica data requisiti	Verifica corrispondenza
☒	☒	Collega	4a Servizi prestati nel profilo a concorso	0,25000	Numero mesi	S	N	0,00	N		
☒	☒	Collega	4e Borsa di studio/Assegno di ricerca inerenti al profilo a concorso post titolo requisito di accesso	0,20000	Numero mesi	N	S	0,00	N		
☒	☒	Collega	4g Fino a 10 ore (in un anno accademico)	0,02000	Numero mesi	N	S	0,00	N		
☒	☒	Collega	4h Da 11 a 30 ore (in un anno accademico)	0,05000	Numero mesi	N	S	0,00	N		
☒	☒	Collega	4i Oltre 31 ore (in un anno accademico)	0,08000	Numero mesi	N	S	0,00	N		
☒	☒	Collega	4l Corsi, Convegni, Congressi, Seminari, Incontri, Formazione sul Campo, Tavole Roonde, Eventi, FAD e	0,02000	Attribuzione punteggio singola info			0,00	N		
☒	☒	Collega	4m Corsi NON esame	0,01000	Attribuzione punteggio singola info	N	N	0,00	N	N	N
☒	☒	Collega	4n Altri titoli	0,02000	Attribuzione punteggio singola info			0,00	N		
☒	☒	Collega	4o Servizio presso privati	0,25000	Numero mesi	S	S	0,00	N	N	N
☒	☒	Collega	4p Servizio presso privati accreditati S.S.N.	0,30000	Numero mesi	S	S	0,00	N	N	N



A.U.N.A.

concorso per titoli ed esami, per n. 40 posti di infermiere (area professionisti della salute e dei funzionari)

COGNOME	NOME	TITOLI DI CARRIERA	TITOLI ACCADEMICI E DI STUDIO	PUBBLICAZIONE E TITOLI SCIENTIFICI	CURRICULUM FORMATIVO E PROFESSIONALE	TOTALE TITOLI
ABALASEI	MARIA-MIHAELA	0,000	0,000	0,000	2,880	2,880
AIELLO	FILIPPO	0,000	0,000	0,000	0,020	0,020
ALTOMARE	ALESSIO	0,000	0,000	0,000	0,000	0,000
AMBROSINO	ALESSANDRA	15,000	0,000	0,000	0,000	15,000
AMBROSIO	CARLO	15,000	0,000	0,000	0,440	15,440
AUTINO	VIRGINIA	0,000	0,000	0,000	0,000	0,000
BAIOCCHI	SARA	0,000	0,000	0,000	0,000	0,000
BENEDIC	GABRIELA	0,000	0,000	0,000	0,000	0,000
BERNUNZO	DÉSIRÉE	4,600	0,000	0,000	2,475	7,075
BISCEGLIA	NICCOLO'	0,800	0,300	0,000	0,145	1,245
BORGHETTI	SIMONA	9,800	0,300	0,000	1,380	11,480
BUDESTEAN	NADEJDA	15,000	0,000	0,000	0,000	15,000
CALVI	VALENTINA	0,000	0,000	0,000	1,033	1,033
CANGIANIELLO	DANIELA	0,000	0,000	0,000	0,000	0,000
CAPOSECCO	PASQUALE	0,000	0,000	0,000	5,260	5,260
CARUGATI	CLAUDIA	15,000	0,000	0,000	0,830	15,830
CASTRIOTTA	GIANMARCO	0,000	0,000	0,000	0,950	0,950
CATALANOTTO	ANTONIETTA	0,000	0,000	0,000	0,000	0,000
CERULLO	ANNA	11,300	0,000	0,000	0,000	11,300
CHELO	VALENTINA	0,000	0,000	0,000	0,000	0,000
COLOMBO	MARINA	0,000	0,000	0,000	0,090	0,090
COLOMBO	MASSIMO	4,450	0,000	0,000	6,466	10,916
CORAZZINI	GIADA	0,000	0,000	0,000	0,000	0,000
CRAPAROTTA	NOEMI	0,000	0,000	0,000	0,000	0,000
D'ALESSIO	ROSSELLA	7,500	0,300	0,000	0,496	8,296
D'ELIA	SONIA	15,000	0,000	0,000	0,020	15,020
DANI	ELDA	7,683	0,300	0,000	0,359	8,342
DE BENEDITTIS	ALESSIA	0,000	0,000	0,000	0,000	0,000
DI LEO	MARIKA	5,500	0,000	0,000	1,340	6,840
DI MARO	ROSSANA	0,000	0,300	0,000	0,000	0,300
DUCCI	ERICA	15,000	0,200	0,040	0,910	16,150
FABBRIZIO	DEBORAH	15,000	0,000	0,000	0,220	15,220
FAZIO	CHIARA	8,200	0,000	0,000	0,000	8,200
FERRARA	DARIO	4,200	0,300	0,000	1,162	5,662
FIGINI	FRANCESCA	0,000	0,000	0,000	0,000	0,000
FILPO	PIERFRANCESCA	5,100	0,000	0,000	0,562	5,662
FIORETTO	CHIARA STELLA	15,000	0,000	0,000	0,250	15,250

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FRATIANNI	SARA	0,800	0,000	0,000	0,080	0,880
GUI	GIULIA	0,000	0,000	0,000	0,000	0,000
HOXHAJ	SILVANA	2,600	0,000	0,000	0,808	3,408
HYRA	MONIKA	2,800	0,000	0,000	0,354	3,154
ITALIA	ANGELO	0,000	0,300	0,000	0,000	0,300
JOY PEREIRA	GLINDA	0,000	0,000	0,000	0,020	0,020
LATAGLIATA	LEONARDO	0,000	0,000	0,000	0,770	0,770
LEONE	SONIA	0,000	0,000	0,000	0,000	0,000
LO CASTRO	MARIKA	0,000	0,000	0,000	0,000	0,000
LOMBARDI	SUSMITA	0,000	0,000	0,000	0,000	0,000
LOPRESTI	CARLOTTA	0,000	0,000	0,000	0,000	0,000
MAKSYMUK	HALYNA	0,000	0,000	0,000	0,925	0,925
MANCINI	CAMILLA	0,000	0,000	0,040	0,000	0,040
MARCU	MARCELA AURELIA	0,000	0,000	0,000	0,562	0,562
MARINELLI	SARA	15,000	0,000	0,000	2,104	17,104
MASPERI	GIULIA	0,000	0,000	0,000	0,000	0,000
MASSARO	LOREDANA	5,400	0,000	0,000	0,687	6,087
MATTAVELLI	NICOLO'	0,000	0,000	0,000	0,000	0,000
MATTEUCCI	SOFIA	0,000	0,000	0,240	0,300	0,540
MAZZOTTA	DEBORAH	0,000	0,300	0,000	0,750	1,050
MERAVIGLIA	IRENE	0,000	0,000	0,000	0,000	0,000
MINGIARDI	LORENZO	15,000	0,000	0,000	0,020	15,020
MOLA	FEDERICA	15,000	0,000	0,000	0,293	15,293
MONINA	CHIARA	5,500	0,000	0,000	0,208	5,708
MURA	MONICA	15,000	0,000	0,000	0,000	15,000
OLIVERIO	VALENTINA	4,800	0,000	0,040	0,000	4,840
PALLADINO	MATTEO	0,000	0,000	0,000	0,000	0,000
PARENTELA	LAURA	5,400	0,300	0,000	1,666	7,366
PERNICE	MAURIZIO	15,000	0,000	0,000	0,125	15,125
PEZZONI	ILENIA	15,000	0,000	0,000	0,210	15,210
PICARIELLO	ANNITO	0,000	0,000	0,000	0,500	0,500
PIPITONE	SALVATORE	8,300	0,600	0,010	0,926	9,836
PIZZARELLI	SIMONE ADRIANO	0,000	0,000	0,000	0,000	0,000
PONZINI	MARTA	0,000	0,000	0,000	0,020	0,020
ROCCA	JESSICA	4,700	0,000	0,000	0,330	5,030
RUSSO	PAOLA	0,000	0,000	0,000	0,000	0,000
SACCO	LUCIA	4,400	0,300	0,000	1,958	6,658

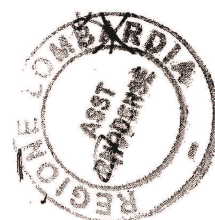
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SALVO	VERONICA SOLANGE	0,000	0,000	0,000	0,020	0,020
SANTOSTEFANO	GIOVANNA	15,000	0,000	0,000	0,282	15,282
SARMIENTO	CATALINA	2,900	0,300	0,000	5,810	9,010
SCHILLACI	GIANLUCA	8,300	0,000	0,000	0,000	8,300
SCIARA	ROSARIA VALENTINA	15,000	1,400	0,120	0,100	16,620
SFLIGIOTTI	CRISTINA	9,500	0,000	0,000	0,437	9,937
SIMONI	VJOLLCA	12,916	0,300	0,000	1,997	15,214
SOLDANO	SARA	0,000	0,000	0,000	0,000	0,000
SPINELLI	ROSARIA	4,400	0,300	0,000	1,500	6,200
STASI	MARCELLA	1,000	0,300	0,000	2,689	3,989
STRINGARO	GIUSEPPE	0,900	0,000	0,000	0,025	0,925
TANSELLA	LUCA	0,000	0,000	0,000	0,000	0,000
TREVISOL	EVA IDA	15,000	0,200	0,000	0,000	15,200
TRIOLO	TOMMASO	0,400	0,000	0,000	0,000	0,400
TURRA	LISA	0,000	0,000	0,000	0,000	0,000
URSO	ANDREA	5,600	0,000	0,000	0,000	5,600
VELUDO	ILARIA	0,000	0,000	0,000	5,120	5,120
VERARDO	MARGHERITA	15,000	0,000	0,000	0,000	15,000
VITOBELLO	GAIA ANNA	0,000	0,000	0,000	0,000	0,000
WYPLER	KRYSTYNA BEATA	0,000	0,000	0,000	7,000	7,000

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

PROVA SCRITTA 1

1. **Il ferro per via orale deve essere assunto:**
 - a. A stomaco pieno
 - b. Lontano dai pasti
 - c. Con molta acqua
2. **Quando parliamo di ipertensione arteriosa, quale delle seguenti affermazioni è falsa?**
 - a. Interessa il 30% della popolazione adulta
 - b. Aumenta nel sesso femminile dopo la menopausa
 - c. Non si presenta nei pazienti diabetici
3. **Qual è il segno/sintomo da monitorare in un paziente con BPCO riacutizzata?**
 - a. Attivazione dei muscoli accessori e dispnea
 - b. Glicemia
 - c. Pressione arteriosa
4. **Cosa si intende per ICA?**
 - a. Infarto cardiaco acuto
 - b. Infarto cerebrale acuto
 - c. Infezioni correlate all'assistenza
5. **Quale tra le seguenti classi di farmaci servono per curare l'ipertensione arteriosa?**
 - a. Ace inibitori
 - b. Antibiotici
 - c. Ipoglicemizzanti
6. **In un paziente con infezione delle vie urinarie è consigliato:**
 - a. Garantire adeguato apporto di liquidi
 - b. Inserire il catetere vescicale
 - c. Monitorare frequenza cardiaca
7. **Quando è richiesto il consenso informato?**
 - a. Negli interventi chirurgici
 - b. Negli esami endoscopici
 - c. Entrambe le risposte sono corrette
8. **La somministrazione di vaccini rientra in un piano di prevenzione?**
 - a. Primaria
 - b. Secondaria
 - c. Terziaria
9. **Il prelievo transaddominale di liquido amniotico è detto?**
 - a. Toracentesi
 - b. Paracentesi
 - c. Amniocentesi



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

- 10. Se giunge in PS un paziente che ha ingerito acido cosa è senz'altro da evitare?**
- a. Somministrare liquidi endovenosa
 - b. Contattare il Centro anti veleni
 - c. Indurre il vomito al paziente
- 11. Cosa si intende con il termine disfagia?**
- a. Difficoltà a deglutire cibi solidi e/o liquidi
 - b. Sensazione dolorosa durante i rapporti sessuali
 - c. alterazione o dall'indebolimento della capacità di percepire e distinguere i sapori
- 12. in un paziente che giunge in Ps con trauma cranico quale strumento utilizzeresti per monitorare lo stato di coscienza?**
- a. Scala Glasgow
 - b. Scala Morse
 - c. Indice di Apgar
- 13. Un tetraplegico ha interessati:**
- a. Due arti omolaterali
 - b. Entrambi gli arti inferiori
 - c. Tutti e 4 gli arti
- 14. A cosa è dovuto l'idrocefalo?**
- a. Aumento del contenuto idrico nel volume cerebrale
 - b. Aumento del volume dei ventricoli
 - c. Aumento della pressione intracranica
- 15. La principale misura di prevenzione nella trasmissione delle malattie infettive risulta essere:**
- a. Garantire una buona qualità dell'aria
 - b. Potabilizzazione dell'acqua
 - c. Lavaggio delle mani
- 16. La pressione arteriosa diastolica di un adulto è compresa nei seguenti range di normalità:**
- a. 100-140 mmHg
 - b. 70-90 mmHg
 - c. 90-110 mmHg
- 17. L'iscrizione all'ordine professionale è obbligatoria ai fini dell'esercizio professionale?**
- a. Sì, per tutti gli infermieri
 - b. Solo per gli infermieri della sanità pubblica
 - c. solo per gli infermieri della sanità privata o liberi professionisti

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

- 18. Quale Legge ha abolito definitivamente la parola “mansionario” riferendosi alla professione infermieristica?**
- a. Legge 833/78
 - b. Legge 502/1992
 - c. Legge 42/1999
- 19. In un paziente con emorragia polmonare l’infermiere potrà osservare**
- a. Emoftoe
 - b. Ematuria
 - c. Melena
- 20. Il modello assistenziale caratterizzato da un'organizzazione del lavoro in serie per linee di attività in cui ad ogni infermiere sono assegnati specifici compiti, prende il nome di:**
- a. Modello per intensità di cura
 - b. Modello per piccole équipe
 - c. Modello funzionale o per compiti
- 21. In un paziente con tromboflebite acuta agli arti inferiori cosa è assolutamente vietato?**
- a. Riposo a letto
 - b. Massaggio della zona dolente
 - c. Assunzione di liquidi
- 22. In presenza di un paziente in arresto cardiocircolatorio e riferendosi alle azioni o interventi possibili sul medesimo, quale tra le seguenti affermazioni é falsa?**
- a. Il massaggio cardiaco esterno non dev'essere effettuato prima dell'arrivo del medico
 - b. Il massaggio cardiaco esterno va iniziato prima possibile
 - c. Il massaggio cardiaco deve essere eseguito su paziente supino su supporto rigido
- 23. Generalmente, la relazione di aiuto nei confronti del paziente si realizza:**
- a. Quando si informa il paziente su procedimenti diagnostici e terapeutici che lo riguardano
 - b. Quando attraverso la comunicazione nasce un clima di fiducia e di rispetto
 - c. Ogni volta che l'infermiere si sostituisce al paziente per risolvere le sue esigenze cliniche
- 24. La manovra di heimlich è utile per:**
- a. Prevenire il rischio di malnutrizione
 - b. Disostruire le vie aeree da corpi estranei
 - c. Cambiare postura in una persona allettata
- 25. Il virus dell'epatite B si introduce nell'organismo attraverso:**
- a. Via ematica, attraverso saliva, sudore, sperma, muco vaginale
 - b. Le particelle di droplet nell'aria
 - c. Via oro-fecale da acque, verdure o cibi contaminati

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

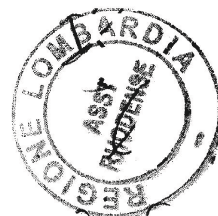
- 26. Quale tra i seguenti interventi riguardanti l'assistenza in un paziente affetto da demenza è più appropriato?**
- a. applicare solidi mezzi di contenzione al paziente in assenza di pericolo per sé e per gli altri
 - b. Assegnare al paziente una stanza vicino a scale e uscite
 - c. Assegnare al paziente una stanza vicino all' infermeria per favorire il monitoraggio
- 27. A cosa deve far riferimento l'infermiere nel corso del proprio operato?**
- a. Profilo professionale, codice deontologico, formazione di base e post base
 - b. Evidence Based Practice e Linee Guida
 - c. Entrambe le risposte sono vere
- 28. La sinfisi pubica anatomicamente è:**
- a. Un legamento
 - b. Un tendine
 - c. Un'articolazione
- 29. Nell'occlusione intestinale l'alvo è:**
- a. Chiuso a gas e feci
 - b. Aperto a gas e feci
 - c. Aperto ai gas
- 30. L'Evidence-Based Practice è:**
- a. Un processo sistematico di reperimento, valutazione e buon uso dei risultati della ricerca contemporanea, come fondamento delle decisioni cliniche
 - b. La trasformazione di quesiti clinici in quesiti di ricerca
 - c. La sintesi tra i risultati della ricerca e la competenza professionale dell'infermiere

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PROVA SCRITTA 2

1. **Quali sistemi di erogazione sono indicati per somministrare ossigeno ad alti flussi?**
 - a. Maschera di Venturi o, maschera con reservoir
 - b. Cannule nasali
 - c. Maschera facciale
2. **Quale delle seguenti teoriche afferisce alla scuola dei bisogni?**
 - a. M. Cantarelli
 - b. Rizzo-Parse
 - c. H. Peplau
3. **La guarigione di una ferita per seconda intenzione avviene:**
 - a. quando il tessuto di riparazione della ferita viene prodotto in eccesso e la cicatrice si presenta estesa ed eccedente
 - b. Riguarda le abrasioni superficiali nelle quali non vengono interessati i tessuti sottocutanei
 - c. Riguarda l'eritema della cute
4. **L'aspirazione endotracheale di secrezioni va eseguita:**
 - a. Solo su indicazione medica
 - b. Tre volte al giorno
 - c. Al bisogno e monitorando la saturazione di Ossigeno
5. **La scialorrea è una condizione caratterizzata da:**
 - a. Aumento della salivazione
 - b. Ridotta salivazione
 - c. Aumento della secrezione gastrica
6. **L'evento sentinella è:**
 - a. Un evento che dovrebbe verificarsi sempre
 - b. Un evento che non si è verificato ma che potrebbe verificarsi
 - c. Un evento che non dovrebbe verificarsi, indice di qualità insufficiente che richiede immediatamente indagini e interventi migliorativi
7. **Lo studio descrittivo che esamina un singolo caso è detto:**
 - a. Studio trasversale
 - b. Case report
 - c. Metanalisi
8. **Cosa si intende per infezione batterica?**
 - a. Colonizzazione batterica
 - b. Processo di attiva moltiplicazione batterica
 - c. Presenza transitoria di batteri



9. Il linfoma è una malattia:

- a. Infettiva
- b. Oncologica
- c. Degenerativa

10. Quale di questi non è un effetto degli analgesici oppiacei:

- a. Aumento della frequenza del respiro
- b. Miosi
- c. Ipotensione

11. Quale fra le seguenti patologie non è suscettibile di screening:

- a. Tumore cerebrale
- b. Tumore della mammella
- c. Tumore del colon retto

12. Si parla di ipercolesterolemia se i valori ematici di colesterolo sono superiori a:

- a. 200mg/dl
- b. 300mg/dl
- c. 150mg/dl

13. I segni e sintomi di ipoglicemia sono:

- a. amnesia, poliuria
- b. Sudorazione fredda, nervosismo, stato confusionale
- c. Febbre dispnea e cianosi

14. Come si definisce l'enunciazione di un problema del paziente e dei relativi fattori scatenanti?

- a. Obiettivo assistenziale a medio e lungo termine
- b. Diagnosi infermieristica
- c. Prestazione infermieristica

15. La meningite è un'infezione:

- a. del fegato
- b. Del pancreas
- c. Delle meningi

16. La formazione permanente (ECM) è obbligatoria per:

- a. Infermieri
- b. Medici
- c. Entrambi

17. La prevenzione primaria:

- a. È rivolta alla popolazione sana
- b. Aumenta i costi sanitari
- c. Interessa i malati cronici

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18. Cosa si intende per caring infermieristico?

- a. una pratica che si realizza tramite azioni competenti e disponibilità a prendersi cura della persona assistita in modo intenzionale
- b. Prendere decisioni al posto dell'assistito
- c. Effettuare medicazioni secondo protocollo

19. Qual è la priorità nell'assistenza a un paziente con sospetto arresto cardiaco?

- a. rilevare glicemia capillare
- b. Iniziare la rianimazione cardiopolmonare (RCP)
- c. Posizionare il paziente in posizione laterale di sicurezza

20. Rispetto alla normativa sulla privacy, la patologia del paziente rientra fra:

- a. I dati genetici
- b. I dati sensibili
- c. I dati statistici

21. L'angina pectoris è spesso provocata da:

- a. Prolungata stazione eretta
- b. Assunzione di alcolici
- c. Sforzi fisici intensi

22. Indicare il range di normalità del sodio:

- a. 135-145 mmol/l
- b. 35 – 55 mmol/l
- c. 450 – 550 mmol/l

23. Quale organo è responsabile della filtrazione del sangue?

- a. Fegato
- b. Polmoni
- c. Rene

24. Qual è lo scopo principale della mobilizzazione precoce di un paziente allettato?

- a. Migliorare il tono muscolare e prevenire complicanze come la trombosi venosa profonda
- b. Evitare il rischio di caduta
- c. Favorire il sonno

25. Qual è il tempo di assorbimento più rapido tra le seguenti vie di somministrazione?

- a. Via orale
- b. Via sottocutanea
- c. Via endovenosa

26. Quale scala può essere utilizzata per valutare il dolore in un paziente adulto?

- a. Scala Glasgow
- b. Scala Numerica NRS (0-10)
- c. Scala di Norton

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27. Tutti i seguenti sono fattori di rischio per le cadute tranne:

- a. Pavimenti e scale scivolosi
- b. Indossare calzature chiuse e comode con soletta antiscivolo
- c. Bagni senza supporti per sollevarsi dal WC o per fare la doccia

28. L'allettamento predispone alla formazione di lesioni da pressione prevalentemente nelle seguenti zone:

- a. Mento, guancia, dorso della mano
- b. Sacro, talloni, malleolo dx e sx
- c. Ginocchio, mento, dorso nasale

29. Il consenso all'intervento chirurgico deve essere richiesto al paziente:

- a. Sempre
- b. Solo in caso di manovre pericolose
- c. Mai

30. Quale strumento utilizzeresti per identificare il rischio di lesioni da pressione?

- a. Scala Stratify
- b. Scala di Braden
- c. Scala Morse

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PROVA SCRITTA 3

1. Quale di queste affermazioni relativa all'utilizzo dei guanti non è corretta?
 - a. Occorre cambiare i guanti passando da un paziente all'altro
 - b. L'uso dei guanti evita il lavaggio delle mani
 - c. Occorre utilizzare i guanti durante l'esecuzione di un prelievo venoso
2. Una "malattia infettiva che colpisca simultaneamente più collettività e la cui diffusione interessa più aree geografiche del mondo, con un alto numero di casi gravi ed una mortalità elevata" è detta:
 - a. Pandemia
 - b. Endemia
 - c. Epidemia
3. In quale delle seguenti situazioni cliniche si verifica maggiore perdita di elettroliti?
 - a. Diarrea
 - b. Iperpiressia
 - c. Shock settico
4. L'osservazione di un fenomeno in un determinato giorno o intervallo di tempo, comunque piccolo, rappresenta uno studio di:
 - a. Incidenza
 - b. Prevalenza
 - c. Varianza
5. Nella scuola dei bisogni l'oggetto di studio della disciplina infermieristica è:
 - a. L'uomo ed il suo bisogno di assistenza infermieristica
 - b. L'uomo e le sue patologie
 - c. L'uomo ed il suo ambiente di vita
6. L'apertura spontanea di una ferita chirurgica sé chiamata:
 - a. Eviscerazione
 - b. Deiscenza
 - c. Ernia
7. Quali sono i sintomi dell'edema polmonare acuto?
 - a. Ipotensione marcata, sonnolenza, dispnea
 - b. Dispnea, febbre, decubito supino
 - c. Dispnea, febbre, diarrea
8. Quale procedura è indispensabile per eseguire un cateterismo vescicale?
 - a. Puntura sovrapubica
 - b. Disinfezione del meato uretrale esterno
 - c. Porre il paziente in decubito prono

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9. La bradipnea è una respirazione:

- a. Irregolare con frequenza diminuita
- b. Frequente e superficiale
- c. Regolare con frequenza diminuita

10. Una emorragia rettale è definita:

- a. Proctorragia
- b. Emottisi
- c. Ematemesi

11. Lo shock settico può presentarsi con:

- a. Dispnea
- b. Tachicardia
- c. Dispnea e tachicardia

12. Cosa significa il termine "via intramuscolare"?

- a. Somministrazione direttamente in un muscolo
- b. Somministrazione tramite infusione endovenosa
- c. Somministrazione orale

13. Qual è la manovra corretta per il lavaggio sociale delle mani secondo le linee guida internazionali?

- a. Utilizzare il sapone antibatterico senza sfregare le mani
- b. Lavarsi le mani con soluzione alcolica per almeno 20 secondi, strofinando anche tra le dita
- c. Lavarsi le mani solo quando si toccano i pazienti

14. Rispetto all'esecuzione del prelievo venoso NON è corretto:

- a. Disinfettare la cute e fare il prelievo subito dopo
- b. Non toccare il sito di prelievo durante la disinfezione
- c. è necessario indossare guanti sterili

15. Qual è la funzione principale della tecnica di monitoraggio non invasivo della pressione arteriosa?

- a. Misurare la glicemia capillare
- b. Valutare lo stato di perfusione e la funzione cardiovascolare
- c. Verificare la presenza di edema polmonare

16. Come deve comportarsi un infermiere se il paziente rifiuta una cura?

- a. Non è necessario informare il medico
- b. Deve rispettare il rifiuto, ma spiegare al paziente i rischi e le conseguenze della sua decisione ed informare il medico se necessario
- c. Deve insistere fino a quando il paziente non accetta

17. In caso di emergenza, quale di queste manovre va eseguita immediatamente in caso di arresto cardiaco?

- a. Somministrare un farmaco anticoagulante
- b. Iniziare le manovre di RCP (rianimazione cardiopolmonare)
- c. somministrare antibiotico

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- 18. Quale di questi valori di frequenza cardiaca è considerato normale in un adulto a riposo?**
- a. 40-60 battiti al minuto
 - b. 60-100 battiti al minuto
 - c. 150-180 battiti al minuto
- 19. Qual è la procedura corretta per smaltire un ago infetto?**
- a. Gettarlo direttamente nel cestino dei rifiuti.
 - b. Smaltirlo in un contenitore rigido apposito per rifiuti taglienti e pungenti.
 - c. Incappucciare l'ago e smaltire negli appositi contenitori
- 20. Qual è il primo passo del protocollo RCP secondo le linee guida internazionali?**
- a. Defibrillazione precoce
 - b. Ventilazioni di soccorso
 - c. Valutazione della sicurezza della scena
- 21. Qual è il metodo più efficace per prevenire le infezioni correlate all'assistenza sanitaria (ICA)?**
- a. Utilizzare guanti sterili per ogni procedura
 - b. Lavarsi le mani correttamente e frequentemente
 - c. Somministrare antibiotici profilattici a tutti i pazienti
- 22. Quale di queste è una complicanza comune di un catetere vescicale a permanenza?**
- a. Ipotermia
 - b. Infezione delle vie urinarie
 - c. Tachicardia
- 23. In caso di somministrazione di insulina rapida, quale delle seguenti aree corporee è la più indicata per l'iniezione?**
- a. Regione glutea
 - b. Addome
 - c. Regione dorsale
- 24. Quali sono le scale di valutazione del rischio di Lesioni da decubito?**
- a. Norton, Braden, Conley, Tinetti
 - b. Norton, Norton Plus, Conley, Braden
 - c. Norton, Norton plus, Braden, Waterlow
- 25. Durante l'inserimento del sondino nasogastrico il paziente deve essere istruito a:**
- a. Assumere la posizione supina e tossire al passaggio del sondino
 - b. Tenere il capo inclinato in avanti e deglutire al passaggio del sondino
 - c. Tenere il capo esteso all'indietro e deglutire al passaggio del sondino
- 26. Per effettuare un prelievo per emogasanalisi è necessario utilizzare una siringa:**
- a. Da 5 ml non eparinata
 - b. Da insulina
 - c. Da 2 ml eparinata

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27. I test di screening rientrano nella prevenzione:

- a. Primaria
- b. Secondaria
- c. Terziaria

28. Per la valutazione della funzionalità renale quale dei seguenti esami è più attendibile?

- a. Creatininemia;
- b. Amilasemia;
- c. Lipasemia.

29. I cibi maggiormente ricchi di proteine sono:

- a. carne, latte, pesce, ortaggi
- b. latte, pesce, uova, carne, legumi
- c. frutta, pesce, latte , uova, legumi

30. Al fine di promuovere la guarigione di una lesione da pressione è indicato:

- a. Frizionare energicamente la cute con garza e soluzione fisiologica
- b. Eliminare o attenuare la pressione sulla lesione
- c. Applicare presidio assorbente

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PROVA PRATICA 1

La signora Vittoria ha 72 anni, vive con il marito in una casa in periferia della città. La signora giunge in ospedale accompagnata dalla figlia, inviata dal medico di medicina generale perché da 3 giorni riferisce "respiro corto". La signora inoltre riferisce di sentirsi stanca e di dormire poco e male, riposa infatti qualche ora solo se seduta in poltrona. Riferisce inoltre un aumento di peso di 3 kg negli ultimi 3 giorni e alvo chiuso da 4 giorni. La signora è sempre stata autonoma, la figlia la aiutava solo nelle faccende domestiche più pesanti. Da qualche giorno, necessita di aiuto nella vestizione e si affatica facilmente. La signora Vittoria è fumatrice e conduce uno stile di vita piuttosto sedentario, è affetta da ipercolesterolemia. L'infermiere di triage rileva i seguenti PV: 160/90 mmHg, FC: 102 bpm, TC: 37.4, SpO2 90% in A.A, BMI: 29. Scala di Morse: 53 Il medico richiede un'ecografia di controllo e pone diagnosi di scompenso cardiaco.

Domanda 1: Quali sono i fattori di rischio modificabili che possono aver aumentato il rischio di insorgenza di scompenso cardiaco nella signora Vittoria?

- a. Ipertensione, ipercolesterolemia, abitudine al fumo di sigaretta, obesità
- b. Età, genere
- c. Età, genere, luogo di residenza

Domanda 2: Si ritiene necessario posizionare un catetere venoso periferico, quale vena privilegerà l'infermiere?

- a. Vena basilica del braccio non dominante
- b. Vena basilica del braccio dominante
- c. La vena del dorso del piede

Domanda 3: Dopo aver rilevato i parametri vitali l'infermiere comunicherà al medico che la paziente è:

- a. Ipertesa
- b. Bradicardica
- c. Normotesa

Domanda 4: Il medico prescrive all'infermiere la somministrazione di un farmaco diuretico. Quali interventi dovrà effettuare l'infermiere in turno prima della somministrazione del farmaco alla signora Vittoria?

- a. Monitorare la diuresi e rilevare la pressione arteriosa prima e dopo la somministrazione
- b. Rilevare la saturazione prima e dopo la somministrazione
- c. Rilevare la glicemia prima e dopo l'assunzione

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Domanda 5: L'infermiere ha somministrato la scala Morse per valutare il rischio di:

- a. Dispnea
- b. Insonnia
- c. Caduta

Domanda 6: Dopo aver rilevato il BMI l'infermiere comunicherà, durante il passaggio di consegna, che la signora Vittoria è:

- a. Normopeso
- b. Sottopeso
- c. Sovrappeso

Domanda 7: La paziente viene trasferita in U.O di Medicina e prescritta O2 terapia a 1.5 l/min. Quale dispositivo posizionerà l'infermiere?

- a. Occhiali
- b. Maschera con reservoir
- c. Maschera con Venturi

Domanda 8: L'infermiere in turno rileva un alto rischio di cadute, quali sono gli interventi infermieristici che potrà effettuare?

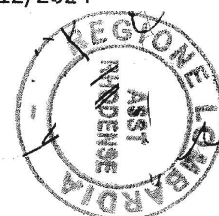
- a. Sistemare il paziente in una stanza lontana alla sala infermieri, educare l'assistito a non chiedere aiuto quando si mobilizza.
- b. Assicurarsi che l'assistito indossi calzature idonee (per esempio con suole antiscivolo e sistema di allacciatura sicuro), assicurare alla persona un sistema di chiamata (campanello) con cui possa facilmente chiedere assistenza quando si deve mobilizzare
- c. Allontanare dalla portata del paziente il sistema di chiamata (campanello) e assicurarsi che l'assistito indossi calzature senza protezione antiscivolo e senza allacciature posteriori.

Domanda 9: Il medico prescrive la somministrazione di Ramipril 5 mg, l'infermiere verifica la disponibilità di Ramipril 2.5 mg. Quante compresse dovrà somministrare?

- a. 3 compresse
- b. 2 compresse
- c. Mezza compressa

Domanda 10: L'infermiere, dopo aver rilevato la frequenza cardiaca, potrà riferire al medico che la signora Vittoria è:

- a. Dispnoica
- b. Diabetica
- c. Tachicardica



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PROVA PRATICA 2

Il signor Massimo è un assistito di 70 anni, ricoverato nel reparto di Urologia per essere sottoposto a intervento a seguito di diagnosi di tumore vescicale. Durante l'accertamento l'infermiere rileva le seguenti informazioni: PA 120/70 mmHg, FC 105 bpm, FR 20 atti/m, SpO2 97% aa, DTX 40 mg/dl, BMI= 20, Scala di Braden= 22; NRS=7. Il signor Massimo presenta sudorazione profusa ed è molto pallido.

Domanda 1: Rispetto alla frequenza cardiaca il signor Massimo risulta:

- a. Dispnoico
- b. Piretico
- c. Tachicardico

Domanda 2: L'infermiere somministra la scala di Braden al fine di:

- a. Identificare la classe di scompenso cardiaco
- b. Identificare il rischio di malnutrizione
- c. Identificare il rischio di sviluppare lesioni da pressione

Domanda 3: Durante la valutazione del dolore, quali altri dati può raccogliere l'infermiere?

- a. Solo l'intensità
- b. Tipologia, localizzazione, eventuale irradiazione
- c. Solo la tipologia

Domanda 4: L'infermiere, dopo aver rilevato i parametri vitali, comunicherà al medico che il paziente presenta:

- a. Valori pressori inferiori alla norma
- b. Valori pressori superiori alla norma
- c. Valori pressori nei range di riferimento

Domanda 5: L'infermiere può correlare la sudorazione profusa e il pallore del signor Massimo a:

- a. Ipertensione
- b. Dispnea
- c. Ipoglicemia

Domanda 6: Quale tra i seguenti interventi è fondamentale per prevenire complicanze nell'immediato post operatorio del signor Massimo?

- a. Monitorare il flusso urinario e la presenza di ostruzioni nel catetere
- b. Rimuovere il catetere vescicale prima possibile indipendentemente dal flusso
- c. Somministrare antibiotico senza prescrizione medica



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Domanda 7: Qual è un segno possibile di infezione delle vie urinarie in un paziente operato di tumore vescicale?

- a. Urine limpide e chiare
- b. Presenza di febbre e cambiamento del colore delle urine
- c. Aumento della diuresi senza dolore

Domanda 8: Quale tra i seguenti valori ematici è fondamentale monitorare dopo l'intervento?

- a. Colesterolo
- b. Emocromo
- c. Trigliceridi

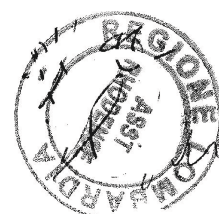
Domanda 9: Nel post operatorio il signor Massimo riferisce nausea, quali interventi potrà effettuare l'infermiere:

- a. Avvicinare al paziente sostanze che sono fonte di odori
- b. Sollevare la testata del letto, somministrare i farmaci antiemetici prescritti
- c. NON Consultare il medico per provvedere a un adeguato controllo del dolore e abbassare la testata del letto

Domanda 10: L'infermiere deve somministrare 500 mg di Paracetamolo. E' disponibile solo Paracetamolo 1000 mg, quante compresse dovrà somministrare l'infermiere al signor Massimo?

- a. 2 compresse
- b. Mezza compressa
- c. 1 compressa

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PROVA PRATICA 3

La sig.ra Sandra di 50 anni, si presenta in Pronto Soccorso dopo incidente stradale verificatosi 1 ora prima. In triage vengono rilevati i seguenti parametri vitali: SpO2 99% A.A, FR: 12, FC: 85 bpm, PA 130/80 mmHg, NRS: 9. La paziente nega trauma cranico, si presenta lucida e orientata nel tempo e nello spazio, in anamnesi pregresso intervento di emitiroidectomia, in terapia farmacologica con Levotiroxina. La signora Sandra viene accompagnata in sala visite dove le viene prescritta la somministrazione di un antidolorifico per via intramuscolare e alcuni esami ematici. Il medico prescrive una radiografia dell'anca. L'esame refertato rileva una frattura del femore sinistro. La signora viene quindi ricoverata presso l'Unità Operativa di Ortopedia e Traumatologia per essere sottoposta, il giorno successivo, ad intervento di "osteosintesi della frattura di femore sinistro". L'infermiere rileva un BMI: 20, decide di indagare il rischio di malnutrizione e il rischio di sviluppare lesioni da pressione.

Domanda 1: Qual è la principale precauzione cui si deve attenere l'infermiere nella mobilizzazione della signora Sandra?

- a. Evitare il carico sull'arto fratturato
- b. Mantenere la posizione laterale di sicurezza
- c. Consigliare di appoggiare il piede sx per migliorare la circolazione

Domanda 2: Con quale angolatura l'infermiere somministrerà l'antidolorifico alla signora Sandra prescritto per via intramuscolare?

- a. 15°
- b. 45°
- c. 90°

Domanda 3: Quale scala di valutazione potrà utilizzare l'infermiere per la valutazione del rischio di malnutrizione nel caso sopra descritto?

- a. Barthel
- b. Conley
- c. MUST

Domanda 4: La signora Sandra riferisce, durante l'accertamento iniziale, che ha una frequenza di evacuazioni abituale di una volta a settimana da circa 1 anno con feci caprine e che non si scarica da una settimana. Quale dei seguenti, è un intervento appropriato e prioritario rispetto alla situazione descritta:

- a. Monitorare il rischio di caduta
- b. Eseguire un clistere evacuativo
- c. Inserire un catetere vescicale

Domanda 5: Il medico prescrive la somministrazione di un clisma fleet per la signora Sandra. Quale posizione dovrà assumere l'assistita per la somministrazione?

- a. Laterale destra con un arto flesso
- b. Laterale sinistra con un arto flesso
- c. Genu-pettorale

Domanda 6: Nell'ambito della valutazione del rischio di sviluppare lesioni da pressione, l'infermiere deve:

- a. Rilevare il rischio all'ingresso in U.O. e ad intervalli regolari (almeno settimanalmente)
- b. Rilevare il rischio ad ogni variazione della situazione clinico-assistenziale del paziente
- c. Entrambe le risposte sono corrette

Domanda 7: Secondo il BMI rilevato il paziente è:

- a. Sottopeso
- b. Sovrappeso
- c. Normopeso

Domanda 8: La signora Sandra nel post operatorio manifesta un'aritmia cardiaca, quale dovrebbe essere la priorità infermieristica?

- a. Monitorare i livelli di elettroliti nel sangue.
- b. Effettuare un ECG, monitorare i parametri vitali e darne comunicazione al medico.
- c. Aumentare il consumo di lipidi per favorire l'apporto al muscolo cardiaco.

Domanda 9: Il medico prescrive per la paziente un antiaritmico. Prima di procedere con la somministrazione, è bene che l'infermiere verifichi che nella prescrizione medica siano indicati:

- a. Nome e cognome del paziente, nome del farmaco/principio attivo e biodisponibilità
- b. Nome del farmaco/principio attivo, i parametri vitali a cui attenersi e il volume di distribuzione
- c. Nome e cognome del paziente, nome del farmaco/principio attivo, dosaggio, via di somministrazione, frequenza e orari di somministrazione

Domanda 10: L'infermiere deve somministrare Levotiroxina 25mcg. E' disponibile solo Levotiroxina 50 mcg , quante compresse dovrà somministrare?

- a. Mezza compressa
- b. 3 compresse
- c. 2 compresse

ASST RHODENSE, 16/12/2024



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

PROVA ORALE 1

1. Quali sono le fasi del processo di assistenza infermieristica?
2. Nutrizione enterale: complicanze e prevenzione.
3. La prevenzione delle lesioni da pressione.
4. Quali sono gli stadi della lesione da pressione?
5. Quali sono gli strumenti per la valutazione del rischio di caduta?
6. Quali sono gli obiettivi della valutazione precoce del rischio di caduta nel paziente anziano?
7. Quali parametri sono da monitorare in un paziente con insufficienza respiratoria?
8. Gestione di un paziente sottoposto a tracheostomia.
9. Quali sono le complicanze del diabete mellito di tipo 2?
10. Educazione sanitaria nella persona affetta da diabete mellito di tipo 2?
11. Gestione del paziente diabetico.
12. Gestione del paziente con iperglicemia.
13. La pianificazione assistenziale al paziente con ICTUS ischemico acuto.
14. Quali sono i sintomi della malnutrizione nell'anziano?
15. La relazione di cura: definizione e scopo.
16. Gestione del paziente operato di resezione gastrica in prima giornata post-operatoria.
17. Esecuzione del primo soccorso in caso di arresto cardiaco.
18. Gestione di un paziente sottoposto a chemioterapia
19. Il lavaggio sociale delle mani secondo le indicazioni dell'OMS.
20. Posizionamento di un catetere vescicale in una donna
21. Prevenzione della diffusione delle infezioni correlate all'assistenza.
22. Gestione di un paziente con Clostridium Difficile
23. Somministrazione di emoderivati.
24. Indicazioni al posizionamento di un sondino naso gastrico.
25. Quale intervento potrebbe mettere in atto l'infermiere in un paziente con mancato svuotamento gastrico?
26. L'assistenza infermieristica alla persona sottoposta a paracentesi.



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

- 27. L'assistenza infermieristica al paziente nel post-operatorio
- 28. Rischi e complicanze nell'uso della contenzione fisica.
- 29. La valutazione del dolore: scale di rilevazione
- 30. Gestione infermieristica della persona con BPCO
- 31. Gestione infermieristica della persona in terapia anticoagulante a basso peso molecolare.

Garbagnate, 07/01/2025

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

PROVA ORALE INFORMATICA 1

1. Cosa si intende per hardware?
2. Cos'è il mouse?
3. Cos'è una e-mail?
4. Cos'è la PEC?
5. Cosa si intende per hard disk esterno?
6. Cos'è power point?
7. Cos'è un browser?
8. Cos'è una rete wi-fi?
9. Cos'è una password?
10. Perché è importante utilizzare delle password?
11. Che cos'è un bit?
12. Cos'è un virus informatico?
13. A cosa serve la firma digitale?
14. Il termine login a cosa fa riferimento?
15. Cos'è una tastiera wireless?
16. Che cos'è un file?
17. Come si elimina un file?
18. Quali file hanno come estensione "exe"?
19. Che cos'è una pendrive?
20. Qual è l'unità di misura della memoria?
21. Cosa indica la locuzione "on line"?
22. Cosa si intende per pixel?
23. Definizione di cd rom
24. Cos'è una web-cam?
25. Che tipo di computer è il notebook?
26. Cos'è un motore di ricerca?
27. Cos'è Bing?



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

- 28. Cos'è un database?
- 29. Cosa significa "cliccare"?
- 30. Cos'è un programma di videoscrittura?
- 31. Esempio di programma di videoscrittura

Garbagnate, 07/01/2025



PERSON-CENTRED CARE

Implementing fundamental care in clinical practice

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Conflict of interest

None declared

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Abstract

Modern healthcare environments are becoming increasingly complex. Delivering high-quality fundamental care in these environments is challenging for nurses and has been the focus of recent media, policy, academic and public scrutiny. Much of this attention arises from evidence that fundamental care is being neglected or delivered inadequately. There are an increasing number of standards and approaches to the delivery of fundamental care, which may result in confusion and additional documentation for nurses to complete. This article provides nurses with an approach to reframe their thinking about fundamental care, to ensure they meet patients' care needs and deliver holistic, person-centred care.

Keywords

communication, essential nursing care, fundamental care, Fundamentals of Care Framework, nurse-patient relationship, nursing process, person-centred care

Aims and intended learning outcomes

The aim of this article is to provide nurses with practical evidence-based approaches to meet patients' fundamental care needs. After reading this article and completing the time out activities you should be able to:

- » Outline the three dimensions of the Fundamentals of Care Framework (Kitson et al 2013).
- » Identify the different stages involved in the Fundamentals of Care Practice Process (Conroy et al 2016).
- » Apply the Fundamentals of Care Practice Process to patient care.
- » Explain the importance of meeting fundamental care needs to other members of the healthcare team, patients and family members.

Relevance to The Code

Nurses are encouraged to apply the four themes of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives to their professional practice (Nursing and Midwifery Council (NMC) 2015). The themes are: Prioritise

people, Practise effectively, Preserve safety, and Promote professionalism and trust. This article relates to The Code in the following ways:

- » It provides a practical, evidence-based approach that nurses can use to deliver holistic, person-centred fundamental care. The Code states that nurses must make sure they deliver the fundamentals of care effectively.
- » Nurses must work in partnership with people to make sure they deliver effective care. This article states that establishing a positive nurse-patient relationship is essential to provide effective care.
- » It emphasises the importance of knowing enough information about the patient to act appropriately. The Code states that nurses must avoid making assumptions, and recognise diversity and individual choice.
- » Nurses must assess patients' needs and deliver treatment to the best of their abilities, based on the best evidence available and best practice. This article provides an approach that nurses can use to integrate their knowledge and skills to

assess patient needs, and to plan, deliver and evaluate care.

Introduction

Nurses often practise in challenging healthcare environments, and they may support patients and families who are experiencing stressful, complex and life-threatening situations on a daily basis. They might also have to manage the effects of staff shortages, funding cuts and a variable skill mix among staff (Aiken et al 2014a). The healthcare organisations in which nurses practise are likely to be under pressure to deliver care at a reduced cost and with increased efficiency, resulting in time pressures and models of care that can be perceived as depersonalised and mechanistic (Maben et al 2010, Griffiths et al 2012, Kitson et al 2014). Nursing as a profession is under increased scrutiny, most notably following the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013) in the UK, which identified many failings in care. Subsequent reports have also identified areas of nursing care that require significant improvement (Berwick et al 2013, Keogh 2013, Ausserhofer et al 2014). Therefore, it is important for nurses to consider how they can manage and overcome these challenges.

There are a range of care standards, frameworks and policies for fundamental care, such as Guidance for Providers on Meeting the Regulations (Care Quality Commission 2015) and Delivering Transforming Health: Our Next Steps (SA Health 2015). However, most of these do not offer an integrated or comprehensive approach that enables nurses to understand what such care should entail in practice, and how it can be achieved. Therefore, the authors' research team in South Australia and members of the International Learning Collaborative (ILC) (intlearningcollab.org), an organisation dedicated to transforming the delivery of fundamental care globally, have begun to systematically investigate the nature of fundamental care, and who is responsible for ensuring that patients receive person-centred fundamental care.

The aim of this article is to enable nurses to reframe their thinking about patients' fundamental care needs and to provide an evidence-based practical approach for nurses to attend to these needs. The Fundamentals of Care Framework (Kitson et al 2013) is outlined, which suggests that three important dimensions are required for the delivery of holistic, person-centred fundamental care. The article then describes how the Fundamentals of Care Practice Process (Conroy et al 2016) can be used to apply the framework to patient care.

TIME OUT 1

Reflect on your current understanding of fundamental care. How would you define and describe what it entails? Write down your response and refer to it as you read this article.

Fundamentals of Care Framework

The Fundamentals of Care Framework comprises three dimensions that describe what is involved in delivering high-quality fundamental care (Figure 1) (Kitson et al 2013):

- » A positive and trusting nurse-patient relationship, referred to as 'relationship established'.
- » Meeting patients' different fundamental care needs, referred to as 'integration of care'.
- » A care context that is supportive of these core tasks, referred to as 'context of care'.

The framework is based on the clinical and research expertise of members of the ILC and was developed following a meeting of the ILC in 2012 (Kitson et al 2013). Subsequent work has been undertaken to test and validate the framework (Kitson and Muntlin Athlin 2013, Feo et al 2016a).

The first dimension of the Fundamentals of Care Framework is the nurse-patient relationship (Kitson et al 2013), which is the foundation on which fundamental care should be based (Figure 1). In the framework, establishing a positive nurse-patient relationship requires five elements (Kitson et al 2013):

- » Developing trust with patients.
- » Focusing on patients and giving them undivided attention.
- » Anticipating the patient's needs.

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KEY POINT

Establishing a relationship with a patient is an ongoing process. Once trust has been established, it should be maintained by engaging in interactions that reinforce that trust. For example, if the nurse is unable to attend to a patient immediately, and tells them they will return in five minutes, the nurse should ensure that they do so. The nurse should ensure that they remain focused on the patient, anticipating their needs at different times throughout the care encounter and evaluating the quality and outcomes of the relationship

» Knowing enough about them to act appropriately.
 » Evaluating the quality of the relationship.

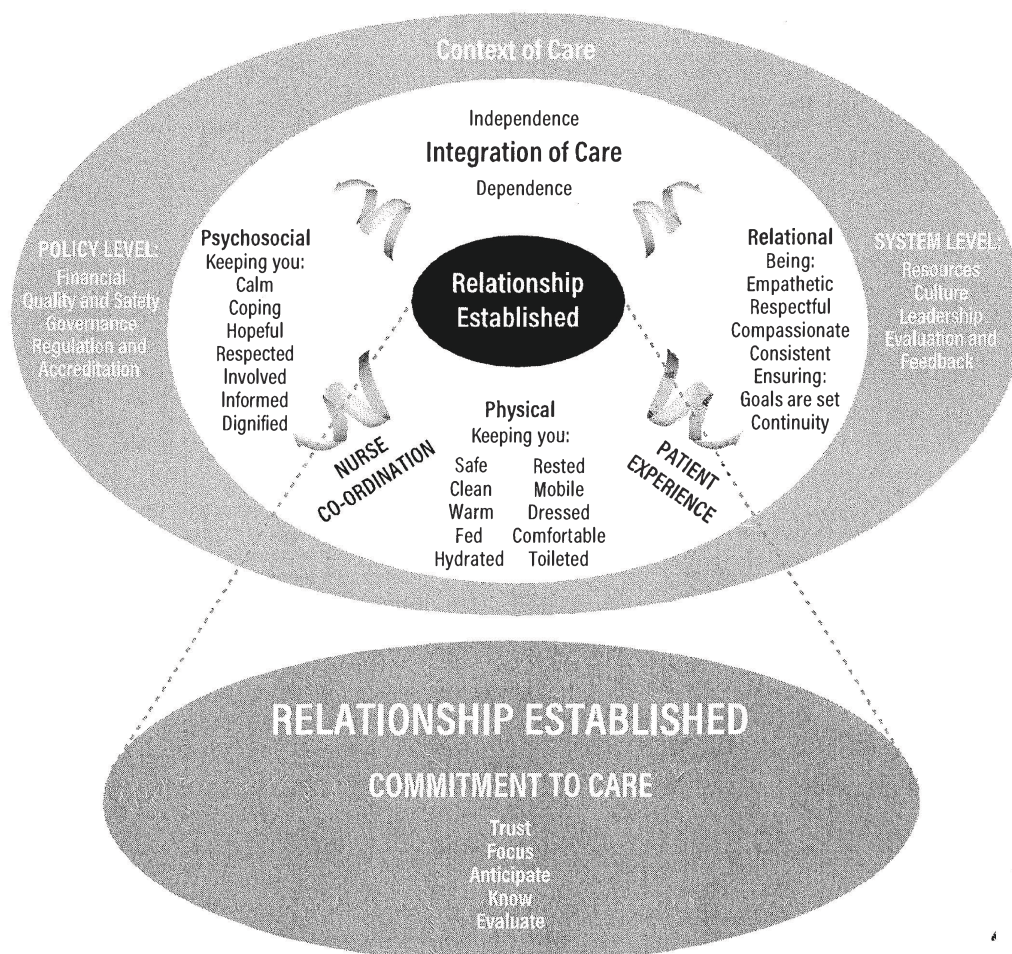
These five elements are involved in a dynamic process. The nurse-patient relationship starts by establishing trust with the patient and their family, and nurses should ensure that they are trustworthy and trusting. Once trust has been established, the nurse should ensure that they focus on the patient and their family, anticipate their needs so that they feel safe, and get to know them and their individual needs, using this information to set goals. The nurse should then evaluate the quality of the nurse-patient relationship and decide if and where changes are required. Establishing a relationship with a patient is an ongoing process. Once trust has been established, it should be maintained by engaging in interactions that reinforce that

trust. For example, if the nurse is unable to attend to a patient immediately, and tells them they will return in five minutes, the nurse should ensure that they do so. The nurse should ensure that they remain focused on the patient, anticipating their needs at different times throughout the care encounter and evaluating the quality and outcomes of the relationship. Further information on the behaviours required to achieve these five elements is detailed in Feo et al (2016a) and Feo et al (2017).

TIME OUT 2

Consider the following scenario. Mary is an 89-year-old woman who was admitted to hospital, via the emergency department, after collapsing at home as a result of influenza A. She had poor eyesight and was mostly deaf. She also experienced short-term memory loss and appeared confused. When she was due to be discharged

Figure 1. Fundamentals of Care Framework



(Feo et al 2016b)

from hospital, the nurse explained to Mary and her son that before she could go home, Mary would need to be seen by the pharmacist, occupational therapist and doctor, and have her intravenous cannula removed. The nurse was aware of Mary's memory loss, so she frequently checked that Mary and her son understood the information given to them. Write down how the nurse demonstrated the five elements required to establish a positive nurse-patient relationship.

The second dimension of the Fundamentals of Care Framework, integration of care, focuses on how patients' fundamental care needs are met and the importance of the nurse-patient relationship in meeting these complex needs (Kitson et al 2013). Such needs can be physical, psychosocial or relational, and may occur concurrently in a care encounter (Kitson et al 2013). For example, delivering fundamental hygiene care requires the nurse to discuss with the patient how to best meet their hygiene and personal care needs, taking into consideration the patient's level of independence and mobility. The nurse should also interact with patients in a way that demonstrates compassion and respect and that enables patients to remain calm, involved and dignified. It is this complexity that makes the delivery of fundamental care more than a straightforward or simple task (Kitson et al 2014).

TIME OUT 3

Refer to the scenario of Mary discussed in Time out 2. Mary was admitted to the medical ward 12 hours after she arrived at the emergency department. Although she was offered breakfast in the emergency department, she did not have any food for 14 hours, because she was unable to eat without assistance. In the medical ward, Mary was placed in a private room, in which the call bell was out of her reach. Her bed did not incline fully and her pillow was without a cover for two days. Mary's son asked a nurse for another pillow, but was informed that none were available. Mary was unable to make telephone calls or watch television because of her poor eyesight and hearing, and she was left to order her meals on her own. She was only able to order meals with the help of her family, when they visited her. When her meals arrived, there was no assistance to ensure she was able to eat the food and open any packets and containers. Consider the different types of needs outlined in the Fundamentals of Care Framework (Figure 1) (Kitson et al 2013). Identify Mary's physical, psychosocial and relational needs. Were these needs met? What would be the consequences for Mary if these needs were not met?

The final dimension of the Fundamentals of Care Framework refers to the context of care (Kitson et al 2013). This recognises that the healthcare systems and organisations in which nurses practise have a crucial role in enabling or hindering the delivery of high-quality fundamental care. The framework does not suggest that delivering such care is the responsibility of nurses alone; healthcare systems and organisations should support nurses in achieving this goal (Kitson et al 2013).

The Fundamentals of Care Framework outlines the system and policy requirements for supporting the delivery of fundamental care (Kitson et al 2013). System requirements include: physical resources, such as equipment, and human resources; culture – the values and norms of the system; leadership, including leadership styles, how roles are defined and supported and how staff are mentored; and evaluation at individual, team and organisational levels that provides constructive feedback. Policy requirements include: financial resources; quality and safety agendas; governance processes and accountability; and regulation and accreditation (Kitson et al 2013).

TIME OUT 4

Revisit the scenario of Mary discussed in Time outs 2 and 3. Imagine that you are the senior nurse on a shift and receive a complaint from Mary's family about her care. Her family expresses dissatisfaction with Mary's physical environment, specifically her bed, the lack of pillows and the cleanliness of her room, and that she was not given assistance to eat her meals. Describe the strategies you might use to address the family's complaint. When providing your answer, consider your professional standards and code of conduct as a nurse. How could the elements of the Fundamentals of Care Framework be used to enhance the care of patients such as Mary? Write brief notes to summarise your ideas.

TIME OUT 5

Reflect on your response to Time out 1. Was your description of fundamental care similar or different to the ideas presented in the Fundamentals of Care Framework? Note down the similarities and the differences.

Fundamentals of Care Practice Process

The Fundamentals of Care Practice Process (Conroy et al 2016) enables

KEY POINT

The Fundamentals of Care Framework outlines the system and policy requirements for supporting the delivery of fundamental care (Kitson et al 2013). System requirements include: physical resources, such as equipment, and human resources; culture – the values and norms of the system; leadership, including leadership styles, how roles are defined and supported and how staff are mentored; and evaluation at individual, team and organisational levels that provides constructive feedback

**KEY POINT**

There are five stages of the Fundamentals of Care Practice Process: concepts, working hypothesis, the Fundamentals of Care Framework, theories and clinical-reasoning process (Conroy et al 2016). The Fundamentals of Care Practice Process starts by identifying the concepts – the ideas or opinions, facts and tacit knowledge – that are presented when the nurse first encounters a patient. What do they know about the patient and their situation? What are the facts? Have they experienced something similar with a patient previously?

nurses to apply the Fundamentals of Care Framework (Kitson et al 2013) to patient care, incorporating their knowledge and experience. Although this article focuses on nursing, it should be acknowledged that nurses work as part of a multidisciplinary team. Thus, it is important for nurses to consider when and how they might involve other members of the multidisciplinary team in patient care.

There are five stages of the Fundamentals of Care Practice Process: concepts, working hypothesis, the Fundamentals of Care Framework, theories and clinical-reasoning process (Conroy et al 2016). The Fundamentals of Care Practice Process starts by identifying the concepts – the ideas or opinions, facts and tacit knowledge – that are presented when the nurse first encounters a patient. What do they know about the patient and their situation? What are the facts? Have they experienced something similar with a patient previously? This information then comes together to form a working hypothesis – an initial understanding of which care interventions that the patient requires. Before implementing these interventions, the nurse should consider the information provided in the Fundamentals of Care Framework about establishing the nurse-patient relationship and the complexity of fundamental care needs (Kitson et al 2013). They should also consider relevant theories that might support the care of the patient. In the final stage, this information is collated to undertake the clinical-reasoning process. Figure 2 shows how these stages come together to deliver patient care.

To understand how the Fundamentals of Care Practice Process (Conroy et al 2016) can be used in practice, consider the scenario outlined in Box 1. Think about what might happen in the scenario (Box 1) if the Fundamentals of Care Practice Process (Conroy et al 2016) is not consulted; for example, if Peter's different care needs are not met. You might consider that Peter requires pain management and a falls assessment. If your initial reaction was simply to manage these two elements, without engaging with Peter and his family

in a meaningful way, what care needs might be overlooked? For example, Peter might become increasingly distressed while in the unfamiliar hospital environment. What might be the consequences for Peter after he is discharged if his care needs are not considered from a holistic perspective, including the support he might require? For example, Peter might become increasingly isolated, distressed and confused. He might be unable to care for himself at home, leading to a loss of independence, frailty, deterioration and an increased risk of falls.

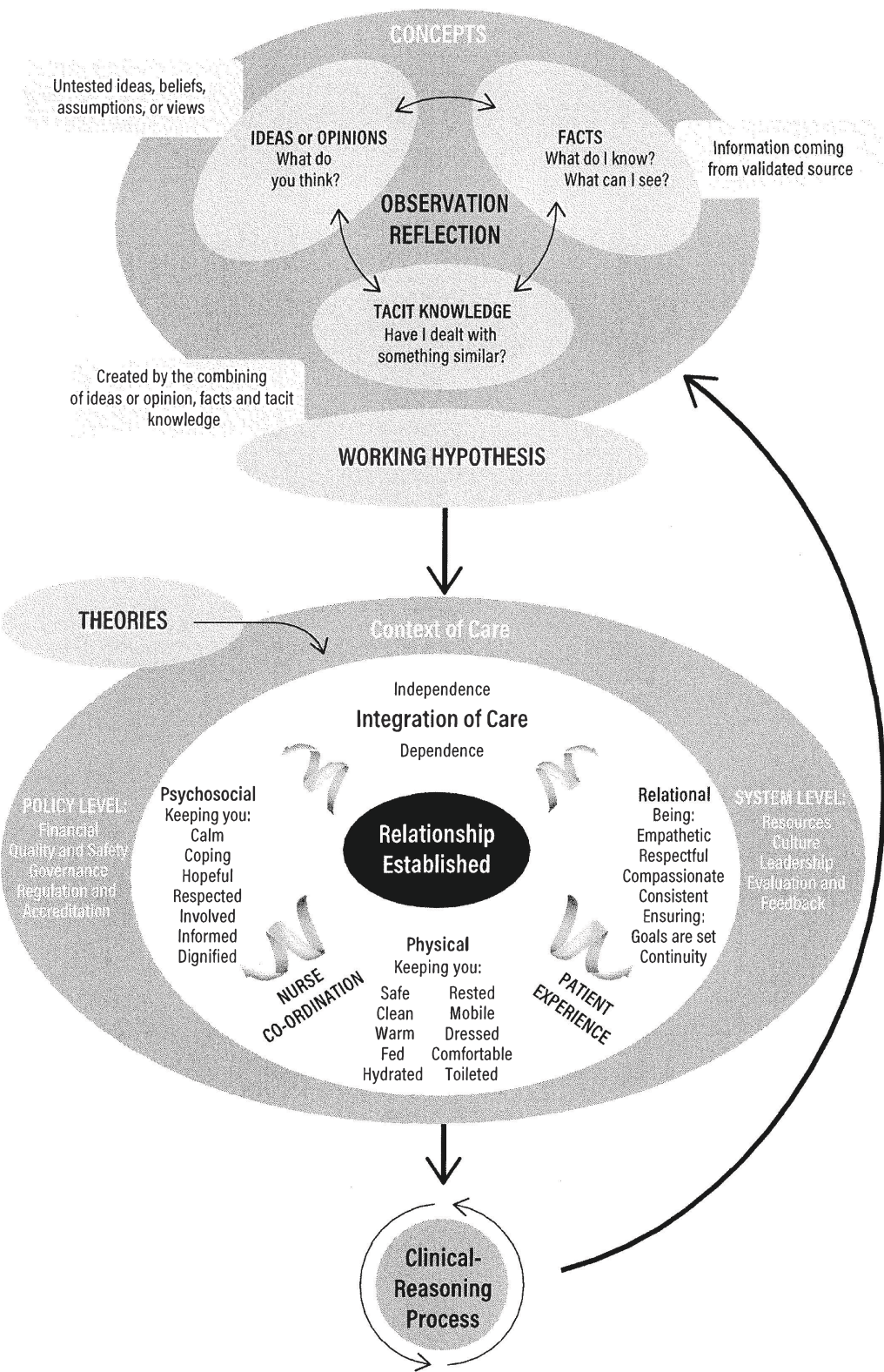
The five stages of the Fundamentals of Care Practice Process are now discussed in detail. Consider how this process could be used to approach the scenario in Box 1.

Concepts

Concepts are general ideas that we use to make sense of the world. Three different types of concepts can influence the care provided to a patient: ideas or opinions, facts and tacit knowledge (Figure 2) (Conroy et al 2016). Ideas or opinions refer to the assumptions that are made about a patient's needs, based on initial contact with them. Facts refer to evidence – what can be observed, or information obtained about the patient. Tacit knowledge refers to previous experience of a similar situation in a personal or professional capacity. The nurse might not have all three types of concept for every patient; however, they can develop a working hypothesis about what is required for the patient by combining the concepts that are available.

In the scenario in Box 1, consider what ideas you have formed about Peter. You might think his fall is an indication of frailty, that he is lonely following the loss of his partner, and that he is having difficulty carrying out his daily self-care routines. You might surmise that his confusion and distress result from his being in hospital, or are a sign of decline in his cognitive state. Next, consider what the facts are in the scenario. You know that he has fractured his hip, has had surgery and is in pain. You also know that his partner died recently. Finally, consider what tacit knowledge you have that is relevant to the scenario. Think about whether you have any experience in

Figure 2. Fundamentals of Care Practice Process



(Conroy et al 2016)



this area. You might know people who have had similar experiences and who have shared their feelings and thoughts with you. You might have previously cared for an older person who had a hip fracture or who had experienced the death of a family member or friend.

Working hypothesis

The working hypothesis is an initial understanding of the patient's care needs, which will be addressed with the patient, their family and the healthcare team (Conroy et al 2016). This hypothesis is derived from the integration of the different concepts identified in the previous stage. For each patient, the nurse might identify multiple care needs, and therefore develop multiple working hypotheses. The nurse should determine which of the patient's care needs is the most important priority and address that first. The working hypotheses might change during further interactions with the patient, as the nurse gains more information about them.

In the scenario in Box 1, what are your working hypotheses? You could identify that Peter requires pain management and a falls risk assessment. He might require assistance with his fundamental care needs, as well as social support, once he returns home. The nature of this assistance should be determined once you get to know Peter. You might also decide he requires a cognitive assessment or to have his cognitive state monitored. Table 1 shows how concepts might come together to form different working hypotheses.

Fundamentals of Care Framework

The Fundamentals of Care Framework provides an integrated way of considering and addressing a patient's needs, in relation

to the working hypotheses developed (Kitson et al 2013). The three dimensions of the framework help to establish a relationship with the patient and the family and to deliver care in a holistic, person-centred way. The framework also takes into account the patient's physical, psychosocial and relational needs, and the context in which care is provided.

Consider how the Fundamentals of Care Framework may inform the care you provide for Peter. For example, you may be aware that you should establish a positive and trusting relationship with him and his family. In accordance with the framework, you should develop trust, focus on him, anticipate his needs and concerns by helping him to become familiar with the hospital environment, get to know him and his experiences, and evaluate how the relationship is progressing. You may decide that an important part of this will involve talking to Peter about the death of his partner in a sensitive and respectful way that is in keeping with his wishes.

You may also be aware that you should consider Peter's different care needs; his physical fundamental care needs, such as pain management and assistance with toileting and mobilising, as well as his psychosocial and relational needs, such as comfort, support and reassurance, so that he feels calm and able to cope. Reflect on the context in which you practise. You know that many acute care environments are not conducive to the support of older patients. Therefore, Peter might require additional support, for example assistance moving around the hospital ward.

Theories

Theories can help nurses to understand a situation, innovate, solve problems and think critically. In the Fundamentals of Care Practice Process (Conroy et al 2016), theories provide information that enables nurses to apply the Fundamentals of Care Framework (Kitson et al 2013) to their clinical practice. Multiple theories can inform the framework. Therefore, it might be necessary to use information from a range of theories, including theories from

BOX 1. Scenario: Peter

You are working in the acute surgical ward of a hospital. An older man, Peter, is admitted after fracturing his hip following a fall at home, for which he required surgery. After the fall, he was taken to the emergency department by ambulance and accompanied by his adult children. Peter's children explained to the emergency department staff that their father's partner had recently died and he now lives alone. Although Peter had been carrying out most of his everyday activities, such as cooking, cleaning and shopping, his children had noticed that this was becoming increasingly difficult for him. On admission to the ward Peter appears to be in pain, distressed and confused.

other disciplines, depending on the patient and care environment.

In the scenario involving Peter (Box 1), the theories that might inform the care you provide include those related to grief and loss, for example Kübler-Ross's (2014) five stages of grief model, and to self-care, for example the Roper-Logan-Tierney model of nursing (Roper et al 1996), which is based on activities of daily living. Relevant theories to help establish a relationship with Peter include Peplau's interpersonal relations theory and Orlando's dynamic nurse-patient relationship theory (Peden et al 2015). Another relevant theory is the Neuman systems model (Neuman and Fawcett 2011), which is a framework for thinking about patients' relationship to stress.

Clinical-reasoning process

Once relevant theories have been identified, the nurse can then progress to the clinical-reasoning process and develop a care plan for the patient (Conroy et al 2016). In Peter's case, this would involve assessing his risk of pressure injury, given his reduced mobility. You might also observe the way in which Peter communicates as an indication of his cognitive state. You might monitor his progress by observing him and talking to him and his family to establish his level of dependence or independence. You could talk to Peter and his family to understand his ability to undertake self-care activities, the social support he has at home, and any additional support he might require once he returns home.

Benefits of using the Fundamentals of Care Practice Process

The use of the Fundamentals of Care Practice Process (Conroy et al 2016) to approach the scenario in Box 1 demonstrates how the possibility of making assumptions about a patient's care needs may be reduced, and the most appropriate ways to address these needs can be identified. Unless relevant theories and frameworks are considered, patient care may become task-based.

It is necessary to undertake the Fundamentals of Care Practice Process (Conroy et al 2016) with each patient the nurse cares for, and it may be necessary to

carry out this process multiple times for the same patient. Progressing from concepts to theories and practice is an ongoing process; multiple working hypotheses will likely be identified for each patient, and the outcome of care interventions should be evaluated to determine whether the hypotheses were correct. This is reflected in the arrow in that moves from the clinical-reasoning process back to concepts in Figure 2. New concepts will also arise while caring for a patient, which should be addressed. For example, while caring for Peter you might learn that he has a dog at home and he is worried about the dog's care while he is in hospital.

TIME OUT 6

Using the Fundamentals of Care Practice Process (Conroy et al 2016), reflect on a time when you provided person-centred fundamental care to a patient and their family. Identify what the actions you took and map them to the stages of the Fundamentals of Care Practice Process. How close to the process was your practice? Has the process helped you to make sense of the complex information you had to manage, and if so, in what way?

It is important for nurses to consider the feasibility of implementing the Fundamentals of Care Practice Process (Conroy et al 2016) in the complex, time-poor settings in which they may practise. However, this process does not require nurses to learn a new set of skills or to focus on fundamental care at the expense of other aspects of nursing care; nor does it require additional documentation. Rather than adding to existing documentation or duplicating it, the process provides guidance for nurses on how they can combine the knowledge and skills they already have to prioritise and provide

TABLE 1. Integrating concepts to form working hypotheses about the patient's care needs and potential interventions

Concepts	Working hypothesis
Frailty and potential risk for subsequent falls	Falls risk assessment
Loneliness resulting from the death of his partner	Social support
Difficulties undertaking daily self-care activities	Assistance with fundamental care needs
Confusion and distress	Cognitive assessment
Pain	Pain management

**KEY POINT**

Healthcare organisations and systems worldwide should establish cultures that value and support fundamental care and the importance of positive nurse-patient relationships in achieving such care (Bridges et al 2013). One way to achieve this is for managers and leaders to link fundamental care to their organisation's performance indicators (Kitson et al 2013). The ability to prioritise and deliver high-quality fundamental care could also be integrated into nurse recruitment, as an essential selection criterion in job descriptions and interview processes

high-quality fundamental care. It provides a way for nurses to structure their thinking and approach to fundamental care, and to evaluate and reflect on the care that they deliver. It may also enable nurses to demonstrate the complexity of delivering fundamental care to the healthcare team, and to explain how the team's input and support is vital to achieve this. The Fundamentals of Care Practice Process may also help nursing students and newly qualified nurses to make sense of the complex and often overwhelming amount of information they are required to process when caring for patients.

System-level strategies to enhance fundamental care

The Fundamentals of Care Framework (Kitson et al 2013) specifies that for high-quality fundamental care to occur, healthcare systems should be committed to this endeavour. This may be challenging. However, nurses should begin to address some of the broader issues they may encounter in their practice. Feo and Kitson (2016) suggested that improving the delivery of fundamental care requires healthcare systems to change the way they value such care. Healthcare organisations and systems worldwide should establish cultures that value and support fundamental care and the importance of positive nurse-patient relationships in achieving such care (Bridges et al 2013). One way to achieve this is for managers and leaders to link fundamental care to their organisation's performance indicators (Kitson et al 2013). The ability to prioritise and deliver high-quality fundamental care could also be integrated into nurse recruitment, as an essential selection criterion in job descriptions and interview processes.

Magnet status is an award given by the American Nurses' Credentialing Center to hospitals that meet a set of criteria designed to measure the strength and quality of the nursing. Magnet hospitals and recent research on the nursing workforce have demonstrated that adequate skill mix, education level, autonomy, leadership and supportive learning environments are

vital to improving patients' and nurses' experiences of care (Aiken et al 2014b, Auer et al 2014). Determining who is responsible for managing and delivering fundamental care is also essential. In many international settings, a division in care delivery has been observed, with registered nurses carrying out technical, cure-directed acts, while healthcare assistants or carers focus on providing fundamental care (De Bellis 2010, Willis 2012, Darbyshire and McKenna 2013, Hasson et al 2013, Wolf 2014). This is further complicated by the proliferation of nursing and caring roles, most recently the nursing associate role in the UK.

There is also a tendency for fundamental care to be divided into discrete tasks and delivered in isolation by different healthcare professionals, for example physiotherapists or dieticians. Although such specialisation can benefit patients, it has been suggested that fundamental care is becoming increasingly disaggregated, delivered without collaboration with and between nursing, caring and other healthcare staff, and with no-one taking responsibility for its delivery (Feo and Kitson 2016). Therefore, it is crucial for healthcare staff roles to be clarified, to ensure that patients' fundamental care needs are not overlooked, and that this care is delivered in a holistic manner.

Nurses can influence change in their organisation at an individual level, by engaging in dialogue about fundamental care and advocating for its value, to ensure such care becomes a priority. Engaging in reflective practice and sharing experiences with other nurses and members of the healthcare team can help to reinforce the importance of fundamental care in achieving optimal patient outcomes. Nurse-led campaigns and patient advocacy groups can also influence policymakers and decision-makers in relation to the importance of fundamental care to patients and their families.

TIME OUT 7

Revisit the scenario of Mary, discussed in Time outs 2, 3 and 4. In this scenario, some elements were within the nurses' control and some were not. In this scenario, identify and describe:

- » What nurses had responsibility for.

- » What nurses had control over.
- » What nurses did not have control over.
- » What nurses can do to influence those elements that are not directly in their control.

Conclusion

The Fundamentals of Care Practice Process is a practical, evidence-based approach that nurses can use in their clinical practice to ensure the delivery of holistic, person-centred fundamental care. This approach enables nurses to integrate their skills and knowledge, together with relevant theories and the Fundamentals of Care Framework, to identify the patient's

care needs and to determine which care interventions they might require. This process also provides nurses with a way to deliver these care interventions in a holistic manner, focusing on the individual patient and their family.

TIME OUT 8

Nurses are encouraged to apply the four themes of The Code (NMC 2015) to their professional practice. Consider how developing an effective nurse-patient relationship relates to the four themes of The Code.

TIME OUT 9

Now that you have completed the article, you might like to write a reflective account as part of your revalidation.

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Fundamental care

TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 888

1. A dimension of the Fundamentals of Care Framework is:

- a) Establishing a positive and trusting nurse-patient relationship ☐
- b) Meeting patients' different fundamental care needs ☐
- c) A context of care that is supportive of the above core tasks ☐
- d) All of the above ☐

2. Establishing a positive relationship with patients involves five elements outlined in the Fundamentals of Care Framework. The initial element is:

- a) Evaluate the quality of the relationship ☐
- b) Focus on the patient and give them your undivided attention ☐
- c) Develop trust with the patient ☐
- d) Anticipate the patient's needs ☐

3. Trust can be maintained by:

- a) Engaging in interactions that reinforce trust ☐
- b) Maintaining a focus on the patient ☐
- c) Anticipating the patient's needs ☐
- d) All of the above ☐

4. The patient's needs may be classified as physical, relational or psychosocial. Which of the following is considered a psychosocial need?

- a) Keeping the patient involved ☐
- b) Ensuring continuity ☐
- c) Being empathetic ☐
- d) Being consistent ☐

5. In the Fundamentals of Care Framework, being compassionate is categorised as a:

- a) Psychological need ☐
- b) Physical need ☐
- c) Relational need ☐
- d) Emotional need ☐

6. Which of the following is not one of the five stages of the Fundamentals of Care Practice Process?

- a) Reflective practice ☐
- b) Working hypothesis ☐

- c) Concepts ☐
- d) Clinical-reasoning process ☐

7. In the Fundamentals of Care Practice Process, the care plan is developed at the:

- a) Concepts stage ☐
- b) Clinical-reasoning process stage ☐
- c) Working hypothesis stage ☐
- d) Fundamentals of Care Framework stage ☐

8. Which is not a type of concept used in developing a working hypothesis in the Fundamentals of Care Practice Process?

- a) Tacit knowledge ☐
- b) Facts ☐
- c) Theories ☐
- d) Ideas or opinions ☐

9. One theory that considers self-care deficits is:

- a) The Kübler-Ross five stages of grief model ☐
- b) Peplau's interpersonal relations theory ☐
- c) Roper-Logan-Tierney's model of nursing ☐
- d) The Neuman systems model ☐

10. The Fundamentals of Care Practice Process does not:

- a) Provide a way to structure your thinking and approach to care ☐
- b) Require a focus on the fundamentals of care at the expense of other aspects of nursing care ☐
- c) Provide guidance on how to combine knowledge and skills to prioritise and provide high-quality fundamental care ☐
- d) Enable nurses to evaluate and reflect on the care they deliver ☐

How to complete this assessment

This self-assessment questionnaire will help you to test your knowledge. It comprises ten multiple choice questions that are broadly linked to the article starting on page 52. There is one correct answer to each question.

» You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.

» You might like to read the article before trying the questions. The correct answers will be published in Nursing Standard on 19 April.

Subscribers making use of their RCNi Portfolio can complete this and other questionnaires online and save the result automatically.

Alternatively, you can cut out this page and add it to your professional portfolio. Don't forget to record the amount of time taken to complete it.

You may want to write a reflective account based on what you have learned. Visit journals.rcni.com/r/reflective-account

This self-assessment questionnaire was compiled by Beth Knight

The answers to this questionnaire will be published on 19 April

The answers to SAQ 886 on effective teamwork, which appeared in the 22 March issue, are:

1. d 2. d 3. a 4. b 5. b 6. c 7. c 8. a 9. b 10. b

flu

CONCORSO PUBBLICO, PER TITOLI ED ESAMI, PER N.40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

7 GENNAIO 2025

CANDIDATI CONVOCATI - TURNO ORE 8.30

COGNOME	NOME	DOMANDA ESTRATTA
ABALASEI	MARIA-MIHAELA	24
AMBROSINO	ALESSANDRA	4
AMBROSIO	CARLO	3
AUTINO	VIRGINIA	19
BENEDIC	GABRIELA	21
BERNUNZO	DésIRÉE	5
BISCEGLIA	NICCOLO'	25
CALVI	VALENTINA	30
CANGIANIELLO	DANIELA	20
CAPOSECCO	PASCQUALE	16

CANDIDATI CONVOCATI - TURNO ORE 10.30

COGNOME	NOME	DOMANDA ESTRATTA
CARUGATI	CLAUDIA	6
CASTRIOTTA	GIANMARCO	27
CATALANOTTO	ANTONietta	11
CERULLO	ANNA	29
CHELO	VALENTINA	14
COLOMBO	MARINA	15
COLOMBO	MASSIMO	31
CORAZZINI	GIADA	17
CRAPAROTTA	NOEMI	10
D'ALESSIO	ROSSELLA	7
D'ELIA	SONIA	8
DANI	ELDA	1
DE BENEDITTIS	ALESSIA	13
DI LEO	MARIKA	2
TANSELLA	LUCA	28
BUDESTEAN	NADEJDA	26

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

PROVA ORALE 2

1. Cos'è la "posizione di sicurezza" e quando deve essere adottata.
2. Le principali complicanze associate alla somministrazione di farmaci per via endovenosa.
3. Prevenzione delle cadute in ospedale.
4. Prevenzione e gestione del delirium nell'anziano
5. Prevenzione e gestione delle infezioni correlate all'assistenza
6. Segni e i sintomi di uno shock anafilattico.
7. Gestione del paziente con ipoglicemia
8. Gestione di un paziente con ferita chirurgica.
9. I rischi legati all'immobilizzazione prolungata.
10. Ruolo dell'infermiere nella gestione del dolore.
11. Cos'è l'asfissia e come può essere trattata?
12. Cosa si intende per empowerment del paziente.
13. Definire il concetto di cure palliative.
14. Come si svolge un controllo del bilancio idrico e perché è importante?
15. Gestione del paziente con colostomia intestinale.
16. Gestione assistenziale della persona con iperpiressia
17. Segni e sintomi dell'Infarto Miocardico Acuto.
18. Ruolo dell'infermiere nella gestione del sospetto Infarto miocardico acuto in ambito ospedaliero.
19. Assistenza infermieristica alla persona con wandering.
20. Gestione infermieristica del paziente con edema polmonare acuto.
21. Emottisi ed Emoftoe: differenza e accertamento
22. Gestione infermieristica al paziente con emottisi
23. Prevenzione della sindrome da allettamento
24. Assistenza alla persona sottoposta a toracentesi
25. Gestione di una reazione allergica ad un farmaco.
26. Nutrizione parenterale totale: definizione e gestione assistenziale



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

- 27. Assistenza infermieristica pre-operatoria
- 28. Tipologie di isolamento.
- 29. Rischi e complicanze nell'uso della contenzione farmacologica
- 30. Gestione della persona con dolore cronico
- 31. Assistenza infermieristica al paziente sottoposto ad emotrasfusione
- 32. Assistenza infermieristica alla persona sottoposta a trapianto di midollo
- 33. Assistenza infermieristica alla persona affetta da Morbo di Alzheimer
- 34. Gestione infermieristica del paziente affetto da Malattia di Parkinson

Garbagnate, 08/01/2025



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

PROVA ORALE INFORMATICA 2

1. Cosa si intende per periferica?
2. Cos'è excel?
3. Cos'è word?
4. Cosa si intende per software?
5. Cos'è una rete di computer?
6. Cosa significa "backup" di un file?
7. Che cos'è una chiavetta USB?
8. Cosa significa "download"?
9. Cosa indicano le icone sullo schermo di un PC?
10. Cos'è un firewall?
11. Cosa sono le credenziali?
12. Quali file hanno come estensione ".doc"?
13. Quali file hanno come estensione ".ppt"?
14. Che cos'è un power point?
15. Cos'è uno "spam"?
16. Cos'è un APP?
17. Cos'è un monitor touch screen?
18. Che cos'è un pdf?
19. Qual è la combinazione rapida di tastiera per il comando COPIA?
20. Qual è la combinazione rapida di tastiera per il comando INCOLLA?
21. Che cos'è un CD-Rom?
22. Che cos'è Windows?
23. Che cos'è un Social?
24. Esempio di social media?
25. Definizione di Sistema Operativo
26. Definizione di modem
27. Definizione di server



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

28. Cos'è un link?
29. Cos'è una memoria di massa?
30. Cos'è una rete wireless?
31. A cosa serve il cavo ethernet?
32. Cos'è un hard disk?
33. Cosa significa password "forte"?
34. Esempio di programma di elaborazione di calcolo

Garbagnate, 08/01/2025

Editorial

The general results of the RN4CAST survey in Italy

The issue of health workforce shortage and in particular of nurses, has been debated globally for almost three decades (Aiken & Mullinix 1987, Aiken *et al.* 1996, 2001, 2010), and has been exacerbated by the recent global financial crisis. The European RN4CAST project has shifted focus from considering only nursing workforce planning and workforce volumes to considering the impact of adequate nurse–patient ratios and work environment on patient safety and the quality of care (Sermeus *et al.* 2011). The common RN4CAST international protocol (Sermeus *et al.* 2011) enables data to be analysed and compared with those of 13 other countries European countries.

Italy became a partner of the RN4CAST European Consortium in 2013 (Sasso *et al.* 2016), thus becoming the 14th European country to participate in this study. Data collection took place from September–December 2015 across Italy, involving 13 Regions, 40 hospitals, 292 units of general medicine and surgery, 3716 patients and 3667 nurses. It is important to note that in Italy, the three-year baccalaureate degree has been the entry-level requirement for nursing practice since 1999.

Italy's hospital patient–nurse staffing ratio was shown to be 9.5 patients per nurse, which was higher than the average of approximately eight patients per nurse reported by other European countries (Aiken *et al.* 2012, Ausserhofer *et al.* 2014). This is statistically significant if we consider that each additional surgical patient per nurse results in a 7% increase in the likelihood of dying in 30 days of admission, a 23% increase in burnout, and a 15% increase in job dissatisfaction (Aiken *et al.* 2002, 2014). This implies that in Italian hospitals where each nurse cares for an average of nine surgical patients, the risk of mortality is 21% higher than those where nurses care for six patients. However, data collection needs to be finalized before this can be definitely confirmed.

Linked to patient safety and the quality of care is also the concept of 'care left undone'. Care left undone or missed nursing care refers to 'any aspect of required patient care that is omitted (either in part or in whole) or delayed. Missed care is an error of omission' (Kalisch *et al.* 2009).

Care left undone has been identified as a factor that mediates the relationship between nurse staffing and patient outcomes, and the chances of care being left undone are halved when nurses care for six patients compared with when they care for ten patients (Ball *et al.* 2016). In the Italian RN4CAST study, the patient care activities mostly left undone (mean 41%) included oral hygiene, frequently change patient's position, comfort/dialogue with patients, patient and family education, developing or updating care plan, appropriate patient surveillance and planning care. This result also shows that Italian nurses mainly tend to leave undone relational, communication, educational and planning activities, which instead are the ones that mostly distinguish nursing competencies from those of other health professionals, and are obliged to conduct purely practical activities such as administering painkillers, treatment and procedures, and documentation of nursing care.

In the Italian RN4CAST study, 36% of the nurses reported that, if they had the opportunity, they would abandon their profession in the next 12 months and the mean age of these nurses was 41 years, and not those who were close to retirement. Considering Italy's high patient–nurse staffing ratio, this confirmed the findings of Aiken *et al.* (2014), whereby each additional surgical patient per nurse results in a 15% increase in job dissatisfaction. Job dissatisfaction is also influenced by the work environment, which leads to burnout in 38.5% of the Italian nurses, mostly caused by poor professional autonomy, the lack of educational and career opportunities, and low salaries.

These factors negatively influenced way Italian nurses perceived their roles and their professional identity, but did not greatly affect the way patients perceived the quality of care they received. In fact, 65% of the patients reported that they would definitely recommend the hospital they were admitted to friends and relatives, and 78% of declared that they were listened and respected by nurses. This shows that, notwithstanding the great difficulties, Italian nurses on a daily basis work make an enormous effort to ensure the best possible care but at their own expense in terms of burnout and dissatisfaction.

The RN4CAST@IT study has demonstrated that in Italy, there are high patient to nurse workloads in hospitals that

are posing risks to patient safety, and having a negative impact on the quality of care and on nurse retention, particularly due to excessive workloads, burnout and job dissatisfaction. This was also confirmed by the fact that nurses missed more than 40% of the care required for patients during their stay in hospital. Moreover, missed care mostly involved activities that reinforce nurses' professional identity, based on autonomy, decision-making, accountability and leadership (Sandström *et al.* 2011).

Better patient–nurse ratios could significantly improve patient safety and the organization and the quality of care in hospitals. In 1999, California passed legislation mandating that hospitals must have at least one nurse for every six medical and surgical patients (Aiken *et al.* 2002), and the first state to implement minimum patient to nurse staffing ratios in acute hospitals (Coffman *et al.* 2002, Spetz 2004). Today, due to high patient to nurse ratios in Italy nurses often do not have the time to implement appropriate discharge plans. This leads to higher readmission rates that increase healthcare workload and costs.

Nevertheless, due to the global financial crisis, in the attempt to abide by strict spending review policies hospital managers expected to save money by freezing the hiring of new nurses and increased the patient to nurse ratios. The RN4CAST study on the contrary has confirmed that nurses are not the problem of health systems, but the solution, and this was also reinforced by the patients' perceptions of the care they received from the nurses.

Thanks to the evidence provided by the RN4CAST study also in Italy, nursing leaders now have the evidence and the means necessary to play a stronger role in implementing strategies to improve patient to nurse ratios, and create better working environments to ensure high quality care, improve patient safety and job satisfaction. Job satisfaction is very important to reduce burnout and improve retention. In Wales, the Nurse Staffing Levels Act became law on 21 March 2016, and recently, Nicola Sturgeon, First Minister of Scotland announced that: 'Scotland will be next to introduce nurse staffing legislation' (*Nursing Times* 19 June 2016). Now, also thanks to the RN4CAST@IT study, we hope that the positive wave of change that started in Wales and Scotland for nurses will soon reach also Italy.

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Conflict of interest

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CONCORSO PUBBLICO, PER TITOLI ED ESAMI, PER N.40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

8 GENNAIO 2025

CANDIDATI CONVOCATI - TURNO ORE 8.30

COGNOME	NOME	DOMANDA ESTRATTA
DUCCI	ERICA	16
FABBRIZIO	DEBORAH	27
FAZIO	CHIARA	22
FERRARA	DARIO	15
FIGINI	FRANCESCA	18
FIORETTO	CHIARA STELLA	12
FRATIANNI	SARA	1
GUI	GIULIA	32
HOXHAJ	SILVANA	5
JOY PEREIRA	GLINDA	30
LATAGLIATA	LEONARDO	6
LEONE	SONIA	34

CANDIDATI CONVOCATI - TURNO ORE 10.30

COGNOME	NOME	DOMANDA ESTRATTA
LOCASTRO	MARIKA	10
LOPRESTI	CARLOTTA	21
MAKSYMYYK	HALYNA	13
MANCINI	CAMILLA	24
MARCU	MARCELLA AURELIA	3
MARINELLI	SARA	20
MASPERI	GIULIA	28
MASSARO	LOREDANA	11
MATTAVELLI	NICOLO'	14
MATTEUCCI	SOFIA	29
MAZZOTTA	DEBORAH	17
MERAVIGLIA	IRENE	8
MINGIARDI	LORENZO	7
MOLA	FEDERICA	9
MONINA	CHIARA	2
MURA	MONICA	33

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

PROVA ORALE 3

1. Gestione infermieristica del paziente con disfagia
2. La contenzione: strategie di prevenzione e responsabilità professionale
3. La check list preoperatoria
4. Modalità di rilevazione della glicemia.
5. Gestione infermieristica del paziente con deficit cognitivo
6. Rilevazione del rischio di lesione da pressione
7. Gestione infermieristica di una donna sottoposta a mastectomia bilaterale.
8. Nutrizione enterale: definizione e gestione infermieristica
9. Accertamento infermieristico: metodi e strumenti per la raccolta dei dati dall'assistito e dalla sua famiglia.
10. La rachicentesi: definizione e gestione del paziente nel post procedura
11. Gestione infermieristica delle complicanze legate alla puntura lombare
12. Gestione del paziente con accesso venoso centrale
13. Educazione sanitaria nel paziente in terapia con anticoagulanti orali
14. L'assistenza infermieristica alla persona sottoposta a toracentesi.
15. Rilevazione del rischio di malnutrizione.
16. Assistenza al paziente sottoposto a ventilazione non invasiva
17. L'isolamento respiratorio
18. Gestione della persona con dolore acuto
19. Assistenza infermieristica al paziente immunocompromesso
20. Assistenza infermieristica al paziente dializzato
21. Valutazione dello stato di coscienza
22. Assistenza al paziente con emorragia del tratto gastrointestinale
23. Gestione e modalità di somministrazione della nutrizione parenterale
24. Medicazione e cura dello stoma tracheale
25. Assistenza infermieristica nel fine vita
26. Educazione sanitaria: ruolo dell'infermiere



N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

- 27. Gestione infermieristica della persona malnutrita
- 28. Il personale di supporto: responsabilità dell'infermiere
- 29. Gestione infermieristica della persona con insufficienza respiratoria acuta
- 30. Gestione infermieristica della persona con scompenso cardiaco.
- 31. Gestione infermieristica della persona con cirrosi epatica
- 32. Assistenza infermieristica alla persona sottoposta a trapianto di fegato
- 33. Il ruolo dell'infermiere nei trapianti d'organo
- 34. Infermiere di famiglia e comunità: ruolo e responsabilità
- 35. Gestione di un paziente sottoposto a chemioterapia
- 36. Assistenza infermieristica al paziente sottoposto ad emotrasfusione.

Garbagnate, 10/01/2025

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

PROVA ORALE INFORMATICA 3

1. Cosa si intende per “Malware”?
2. Cos’è un “cavallo di troia”?
3. Cosa si intende per PDF?
4. Cosa si intende per file ZIP?
5. Cos’è una memoria RAM?
6. Cos’è un hard disk esterno?
7. Cos’è una cartella in un computer?
8. Qual è la differenza tra hardware e software?
9. Cosa significa Cloud in informatica?
10. Cos’è Google?
11. Cos’è un sito?
12. Cos’è un calcolatore?
13. Cos’è una LAN (Local Area Network)?
14. Cosa significa navigare?
15. Cos’è internet?
16. La combinazione dei tasti Ctrl+Alt+Canc premuti contemporaneamente una sola volta a cosa serve?
17. Qual è la prima azione da fare se il PC non risponde?
18. Cos’è una mailing list?
19. La firma digitale ha valore legale?
20. Cos’è un programma antivirus?
21. Cosa sono i Cookie?
22. A cosa serve il parental control?
23. Per cosa posso utilizzare il comando “copia”?
24. Cos’è un Hacker?
25. Differenza tra internet e intranet
26. Cosa sono Facebook, Instagram, Twitter, TikTok?

N. 40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

27. A cosa serve il mouse?
28. Qual' è il sistema alla base di un calcolatore?
29. Se volessi scrivere un articolo quale programma utilizzeresti?
30. Cos'è una chat?
31. Cosa si intende per "allegato"?
32. In che cosa è diviso il foglio di lavoro excel?
33. Cosa significa password "debole"?
34. Cos'è un Monitor?
35. Quali file hanno come estensione "exe"?
36. Definizione di cd rom e dvd

Garbagnate, 10/01/2025

RESEARCH ARTICLE

Open Access

Exploring the experiences of nurses' moral distress in long-term care of older adults: a phenomenological study



Alireza Nikbakht Nasrabadi¹, Ahmad Hasyim Wibisono², Kelly-Ann Allen^{3,4}, Ameneh Yaghoobzadeh^{5*} and Yee Bit-Lian⁶

Abstract

Background: Moral distress is a poorly defined and frequently misunderstood phenomenon, and little is known about its triggering factors during ICU end-of-life decisions for nurses in Iran. This study aimed to explore the experiences of nurses' moral distress in the long-term care of older adults via a phenomenological study.

Methods: A qualitative, phenomenological study was conducted with 9 participants using in-depth semi-structured interviews. The purpose was to gain insight into the lived experiences and perceptions of moral distress among ICU nurses in hospitals affiliated with Tehran University of Medical Sciences during their long-term care of older adults.

Results: Five major themes are identified from the interviews: advocating, defense mechanisms, burden of care, relationships, and organizational issues. In addition, several subthemes emerged including respectful end of life care, symptom management, coping, spirituality, futile care, emotional work, powerlessness, relationships between patients and families, relationships with healthcare teams, relationships with institutions, inadequate staffing, inadequate training, preparedness, education/mentoring, workload, and support.

Conclusions: This qualitative study contributes to the limited knowledge and understanding of the challenges nurses face in the ICU. It also offers possible implications for implementing supportive interventions.

Keywords: Moral distress, Older adult, Aging, Nursing, Qualitative research, Intensive care, Critical care

Background

Nursing, as a profession, requires regular ethical decision making, which is a vital component of the nurse-patient relationship [1]. In other words, nurses make decisions based on their moral beliefs during the different stages of a patients' life cycle [2]. These decisions can be influenced by the unique situation or context a patient is in, a patient's family or the perspectives of other physicians and nurses [3, 4].

Moral distress is one of the most challenging ethical issues in nursing [5]. Jameton [6] defined moral distress as a psychological discomfort that occurs when a person is unable to complete what they believe to be an ethically responsible action due to internal or external factors. Based on this definition, nurses may have professional work requirements that conflict with their personal morals and beliefs [5].

Corley [7] drew from Jameton's work in her description of the concept of moral distress. She defined it as the physical and intellectual pain accompanied by worrying about the impact of decisions involved in patient care on interpersonal relationships [4].

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healthcare system that is unique from other countries [28, 33]. Shahriari *et al.* indicated that the Iranian healthcare system is dominated by pillars underpinned by religious and cultural views [29]. In Iran, patient care standards are directed by Iranian beliefs in Islamic moral and ethical [32]. Thus, nurses from different social and cultural backgrounds have different ethical and religious knowledge which may influence their moral distress [30].

Overall, consideration of moral distress in various cultural contexts and populations is necessary for improving the understanding of moral distress in nursing [34].

Aim

This study aimed to explore the nurses' experience of moral distress in the long-term care of older adults via a phenomenological study.

Methods

Study design & setting

This qualitative study followed the phenomenological method described by Van Manen [35]. Its goal was to explore the nurses' experience of moral distress in the long-term care of older adults. According to Van Manen, interpretive phenomenology offers a systematic approach that allows a phenomenon to be analyzed, interpreted, and explored, in order to gain a deeper understanding of lived experiences via the interpretation process.

Procedure and participants

Participants of this research were nurses who work in the ICUs of hospitals affiliated with Tehran University of Medical Sciences. The inclusion criteria involved having a Bachelor's or Master's degree and working in an ICU for at least a year. This project was approved by the ethical committee of Tehran University of Medical Sciences.

A purposive sampling method is common in phenomenological studies. Therefore, this study used this type of sampling method with the intention of obtaining in-depth information from each individual. In purposive sampling, participants are selected based on their specific characteristics. According to Van Manen's analysis, stop-sampling (*i.e.*, data saturation) includes abstractness, richness, relatedness, and depth. In this study, 9 ICU nurses were included: 4 males and 5 females.

Data collection

In-depth and semi-structured interviews were used to collect information. Interview questions were asked based on the purpose of the study. Three of these questions included: 1. Please share your first care experience in the clinical setting; 2. How do you feel when you are

taking care of an older person who has been hospitalized for a long time in the ICU?; 3. What does caring for an older person look like in your point of view? Additional research questions were asked based on the information the patients provided in order to achieve an in-depth interview including "Can you explain more to me?" and "Can you give me an example?" Interviews were conducted by one of the researchers (AY) with training in interview procedures and each interview was checked by ANNA. More interviews were conducted as needed. In order to assure the validity and accuracy of the data collection, transcriptions and the coding process were done and checked by ANNA.

On average, each interview lasted between 20 and 60 min. All the interviews were recorded and transcribed verbatim as soon as possible after the interview took place. All participants were coded according to the order of the interview. Van Manen's 6-step analysis method was used for data analysis. These steps are as follows: turning to the nature of lived experience, investigating experience as we live it, reflecting on the essential themes that characterize the phenomenon, describing the phenomenon in the art of writing and rewriting, maintaining a strong and oriented relation to the phenomenon, and balancing the research context by considering both the parts and the whole [35].

Two holistic and selective approaches of Van Manen's thematic analysis process were used to extract themes. According to this approach, the interview was transcribed on paper, then reviewed several times to gain an overall understanding. Afterward, it was written in 2–3 paragraphs, which helped the researcher immerse in the data. Then based on a selective approach, the text of each interview was read out loud, and the sentences or phrases that seemed to describe the essence of the moral distress in long-term care of older adults were selected and revealed. Research team members then shared and discussed the topics and extracted themes.

This process kept motivating other interviews. During these conversations, new findings were obtained, and changes were made to previous findings. The process of returning to the texts was repeated multiple times, in order to resolve any disagreements and inconsistencies in the interpretations. This process continued until the themes were best communicated with each other.

The trustworthiness of the study

Lincoln and Guba's method was also used in the present study [36]. The assessed items of this method were as follows: credibility, dependability, transferability, and confirmability. To examine the validity of the research, a trusted relationship was established with the participants. Each interview was provided to the participants after analyzing it, and their comments were sought

CCNs described how they were able to advocate “doing the right thing.” In other words, knowing these things did not always mean that patients achieved their wishes. Furthermore, when nurses were unable to advocate on behalf of the residents or their relatives, the staff felt powerless to change or influence the care provided, which contributed to their experience of moral distress. Regarding this, participant No. 9 stated:

“I myself feel more responsibility when I care for end-stage patients like cancer patients in ICU. I know that they eventually will die, but I do my best to do all the needed care. I do believe that, although he/she can’t understand what I am doing, I know that I have to be responsible for his/her care”.

Major contributors to moral distress include deficits in knowledge related to end-of-life care and symptom management. The interviewed CCNs recognized providing education as one way to improve end-of-life care and symptom management. The following statements were mentioned by participant No. 5:

“As it is obvious when a patient is admitted to the ICU, he/she needs critical care which requires a competent and knowledgeable nurse to provide all the care as soon as possible. Unfortunately, some nurses can’t control the condition and that makes them feel distressed. Imagine you have a dehydrated old patient who has hypotension. Surely, if you cannot manage this condition, his/her level of consciousness will be decreased soon and make him/her to experience hazardous conditions. Knowledgeable nurses can intervene immediately before negative things happen. It is great that working in such difficult ward-needed certification. This made nurses to be updated and refresh their information. Having experienced nurses in each shift make me feel at ease and confident...”

Defense mechanisms

Two of the subthemes indicated that nurses use coping strategies when facing moral distress. Based on the interviews, these methods help nurses control their conditions and more comfortably partake their duties.

When participants were questioned about coping techniques, each of the nine participants stated at least one method for coping with moral distress. All these methods were related to maintaining self-care and managing personal stress. Methods reported by various participants included talking to peers and crying.

Participant No. 2’s beliefs about her colleagues’ coping mechanism were particularly interesting. She stated, *“Talking with everybody else that went through it with you...because nobody else could really understand it the same way.”*

Participant No. 3 said, *“Working as a nurse, especially with older adults who are at the end-stage of life, makes you feel uncomfortable. It will be exacerbated when you continually work with these kinds of patients. So using techniques which distract you to think about these things will help you to adapt more. I myself start doing yoga recently. Participating in this class makes me feel at ease and relaxed. I recommend you to participate, too.”*

More than half of the CCNs in the current study verbalized that they considered themselves to be “spiritual or religious” persons. They stated that spirituality is one of the components of moral distress. For example, participant No. 8 stated that:

“Moral distress is kind of like an everyday thing particularly in ICU. It’s emotional, spiritual, and even physical at times.”

Moreover, half of the participants pointed to spirituality as a self-care practice for indirectly coping with moral distress. Participant No. 6 noted:

“I think spirituality is a kind of self-care that I have to care of my health and well-being. When facing older adults in critical conditions, I have to relieve myself. Thinking and recalling of the most powerful nature helps me to tolerate these situations and continue to be a nurse. Without any exaggeration, being a nurse, especially in ICU, help me to be more spiritual than before. However, I am working in this unit for about 2 years.”

Also, participants frequently used phrases and words that described calming, comfort, belief, peaceful, and mysterious ways. Here is the statement of participant No. 4:

“I feel like I have a very strong spiritual sense. I feel like some of my patients can feel that just by me going in the room and calming them... I feel like I don’t have an issue with... end of life. So I kind of help families through that. And I think that they do feel that.”

Burden of care

Caring for significantly ill older-adult patients had some barriers that hampered the CCNs’ ability to provide the wanted care. Three subthemes pointed to the following:

Futile care was described by two nurses (participants No 7 and 8):

I was not supported by my doctors and felt belittled and ignorant."

Participants reported their experiences with moral distress in the institutions where they were employed. Individual personalities and interpersonal interactions contribute to positive and negative experiences within the organization, which were also addressed by CCNs.

Participant No. 3 explained that she enjoyed the support of both her managers and nursing peers at a healthcare facility when she was hired as a new nursing graduate. She benefitted from a healthy workplace environment and had colleagues who "had your back." Although she does not have the same support at her current healthcare facility, she had every expectation of a similar work environment, so she now appreciates how "spoiled" she was in her first job. She noted:

"You see and you experience some pretty awful things on a day-to-day basis. So to not have a sense of teamwork, it would definitely make it hard to get through the 12-h shift."

"Our nursing staff was very present in the medical rounds in the morning. He described the patients' conditions and let CCNs to share their medical information which they have learnt. Beside this, he involves the patients as well as his/her family to explain what he has experienced during his/her illnesses. He believed that 'each patient is a book' that can help nurses to learn more. You know, I think he was trying to limit the gap between theory and practice."

Organizational issues

Lack of staff was problematic for end-of-life care in ICUs. Specifically, the amount of time the staff could spend with dying patients was reduced. This lack of time prevented the interviewees from providing the quality of care they felt they were capable of. Subsequently, they experienced distress when unpredicted deaths occurred, especially when older-adult patients died alone because of staffing issues.

For some patients whom death had been recognized, their family members may choose not to be present and this choice was incongruent with the staff's priority to have the family present. This scenario can cause moral distress because the staff may think that "the right thing" is not being done. Participant No. 2 stated:

"Because of lack of staffing was not due to lack of budget, but because no one wanted to work. Staffing got even worse when someone called in sick, and the administration was not able to get a replacement."

"Sometimes, instead of one-hour lunch, you just do 30 minutes because you just want to finish it."

The next subtheme is inadequate training, preparedness, education, or mentoring. Nurses describing this theme valued competence and expertise. Furthermore, they believed that they were inadequate when they floated to another unit, were unfamiliar with an older-adult patient's medical diagnosis, lacked skills required to care for patients, or did not have sufficient skills to operate unfamiliar equipment. Overall, the interviewees felt a duty to their patients. But at critical times, they were unable to act appropriately, due to a lack of training, preparedness, education, or guidance by another nurse.

As one nurse expressed, "We need to be better advocates for ourselves." This sentiment included involving themselves in the creation of policies and procedures, and continually seeking training and support in order to develop expertise in unfamiliar areas. Participants No. 1, 5, 7, and 8 noted, respectively:

"This was not what I was prepared to do."

"Nursing school did not prepare me for this."

"Some nurses are unable to talk to patients [or families] about [end-of-life decisions]."

"We aren't prepared for that."

Participants in one-on-one interviews commented that a lack of support from the administration was evident when addressing staffing issues and dealing with the residents' care plans. Participants felt unsupported and ignored by the administration, and they often felt trapped in their situations. They claimed the administration did not value the nurses' input, made unilateral decisions, and ignored their suggestions about improving their work conditions. This was concerning for participants who felt that the administration would not provide the resources they needed. For example, participant No. 2 believed that:

"When you have some residents who are really problematic, and you're not getting the type of response you want... Not everyone in administration... I have to be honest with you. You can have a supervisor who is very concerned and into the problem and will jump into it. But you can get some who will keep on... pushing everything back on you to do it, despite the fact that you are up to your neck."

Moreover, participants No. 1, 4, 5, and 8 respectively stated:

the ICU from an Islamic lens. Given that nursing is a global profession, this study provides a new insight for non-Muslim nurses who practice in Islamic countries. It also offers possible implications for implementing supportive interventions to improve the wellbeing of nurses and reduce moral distress.

Abbreviations

ICU: Intensive care unit; CCN: Critical care nurse; BSN: Bachelor of Science in Nursing; MSN: Master of Science in Nursing; IDT: Interdisciplinary team

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Authors' contributions

Conception and design: ARN, AY, YBL, KA. Analysis and interpretation: ARN, AY, AHW, KA. Corrections: AY, KA, YBL, AHW. All authors read and approved the manuscript.

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Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request after approval from all the authors.

Declarations

Ethics approval and consent to participate

Ethical considerations in this study included obtaining informed consent from the study participants, recording interviews, not including names of the participants in the audio and transcripts, and keeping all data collected confidential. Informed consent of the participants was provided verbally and in written form. This research was approved by the ethical committee of Tehran University of Medical Sciences, Tehran (IR.TUMS.VCR.REC.1397.443).

Consent for publication

N.A.

Competing interests

The author(s) declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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CONCORSO PUBBLICO, PER TITOLI ED ESAMI, PER N.40 POSTI DI INFERMIERE (AREA PROFESSIONISTI DELLA SALUTE E DEI FUNZIONARI).

10 GENNAIO 2025

CANDIDATI CONVOCATI - TURNO ORE 8.30

COGNOME	NOME	DOMANDA ESTRATTA
OLIVERIO	VALENTINA	18
PALLADINO	MATTEO	35
PARENTELA	LAURA	24
PERNICE	MAURIZIO	25
PEZZONI	ILENIA	27
PICARIELLO	ANNITO	33
PIPITONE	SALVATORE	16
PIZZARELLI	SIMONE ADRIANO	32
PONZINI	MARTA	14
ROCCA	JESSICA	17
RUSSO	PAOLA	2
SANTOSTEFANO	GIOVANNA	36
SARMIENTO	CATALINA	29
SCHILLACI	GIANLUCA	22
TREVISOL	EVA IDA	20

CANDIDATI CONVOCATI - TURNO ORE 10.30

COGNOME	NOME	DOMANDA ESTRATTA
BAIOCCHI	SARA	10
DI MARO	ROSSANA	11
SCIARA	ROSARIA VALENTINA	1
SFLIGIOTTI	CRISTINA	13
SIMONI	VJOLLCA	15
SOLDANO	SARA	28
SPINELLI	ROSARIA	12
STASI	MARCELLA	23
STRINGARU	GIUSEPPE	34
TRIOLO	TOMMASO	31
URSO	ANDREA	8
VELUDO	ILARIA	21
VERARDO	MARGHERITA	5
VITOBELLO	GAIA ANNA	4
WYPLER	KRYSTYNA BEATA	3
HYRA	MONIKA	19