

# Commentary on challenges to critical care nursing practice in the Philippines



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**Key words:** critical care nursing ❖ intensive care ❖ Philippines ❖ workforce ❖

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## SUMMARY

- There is limited information on the state of critical care nursing practice in the Philippines.
- Standards for practice have been formulated by a national specialty organization, while specific competencies have been spelled out in the revised baccalaureate Nursing curriculum and national competency standards.
- Government policies, economic variables, state of nursing workforce, and health care needs of the population challenge the implementation of these standards and improvement of nursing practice in critical care.

## INTRODUCTION

Standards in critical care nursing practice for developed countries (such as Australia, Canada, United Kingdom, United States) are readily accessible and implemented. These standards set the parameters for scope of practice, training requirements, and guide policies for workload determination. However, in developing countries and those with economies in transition, like the Philippines, challenges continue to prevent standardization of critical care nursing (CCN) practice.

More than a decade ago, the seminal paper by Rogado (2005) described CCN practice in the Philippines as a recognized specialty and one that has the greatest need for post-baccalaureate and in-service training. This was similarly described by Mustafa (2004) as he provided insight into intensive care practice in the developing countries in the Western Pacific Region. Mustafa (2004) expressed the challenges of critical care practice among doctors and nurses by citing difficulties in justifying budgetary needs for maintenance and development, unequal distribution of intensive care units (ICUs), inadequate medical and nursing staff, need for specialty training, and the persistent need to address both communicable and non-communicable disease burden.

There is limited publication available to adequately describe the state of critical care nursing practice in the Philippines. Only one related publication (Rogado, 2005) was generated through database (Ovid Medline, CINAHL) search, while manual search through the Philippine Journal of Nursing's online library (2009-2017) only showed one article in 2016 on the competency of ICU nurses in using technology as part of care (Martinez, 2016). Majority of available information on CCN in the country is from the specialty organization Critical Care Nurses Association of the Philippines (CCNAPI). This lack of available information on this practice reflects the limitations on the determinants to this specialty practice, and somehow implies the on-going challenges faced by CCN.

To provide some perspective on the state of CCN in the country, this paper aims to (1) discuss the current critical care nursing standards in the Philippines, (2) present existing challenges to the full implementation of these standards and critical care nursing practice, and (3) propose possible steps to advance critical care nursing practice.

## STATE OF CRITICAL CARE NURSING PRACTICE IN THE PHILIPPINES

The World Health Organization (WHO, 2012) released an analysis of human resources for health in the Western Pacific Region highlighting the state of Philippine nursing in a regional context. WHO (2012) stated that health services in developing countries continue to respond to influences on healthcare demands from the economy, political climate, demography, epidemiological needs, available technology, and social trends. Adding to these are the constant concerns for communicable diseases and worsening trend of non-communicable diseases (NCDs). These factors give rise to increasing demand for safe and quality care from qualified professionals across healthcare settings. However, this is met by limitations in both health human resources and general resources for healthcare.

Factors that influence the nursing workforce in the Philippines are outmigration, issues in quality of education, and problems in the work environment that increase workload (Romualdez et al., 2011; WHO, 2013). These factors cannot be overlooked because they are the same factors that influence CCN practice in the country. According to the International Labor Organization (ILO) (Lorenzo et al., 2006), majority of the nurses who left the country to work abroad were well trained in specialty areas such as the ICU and coronary care units, with majority having 1-10 years of experience. These led to the depletion of experienced nurses who could have provided quality care and mentoring to new nurses in critical care.

Contrary to other countries where there are several nursing degrees that allow for nursing practice, there is only one entry point to become a nurse in the Philippines - graduating with a bachelor's degree and passing the national licensure examination administered by the Professional Regulatory Board of Nursing (PRC-BON). The Philippine Nursing Act of 2002 (RA 9173) provides guidance to enable the nurse to practice, and mandates the PRC-BON-recognized specialty organizations and the Department of Health (DOH) to develop comprehensive nursing specialty programs such as CCN (Article VII, Section 31). To fulfill this mandate, the specialty organization, CCNAPI, provides training to critical care nurses. On the other hand, the DOH provides the Nurse Certification Program (DOH, 2017) where nurses are given certification on thirteen specialties (cardiovascular nursing, renal nursing, emergency and trauma nursing, orthopedic and rehabilitation nursing, mental

health nursing, infectious disease nursing, pulmonary nursing, maternal and child nursing, pediatric nursing, operating room nursing, anesthesia care nursing, geriatric and gerontology nursing, public health nursing). The program uses a competency-based determination of acquired skills in a specialty area throughout the nurses' career. Critical care nurses may seek certification in specific specialties based on their area of practice. Through self-assessment, provision of necessary documents, and confirmation from accredited institutions as learning providers, nurses can receive certification from the DOH. However, similar to trainings of CCNAPI, the DOH Nurse Certification Program is not a specialization certification, rather, awards certificate of competence valid for three years and will only obtain continuing professional education (CPE) units for each accomplished module or learning package if accredited by the PRC-BON (DOH, 2015). In addition, individual institutions such as tertiary, academic, training hospitals, and other multispecialty organizations are also offering advanced training programs on specific critical care focus, e.g. mechanical ventilation, advanced ECG course to name a few.

At present, existing guidelines and policies are unclear on how to obtain certification and licensure as a critical care nurse specialist that is recognized by the PRC-BON.

### Standards of practice

Gill et al. (2012) provided a comprehensive review of critical care nursing practice, education and staffing among several developed countries (Australia, Canada, New Zealand, United Kingdom and United States). Critical care nurse standards were developed by specialty organizations since 1978 (US) with succeeding revisions based on membership consultations and expert panels. All the countries mentioned used the national entry professional nurse competencies as baseline for their practice standards.

In the Philippines, critical care nursing practice standards were developed and updated by the CCNAPI ([www.ccnapi.org](http://www.ccnapi.org)). Similar to the those examined by Gill et al., CCNAPI aligned the standards using the entry competencies into professional practice as stipulated in the National Nursing Core Competency Standards (ILO, 2014), and defines the goal for practice of critical care nurse to 'promote optimal adaptation of critically ill patients and their families by providing highly individualized care, so that the critically ill patients adapt to their physiological dysfunction as well as the psychological stress in the critical care unit or intensive care unit (ICU)' (CCNAPI, 2014). To achieve this goal, the specialty organization formulated 11 standards:

The critical care nurse:

- functions in accordance with legislation, common laws, organizational regulations and by-laws, which affect nursing practice
- provides care to meet individual patient needs on a 24-hour basis
- practices current critical care nursing competently
- delivers nursing care in a way that can be ethically justified
- demonstrates accountability for his/her professional judgement and actions
- creates and maintains an environment which promotes safety and security of patients, visitors and staff
- masters the use of all essential equipment, available to services and supplies for immediate care of patients
- protects the patients from developing environmental induced infection
- utilizes the nursing process in an explicit systematic manner to achieve the goals of care

- carries out health education for promotion and maintenance of health
- acts to enhance the professional development of self and others.

Similar to the standards presented by Gill et al. (2012), the specialist knowledge and advanced skill of the critical care nurse are reflected in standards 3, 7 and 11. These reflect the nurses' ability to practice competently and with the use of necessary equipment, as well as the pursuit of continuous improvement in practice. On the other hand, the common standards of practice accountability and ethical decision making are reflected in standards 1, 4 and 5. These include accountability in practice through compliance with national legislation and guided by ethical guidelines. Ensuring optimum patient management of care and risk management is reflected in standards 2, 8, 9 and 10. Lastly, standard 6 is congruent with the ACCCN's (Australia) standard focusing on creating a supportive environment for colleagues. However, the CCNAPI standard expands this to include patients and family members. To elucidate the CCNAPI standards, criteria were stated in terms of the structure-process-outcome model to show the interaction between the healthcare environment system, nursing care activities, nurse-patient relationship, and outcomes.

This congruence in practice standards shows the alignment of the developed standards of practice for critical care nurses in the Philippines and the existing nursing practice in the country.

### Staffing and workforce

Staffing ratios and workload are perennial problems in nursing, consistent in both developed and developing countries across the spectrum of nursing practice settings. Reports of poor nurse to patient ratio in the Philippines from the ILO stated that nurse-patient ratio in provincial and district hospitals is at one nurse to 40-60 patients (Lorenzo et al., 2007). This is supported by other studies indicating nurse to patient ratio at 1:38 (Acuin, 2011) and reports of long work hours, poor compensation such as low basic salary and limited benefits, and poor nurse-patient ratio (Dones et al, 2016; Paguio & Pajarillo, 2016; Velasco-Ferrer & Conde, 2015). Although these studies are not restricted to ICUs, these provide some insight to the staffing issues in the country.

According to the Philippine's Department of Budget and Management (DBM, 2013), government hospitals are categorized into three levels based on its functional capacity. Although ICUs are clearly included in Level II and III hospitals, Level I hospitals have post-operative recovery room units where critical care nurses practice. ICUs are categorized into general intensive care units, neonatal intensive care units, and high risk pregnancy units. Depending on the hospital's level and bed capacity, number of healthcare worker positions are allotted and staffing positions are computed. The bases for the said computation are patient classification or the nursing hours needed by type of patients, and ratio of professional to non-professional personnel, in order to 'provide the appropriate number and mix of nursing staff (nursing care hours) to the actual or projected patient care needs that will lead to the delivery of effective and efficient nursing care' (p.27).

Based on this DBM standard, nurse to staff and nurse to bed ratios in critical care units are as follows: 1 Supervising Nurse (Nurse III) to 30 Staff Nurses; 1 Head Nurse (Nurse II) to 15 Staff Nurses; 1 Staff Nurse (Nurse II) to 3 beds per shift; and 1 Nursing Attendant to 15 beds per shift. Supervising Nurses and Head Nurses are administrative positions, while staff nurses provide direct patient care. Nursing attendants, on the other hand, assist in nursing procedures. In reality, based on experience and anecdotes from fellow ICU nurses in provincial government hospitals, the usual occurrence of nurse-patient ratio in ICUs range from 1:2 to 1:5, and are staffed

by registered nurses with either permanent or contractual nursing positions. Due to limitations in the nursing workforce, ICU nurses are at times pulled-out of the units and rotated to general wards to augment staffing. Despite the unavailability of documents reflecting the actual nurse-patient ratio in the ICUs of government and private hospitals, the reports over the last decade of poor staffing in the country infer the same problem in the ICUs.

Guided by evidence from international guidelines for CCN practice and in alignment with the Philippine Society of Critical Care Medicine (PSCCM) and Society of Pediatric Critical Care Medicine (SPCCM), CCNAPI's recommendation is consistently set at a nurse-patient ratio of 1:1 regardless of the hospital's level (CCNAPI, 2014). This allows for clarity in determining the ratio that will ensure safe practice across patients requiring critical care. However, acceptance and implementation of these guidelines are far from congruent given the realities in practice and, unfortunately, government staffing mandate by the DBM.

### Specialty training

Standardized education and in-service practice training are still issues in the implementation of the set standards of CCN in the Philippines. Although entry into nursing practice is set through obtaining a bachelor's degree, there may still be variability in the implementation of the country's primary BSN curriculum depending on the academic institution. Moreover, post-baccalaureate and in-service training may not always be accessible to nurses across the archipelago.

Across the countries cited by Gill et al. (2012), baccalaureate degree-prepared RNs appear to be the trend in nurses practicing in critical care units, and even cited evidence in Australia where enrolled nurses were not competent in providing care in ICUs. This is supported by Kleinpell (2014) in her review of ICU nursing workforce and found across studies that the higher number of registered nurses to patient ratio leads to better patient outcomes and improved safety. Hence, among countries where there are several entry points to practicing nursing in critical care, having a bachelor's degree, and an RN status is the recommendation.

In the Philippines, all nurses have a bachelor's degree and are RNs. The Policies, Standards and Guidelines for the Bachelor of Science in Nursing (BSN) Program or Commission on Higher Education Memorandum Order (CMO) Number 15, Series of 2017 (CHED, 2017) requires the course NCM 18 or Nursing Care of Clients with Life Threatening Conditions/Acutely Ill/Multi-Organ Problems/high acuity and emergency situations during the senior year of the BSN program. This course was only set as an elective in the old BSN curriculum. Currently, the required course has a total 9 units, where 5 units are allotted for related learning experiences. This includes lecture sessions, 5 hours of skills laboratory, 255 clinical hours and 51-76 hours of self-directed learning.

Despite the course being required in the 2017 curriculum, which includes extensive clinical practicum provided for the students, CCNAPI still recommends that hospitals provide basic critical care training and orientation to newly-hired nursing staff. This recommendation is also based on the understanding that full curricular implementation takes considerable time, and variation in implementation by higher education institutions exist. Other issues surrounding curricular implementation of CCN course are the availability of competent preceptors and instructors in the field, availability of a base hospital where students can practice, and loss of Nursing faculty due to migration.

The Belfast Declaration (2017) included the commitment to globally advance the state of CCN by 'supporting further development of education and practice in resource limited countries' (European federation of Critical Care Nursing associations, 2017 p.4). This is recognition of the disparities in practice in countries with economies

in transition where resources – both health human resources and technological resources, are limited.

There is no specialization certification course to become critical care nurse specialist in the Philippines. Although the RA 9173 allows for the development of the Comprehensive Nursing Specialty program, existing programs by CCNAPI, the DOH, and other institutions only provide certificate of training. Along with the limited number of nurses practicing in critical care units with CCN trainings, issues on placement after such training arises as Nurse Specialist positions do not exist in government hospitals and are not consistent in private institutions. Hence, those who pursue critical care training do so to obtain additional competencies and CPE units - not necessarily for CCN certification. Moreover, while many practice as critical care nurses, employment and placement are based on their unit assignments and availability of positions and not necessarily based on their training.

Post-baccalaureate training proposed by the CCNAPI include postgraduate courses and certification courses, and recommends engagement in CPE. Postgraduate courses on critical care are those part of degree-granting programs accredited by CHED or the PRC-BON. On the other hand, certification courses are those similar to the ones offered by the CCNAPI which covers advance life support, stroke nursing, advanced intravenous therapy course and continuous renal replacement certification. Finally, CPE include updates to improve the nurses' competencies in providing care in the critical care environment, including advanced clinical assessment, palliative care, and others (CCNAPI, 2014).

Similar to the countries examined by Gill et al. (2012), there is variability in the kind of courses offered for CCN and the nurses with CCN certification. They cited that there is limited available evidence on the impact of the proportion of certified nurses in practice to patient outcomes. Hence, this is an area that needs further study. Moreover, the Philippines also does not have a registry of critical care nurses in this field.

## CHALLENGES TO CCN PRACTICE IN THE PHILIPPINES

With the increasing gap between the expanding needs of the population and the shortage of experienced nurses, CCN practice is greatly challenged by the adequacy, availability, and accessibility of training, existing positions for practice, and unfavorable work environments. All these are present while the demand for high quality care and changing technology are putting pressure for nurses to increase their competencies.

The improvements in the nursing curriculum to better prepare future nurses for CCN practice are greatly welcomed. With the optimism that future nurses are better prepared, in-service trainings may focus on integrating new nurses and training them within the context of their practice units. However, implementation of the said curriculum takes time, and it is on the shoulders of regulating bodies to ensure that competencies are achieved.

At present, 45 CPE units are required for renewal of registration of nurses in the Philippines every three years (RA 10912, 2016). However, there is neither specific requirement for critical care nurses, nor requirements for certification. The CCNAPI recommendations have yet to be implemented but the trainings provided by the national specialty organization is able to provide necessary CPE units. Furthermore, the cost of engaging in trainings to obtain CPE units fall on the practitioner. Coupled with the low salary of nurses, inaccessibility of trainings to nurses in the provinces, and limited training providers, engaging in CCN programs continue to be a challenge.

The DBM has yet to recognize the recommendations of international and national organizations on nurse-patient ratios to deliver safe care. While the DBM allotment for critical care nurses are in place,





their approach to determining the ratio based on census instead of acuity, healthcare units will continue to have more than 2 patients for every ICU nurse. A major challenge is the availability of data to inform policy and the political will to change existing national guidelines. Hence, information on the CCN workforce and its impact on safety and quality care are needed.

All these challenges contribute to the unfavorable work environment of the critical care nurse with heavy workloads due to poor nurse-patient ratio, inadequate positions that limit the hiring of new nurses, the lack of senior nurses to mentor novice nurses, and variability in policies in training and hiring of ICU staff. Given the high demand and complex nature of the critical care environment, workforce issues and teamwork challenges give rise to safety and quality of care issues. Although data is lacking to reflect the state of CCN, one can deduce just how challenging this practice is.

## CONCLUSION

The mandate of the national specialty organization and their active campaign to ensure that critical care nursing practice is specified in the national curricula and national nursing core competency standards, are great leaps toward the right direction. These were all based on the CCN practice standards developed by the organization that are being continually recommended for implementation.

Factors influencing nursing workforce and staffing, quality education, specialty training, and unclear policies and guidelines on specialization certification and licensure are some of the evident challenges to the fulfillment of the recommendations for CCN practice. Given the state of the Philippine's economy, healthcare burden and health human workforce, delays in the full implementation of practice standards and limited improvements in CCN practice are experienced in the frontlines. However, the actual effect and impact are not well-documented to generate data to inform policies and affect change.

Without any concrete basis to conclude that the poor state of critical care nursing practice has negatively affected patient outcomes and nurse outcomes, there will be limited leverage to change policies and improve CCN work environments. Hence, it is recommended that a holistic approach to determine the state of CCN practice in the Philippines and its impact on quality care, economic implications and nursing workforce be taken. This can be achieved by including all stakeholders and organizations with focus on critical care be involved in research and policy development. This will ensure that perspective of both practitioners in the field and patients and their families are appropriately recognized. These studies can propel directed quality improvements at the national, system and unit level, and provide rationale to evaluate, improve, and push for the full implementation of CCN practice standards.

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