

Kurikulum Berbasis Kompetensi

PANDUAN

BLOK HIV AND LONG TERM CARE



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AREA KOMPETENSI BLOK

A. Kompetensi blok

Setelah menyelesaikan blok ini, diharapkan mahasiswa mampu menyusun asuhan keperawatan pada klien dengan *HIV/AIDS* dan *long term care*.

B. Karakteristik mahasiswa

Blok HIV dan long term care ditujukan bagi mahasiswa Ilmu Keperawatan yang telah mendapatkan Ilmu Dasar Keperawatan, Keperawatan Dewasa, dan Ketrampilan Dasar Dalam Keperawatan pada blok sebelumnya. Pada tahap ini mahasiswa masih berada pada masa peralihan menuju *student-centered learning*. Blok HIV and long term care diberikan pada semester VIII kurikulum S-1 ilmu keperawatan UMY. Blok ini ditujukan untuk memberikan dasar pengetahuan dan ketrampilan mengenai HIV dan long term care yang diperlukan pada tahap profesi keperawatan klinik.

C. Tujuan pembelajaran blok HIV/AIDS and long term care

Pada akhir pembelajaran Blok HIV/AIDS and long term care ini, apabila diberikan skenario kasus mengenai klien dengan *HIV and long term care*, diharapkan mahasiswa mampu:

1. Mengetahui penyebab HIV/AIDS dan insidensi HIV/AIDS di Indonesia dan secara global
2. Memahami tentang stigma HIV/AIDS
3. Mengetahui pencegahan, penularan, perawatan dan pengobatan HIV/AIDS
4. Menganalisa dengan kritis tentang konsep *long term care*.
5. Mengaplikasikan teori dan model keperawatan yang digunakan dalam *HIV/AIDS and long term care*.
6. Melakukan pengkajian fisik, spiritual dan kultural pada klien dengan *HIV and long term care*.
7. Memahami terapi komplementer pada *HIV/AIDS and long term care*
8. Menyusun rencana asuhan keperawatan dengan tepat pada klien dengan *HIV/AIDS and long term care*

9. Mendemonstrasikan konseling pada klien dengan *HIV/AIDS and long term care*
10. Memahami persepektif Islam tentang penyakit dan kematian

PETUNJUK SKILLS LAB

BLOK HIV/AIDS DAN LONG TERM CARE

MATERI:
KONSELING PRA TES HIV
KONSELING POST TES HIV
KONSELING PADA KLIEN DAN KELUARGA DENGAN *LONG TERM CARE*
PENGAJIAN SPIRITUAL
SHALAT JENAZAH

KONSELING KELUARGA KLIEN DENGAN PALLIATIVE CARE
Penyusun: Erna Rochmawati, S.Kp.,MNSC.,M.Med.Ed.

Family coping

Hope

Nurses as health professionals should recognize that each person's view of reality is different and it is each person's right to choose what to hope for in accordance with this personal view. Therefore, it is the responsibility of nurses to provide patients and family with information, to the extent that they request it, but it is the patient's and family's responsibility and right to also access information from other sources and to determine how they will translate this information into hope.

It should be noted that it is not the responsibility of health practitioners to ensure that hope is realistic.

People can accept and prepare for death while also holding on to hope. By shattering unrealistic hope, we run the risk of stripping individuals of important ways of coping before they are ready to do so. Nurses should listen to patients and families, understand their grounds for hope and reasons for holding onto hope, and assist them in identifying new hopes when they are ready.

Potential indicators of poor family adjustment to a palliative diagnosis:

- Inability to function as a cohesive unit.
- Other major stressors require family energy.
- Lack of constancy in a patient's role performance.
- Lack of positive outside support or willingness to use it.
- Lack of successful past experience in handling stress.
- Inability to perceive a difficult experience as potentially meaningful and growth-producing.

- Closed communication, reluctance to openly express emotions.
- Little or no family participation in care of the dying patient.

Helping families of palliative patients to cope

- Facilitate the expression and understanding of emotion.
- Help maintain and strengthen relationships and communication between family members and the dying patient.
- Help family members differentiate their needs from those of the patient and provide assistance in meeting those needs.
- Help with role reallocation and family reorganization.
- Facilitate understanding of medical information and access to needed resources.
- Be present with family members physically, psychologically, and spiritually

Helping patients and families to prepare for the end-of-life

Teach the family indicators of imminent death.

- Progressive dependence, withdrawal, and detachment.
- Reports of nearing death mystical experiences (*e.g.*, being in the presence of loved ones who have already died, predicting the time of death, *etc.*)
- Physiologic changes.
- Reduced urine output, dark colored urine.
- Changes in patterns and sounds of breathing (periods of apnea or Cheyne-Stokes, possible sound of congestion).
- Progressive coldness, discoloration and mottling.
- Weakening pulse.
- Anxiety, restlessness, confusion, possible hallucinations.
- Fluctuating level of consciousness with gradual decline, accompanied by decreased awareness, dysphagia, and flaccid musculature.

NOTE: Inform the family that the changes they will observe are usually more distressing for them than for the patient.

Suggestions for families

- Instruct family caregivers in symptom management and comfort measures:
 - a. turning, changing, washing, massaging, positioning
 - b. providing sips of fluid if the patient is able to swallow; and
 - c. administering analgesics and other medications.
- Ensure family members have access to appropriate professional and support services, needed equipment and supplies.
- Encourage family members to talk to the patient even if the patient appears not to hear or respond; urge the family to tell the patient what he/she meant to them and how he/she will be remembered, give the permission to die, and say their good-byes.
- Encourage gathering of family and friends, touching and grieving.
- Use role modeling to say the words that need to be said and to communicate non-verbally (*e.g.*, “It’s okay to die”, “you will always be loved”).

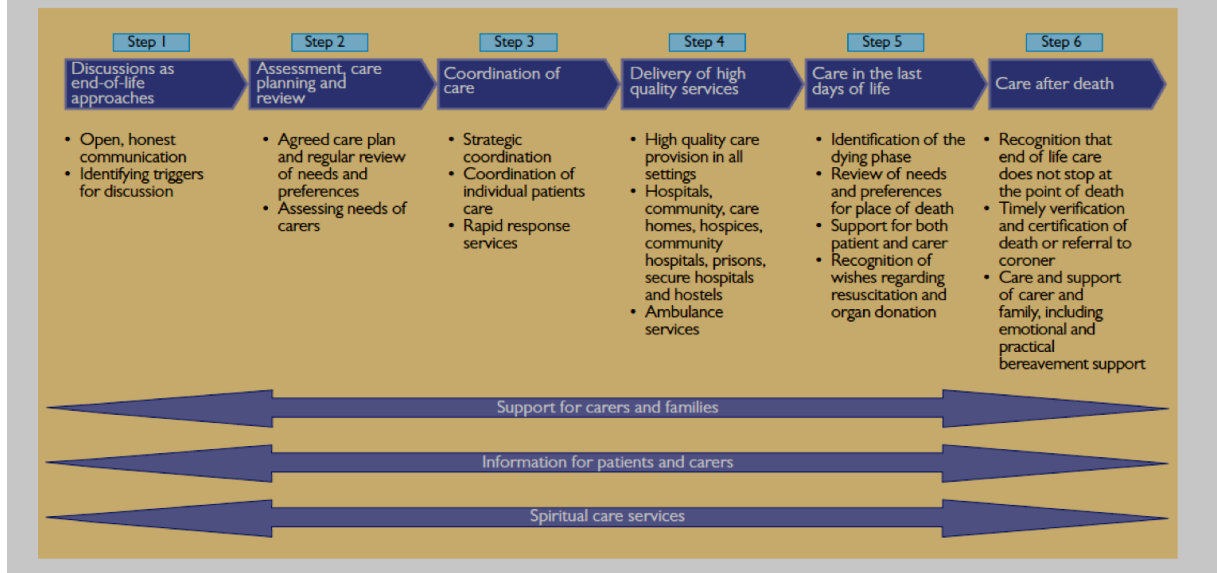
Communicating with families at the time of death

- Allow for silence, it is your presence that counts.
- Don’t be afraid to say “I don’t know what to say”.
- Encourage families to express their feelings or to talk about the deceased to whatever extent they desire. As appropriate, share your memories of the deceased.
- It is **not helpful** to say that **you know how they feel**.
- Ask the family if they would like time alone with the deceased or if they would like you to stay with them.
- Ask the family if there is anything that they feel needs to be done, offer support as appropriate and follow-through.
- Ascertain special requests regarding treatment of the body after death and honor them if possible

Be especially aware of the possible need for involvement with bereaved families:

- who have limited support from relatives, friends or community
- who have experienced the death of a child or young adult, a sudden death or a death that leaves a spouse living alone

Figure 1. End-of-life care pathway. (Reproduced from the End of Life Care Strategy; DH, 2008a).



Source:

Alberta Hospice Palliative Care Resource Manual. Second edition (2001).

Thompson-Hill, Hockey, Salt & O'Neill, 2009, 'The Supportive Care Plan: a tool to improve communication in end-of-life care', *International Journal of Palliative Nursing*, Vol 15, No 5, pp.250-255.

