UNIVERSITÀ
DEGLI STUDI DI MILANO-BICOCCA

COURSE SYLLABUS

Clinical Nursing

2526-1-I0101D917-I0101D914M

Aims

The course introduces the student to the systematic collection of data, the type of data to be collected, their organisation, validation and aggregation, the definition of nursing problems, nursing interventions and procedures that can be carried out in low-complexity care situations, with special reference to fundamentals of care.

At the end of the course the student will have developed:

1. Knowledge and ability to understand
To describe:

1. the conceptual and methodological bases necessary to comprehensively assess the health status of the patient (observation, interview, objective examination, validated assessment scales);
2. the conceptual and methodological bases necessary to interpret data, make correlations, formulate hypotheses and identify the main risks and nursing care problems;
3. the scientific rationale and evidence for nursing interventions and procedures that can be carried out to treat the problem.

2. Ability to apply knowledge and understanding
To identify the main nursing risks and problems of the person for in low complexity care situations, nursing interventions and procedures in response to the problems.

3. Autonomy of judgement
To use an organised approach to examine the whole picture of the person assisted, explore the various plausible problem hypotheses to be tested against the available data, propose possible decisions on health conditions and select the most appropriate interventions based on the available knowledge.

4. Communication skills
To present in a clear and organised manner, using scientific language, the relevant data from the assessment, the possible problem identified and possible care decisions.

To provide examples for therapeutic communication techniques applicable during the initial assessment and the nurse-patient relationship.

5. Ability to learn
6. Develop self-directed learning skills through the analysis and reflection of clinical situations proposed in the classroom, the ability to ask questions, to assess one's own learning needs and to identify resources for integrating the latest best current evidence into professional practice.

Contents

Initial nursing assessment of patient (collection, recording, validation of objective and subjective data), introduction to diagnostic reasoning, nursing interventions/procedures for the prevention/management of the main nursing risks/problems in low complexity care situations.

Lecco, Monza Brianza and Sondrio
The initial assessment will focus on the collection of data according to the Model of Human Processes (MAPU): survival processes (breathing processes, circulation processes); defence processes (consciousness processes, protection processes); energy renewal (nutrition and elimination processes, activity and inactivity processes); relationship processes (communication processes, interpersonal processes, learning processes); development processes (self-realisation processes, meaning-seeking processes). By way of example, some nursing diagnoses according to ICNP® terminology will be presented.

Bergamo
The initial assessment will focus on the collection of data on the bio-physiological, psychological and socio-cultural dimensions of nursing care needs according to V. Henderson: Breath normally (and Circulation); Eat and drink adequately; Eliminate body wastes; Move and maintain desirable postures; Sleep and rest; Select suitables clothes, dress and undress; Maintain body temperature within normal range by adjusting and modifying the environment; Keep the body clean and well groomed and protect the integument; Avoiding danger in the environment and avoid injuring others; Communicate with others in expressing emotions, needs, fears, or options; Work in such a way that there is a sense of accomplishment; Play or participate in various forms of recreation; Learn, discover, or satisfy that leads to normal development and health and use the available health facilities. Some nursing diagnoses NANDA-International® Classification 2024-2026 will be presented as examples.

Detailed program

NURSING CARE in different care settings.

FUNDAMENTALS OF NURSING CARE: application in practice.

HEALTH STATUS ASSESSMENT AND VITAL SIGNS

RESPIRATORY FUNCTION: factors affecting respiratory function, cross-cultural considerations and life stages. Assessment: characteristics of normal respiratory pattern. Alterations: tachypnoea, bradypnoea, cyanosis, dyspnoea (rating scales: NRS, M-Borg, Medical Research Council Dyspnoea Scale MRC-DS; classification of dyspnoea severity), hypoxia, hypoxaemia, cough, sputum production, chest pain, respiratory noises, pathological breathing (Cheyne-Stokes, Biot, Kussmaul). Interventions: health promotion, pulse oximetry, sputum sample collection, posture and walking, hydration, deep breathing, effective coughing, microclimate control.

CIRCULATION: Factors affecting cardiovascular function, cross-cultural and life-stage considerations.

Assessment: characteristics of normal cardiovascular function, arterial pulse, blood pressure and capillary filling time. Alterations: tachycardia, bradycardia, arrhythmia, altered pulse quality, pulse deficit, chest pain, arterial hypertension, arterial hypotension, orthostatic hypotension, oedema, altered skin characteristics, altered blood flow and reduced tissue perfusion. Interventions: modification of risk factors, prevention of venous stasis and deep venous thromboembolism, reduction of oedema, posture, venous sampling.

NUTRITION: recommendations for a healthy diet, Reference Intake Levels of Nutrients and Energy for the Italian population (LARN) and Italian Weekly Lifestyle Pyramid (HINTS), factors affecting nutrition, cross-cultural and life stage considerations. Assessment: characteristics of a well-nourished person, anthropometric measurements, calorie counting, mouth inspection, swallowing assessment, assessment of malnutrition risk (Nutritional Risk Assessment-NRA and Mini Nutritional Assessment-MNA scales), main biochemical parameters (haematocrit, haemoglobin, serum albumin and pre-albumin, serum transferrin, creatinine, immunocompetence), person's level of autonomy. Alterations: overweight, obesity, underweight, sudden and significant weight changes, loss of energy, altered intestinal function, altered skin, mucous membranes, teeth and skin adnexa, lack of appetite, dysphagia, malnutrition, eating disorders (HINTS), nausea, vomiting. Interventions: promotion of adequate nutrition, monitoring of nutritional status, assistance to the person with fasting, vomiting, special diets, dietary supplements and artificial nutrition (HINTS), blood glucose measurement by skin prick, assistance to the person during feeding.

LIQUIDS AND ELECTROLYTES: Factors affecting fluids, electrolytes and acid-base balance (HINTS), cross-cultural and life-stage considerations. Assessment: water balance (with calculation of perspiratio insensibilis), body weight, integumentary assessment, vital parameters, state of consciousness, jugular turgor, central venous pressure (HINTS), intestinal assessment, serum electrolytes, urine specific gravity, person's level of autonomy.
Alterations: hydro-electrolyte imbalance (dehydration, hypovolaemia, excess fluid volume, hypokalemia, hyperpotidaemia, hyponatremia, hypernatremia), acid-base imbalance (HINTS), alteration of vital parameters and state of consciousness. Interventions: health promotion, oral fluid increase/restriction, electrolyte restoration (HINTS), intravenous therapy (HINTS).

URINARY ELIMINATION: factors affecting urinary elimination, cross-cultural considerations and life stages. Assessment: micturition characteristics, diuresis and normal urine, person's level of autonomy. Alterations: diuresis (polyuria, oliguria, anuria), micturition (dysuria, stranguria, frequency/pollachiuria, bladder tenesmus, nocturia, enuresis, urgency, urinary retention, urinary incontinence) and urine characteristics (haematuria, bacteriuria, pyuria, proteinuria, glycosuria, altered colour, odour, clarity and pH), impaired ability to perform/complete elimination-related activities independently. Interventions: promotion of micturition and fluid intake, prevention of urinary tract infections (UTI), care of the non-autonomous/incontinent person (male external urinary catheter, absorbent garments), care of the person with acute and chronic urinary retention, extemporaneous/permanent bladder catheterisation, continuous bladder irrigation with three-way CV and closed-loop system, prevention of CV-related UTI, collection of urine samples from CV, from intermediate micturition, 24 h urine collection, urine examination.

INTESTINAL ELIMINATION: Factors affecting intestinal elimination, cross-cultural considerations and life stages. Assessment: characteristics of normal stools [frequency, colour, quantity, odour, consistency and shape (Bristol Scale)], physical examination of the abdomen and perirectal area, level of autonomy of the person. Alterations: constipation, faecaloma, diarrhoea, faecal incontinence, rectal tenesmus, flatulence, meteorism, abdominal distension, altered stool characteristics (haematochezia, rectorrhagia, melena, acholic stools, ribbon/pencil stools, changes in consistency), impaired ability to perform/complete elimination-related activities independently. Interventions: promotion of bowel function, assistance to the person who is not autonomous, use of laxatives/antidiarrhoeics (HINTS), insertion of a rectal probe, administration of an evacuative clap, removal of faecalomas, collection of faecal samples for occult blood testing.

BODY MOBILITY AND MECHANICS: factors affecting movement, cross-cultural and life-stage considerations. Assessment: postural alignment, postural balance, coordination of movements, gait, joint structure and joint excursion, trophism, muscle tone, muscle strength [Medical Research Council (MRC) scale], activity tolerance, posture-related changes in blood pressure, assessment of the person's level of autonomy in performing activities of daily living [Modified Barthel Index, Index of Dependence in Instrumental Activities of Daily Living (IADL), Index of Dependence in Activities of Daily Living (ADL)]. Alterations: decreased muscle volume/strength/tone, lack of coordination, gait alterations, falls, reduced joint range, pain, activity intolerance, physical/psychosocial

consequences of immobility. Interventions: promotion of physical activity, prevention of osteoporosis, positioning, maintenance of joint mobility, walking, transfers, prevention of complications of immobility.

THERMOREGULATION: factors affecting body temperature, life stage considerations, potential causes of thermoregulation alteration. Evaluation: body temperature measurement, skin assessment, consciousness assessment. Alterations: fever, hyperthermia (exhaustion/heat stroke), hypothermia and frostbite. Interventions: nursing care to the person during febrile phases, in case of hyperthermia and hypothermia.

HYGIENE, SELF CARE AND SKIN INTEGRITY: Characteristics of self-care, cross-cultural and life stage considerations, factors affecting self care and skin/wound healing function. Assessment: skin and skin appendages inspected, wound assessed. Alterations: inadequate hygiene/care, reluctance to/inability to perform self-care activities, pain, itching, rash, primary and secondary injuries, pressure injury staging (LdP) according to EPUAP/NPUAP, incontinence dermatitis. Interventions: promotion of adequate personal hygiene, assistance to the non-autonomous person during partial/total hygiene care, replacement of an occupied bed, assistance to the person with pediculosis, treatment of pruritus and incontinence dermatitis, Risk assessment of developing adult LdPs (Braden index, Norton-Stotts scale) and prevention.

SAFETY: Definition of safety, cross-cultural and life stage considerations, factors affecting safety, inadequate safety manifestations, risk assessment of accidental falls (Conley/Stratify index; STEADI Algorithm). Interventions: promotion of safety in the home/work/health environment, prevention of falls, physical restraint (indications for use, nursing responsibilities, risks, guards, controls and monitoring).

INFECTION PREVENTION AND CONTROL: Healthcare-related infections, risk factors, prevention/control: hand hygiene, use of clean/sterile gloves, use of PPE, isolation (hints), disposal of medical waste, laundry management, handling of biological samples, management of environmental surfaces/furnishings, classification of medical devices according to Spaulding (HINTS), decontamination, cleaning, disinfection, sterilisation and storage; characteristics of normal resistance to infection, Life stage considerations, factors affecting resistance to infection. Manifestations of alteration: types of infection and manifestations. Interventions: health promotion, interventions in the presence of infection (HINTS), diagnostic investigations (blood cultures, urine culture, HINTS on culture of excreta, of a wound, coproculture, pharyngeal and nasal swab).

SLEEP: Factors affecting sleep, transcultural considerations and life stages, characteristics of the normal sleep/wake cycle. Assessment: identification of sleep/wake cycle (exemplification of the Pittsburgh Sleep Quality Index - PSQI scale), physical examination. Alterations: insomnia, narcolepsy, respiratory sleep disorder, restless legs syndrome, circadian rhythm disorders, parasomnias (HINTS). Interventions: recommendations for sleep hygiene, changes in the environment, ensuring intimacy and safety, rituals for sleep, rest, use of routine, HINTS on cognitive measures and use of drugs.

PAIN: considerations on life stages, normative, deontological and transcultural considerations, factors that influence the perception and response to pain, classification of types of pain (acute, persistent, nociceptive, neuropathic, central), consequences of untreated pain. Assessment: physiological and behavioural responses to pain, characteristics of pain in adults (PQRST, Numeric Rating Scale NRS; Visual Analogical Scale VAS; Verbal Rating Scale VRS); HINTS on multidimensional scales (McGill Pain Questionnaire - MPQ; Brief Pain Inventory BPI); HINTS on the assessment of pain in children (Wong-Baker Faces Pain Rating) and in the person with cognitive impairment (Abbey, Pain Assessment in Advanced Dementia - PAINAD). Interventions: non-pharmacological (comfort, skin stimulation, cognitive and behavioral techniques) and pharmacological (HINTS).

COMMUNICATION AND NURSE-PATIENT RELATIONSHIP: The elements of therapeutic communication. Assessment: ability to articulate sound, vocalization and pronunciation of words, elements of paraverbal and non-verbal communication. Alterations: dysarthria, dysphonia, presence of verbal expression of negative emotions (e.g. anger, fear). Interventions: therapeutic communication techniques and non-therapeutic responses, communication in special situations (HINTS).**

SENSORY PERCEPTION: (HINTS) characteristics of normal sensory perception, considerations on life stages, factors that influence sensory perception. Evaluation: (HINTS) physical evaluation of sensory function (sight,

hearing, smell, taste and somatic sensations); state of consciousness, orientation, duration of attention, memory and cognitive skills (see Teaching unit "Cognitive processes"). Alterations: (HINTS) anxiety, cognitive dysfunction, hallucinations, sensory overload and deprivation, sensory deficits (impaired vision, hearing, taste), depression and isolation. Interventions: (HINTS) education, preparation for procedures, nurse-assisted relationship, ensure stimulation, reduction of stimulation, sensory aids, increase safety precautions.

HEALTH EDUCATION AND HEALTH PROMOTION: aims of the health education of the assisted person, the teaching-learning process. Assessment: learning needs (basic knowledge, cultural and linguistic aspects, priorities, realistic approach) and willingness to learn of the assisted person (motivation, adhesion, sensory and physical state, literacy level). Interventions: (HINTS) educational strategies, teaching aids/resources, use of interpreters/translators, time/amount of information, involvement of relatives/significant persons, evaluation of learning.

COGNITIVE PROCESSES: (HINTS) characteristics of normal cognitive processes (consciousness, attention, memory, learning, communication), transcultural and life stage considerations, factors influencing cognitive function. Evaluation: state of consciousness (Glasgow As Scale-GCS), cognitive function (Mini Mental State Examination), orientation, arterial oxygenation, serum electrolytes and glucose, serum ammonia and urea. Alterations: (HINTS) disorganized thinking, alterations in the level of consciousness, impairment of communication (expressive aphasia, receptive, global, dysarthria), memory deficit, delirium and confusion. Interventions: therapeutic communication, orientation to the surrounding environment and reality, environmental restrictions, fluid supply/nutrition, mobility, safety, alternative methods of communication.

SELF CONCEPT: (HINTS) characteristics of the self-concept and self-perception, cross-cultural and life stage considerations, factors that influence the self concept. Assessment: social self (employment, family situation, social groups), personal identity (self-description, strengths and weaknesses), physical self (e.g. concerns about one's body), self-esteem, threats to the concept of self (e.g. illness, role change). Alterations: deficits in self-care, emotional and behavioral changes.

LOSS AND BEREAVEMENT: (HINTS) normal features of the process of mourning and bereavement, cross-cultural and life stage considerations, factors that influence bereavement. Evaluation: (HINTS) physical and psychological signs (e.g. sadness, bitterness, fatigue, detachment, inability to feel joy, anger, crying, sleep disorders, appetite, untreated appearance etc.), strategies/supports for managing stressful situations. Interventions: (HINTS) sending to other professionals. HINTS on assistance to the dying and post-mortem care.

STRESS, COPING AND ADAPTATION: HINTS on the concepts of stress, adaptation, resilience and coping; HINTS on factors that influence coping. Evaluation: HINTS on the evaluation of the coping model (subjective data on stress, anxiety, fear, strategies/ supports for managing stressful situations, physical examination of cardiovascular, respiratory, gastrointestinal, musculoskeletal and tegumentary system. Interventions: (HINTS) lifestyle changes, physical exercise, relaxation techniques, environmental changes, crisis intervention and de-escalation.

HUMAN SEXUALITY: (HINTS) transcultural and life stage considerations, factors affecting sexuality, impact of disease and disability on sexuality. Assessment: (HINTS) examination of male and female genitals, breast examination, sexual activity, protection against sexually transmitted infections, pregnancies, sexual function, changes in gender identity, diseases, environment, surgery. Alterations: (HINTS) sexual abuse, erectile dysfunction, ejaculatory, orgasmic, genito-pelvic pain and penetration disorder. Interventions: (HINTS) education (self-awareness, self-examination, sexual education, responsible sex), use of contraceptives, sending to other professionals.

SPIRITUAL HEALTH: (HINTS) characteristics of spirituality, transcultural and life stage considerations, factors that influence the spiritual dimension. Assessment: assessment of the spiritual dimension (e.g. concept of God or divinity, practices and rituals, source of hope and strength, relationship between spiritual beliefs and health status, goals in life, important aspects for the person). Interventions: (HINTS) support during spiritual practices, listening and support, sending to other professionals.

Prerequisites

This course is based on the knowledge of Foundations of Nursing and Midwifery Sciences, Biomedical Sciences 1, Hygiene, Occupational Medicine and Medical Statistics.

Teaching form

All the lessons (n. 16 lessons of 3 hours each) are carried out in dispensative mode (deductive lesson) in the initial part which is aimed at engaging students interactively in the following part (inductive lesson, with the possibility of guided discussion, in plenary and small groups, of simulated clinical cases and video sequences). All activities are carried out in-person.

Textbook and teaching resource

Bibliography for the exam:

1. Craven RF, Hirnle CJ, Henshaw CM (2024) Principi fondamentali dell'assistenza infermieristica. VII edizione. Rozzano (MI): CEA (capitoli 6, 14, 17 - 20, 24 - 37, 39 - 43).
2. European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. (2019). Prevenzione e trattamento delle ulcere/lesioni da pressione. Guida rapida di riferimento. Emily Haesler (Ed.). EPUAP/NPUAP/PPPIA (ed. italiana a cura di AISLEC). Disponibile da: https://epuap.org/pu-guidelines/
3. Gould VC and the Healthcare Infection Control Practices Advisory Committee – HICPAC. (2009). Guideline for prevention of catheter-associated urinary tract infections. HICPAC. (Last update: 6 June, 2019). Disponibile da: https://www.cdc.gov/infection-control/hcp/cauti/?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html
   TESTO DI APPROFONDIMENTO PER LE SEDI DI LECCO, MONZA BRIANZA E SONDRIO:

Further bibliography (evidence-based care sheets, skill sets and didactic videos), available in Nursing Reference Center Plus on the website of the Library of Medicine and Surgery:

Peripheral Blood Cultures
Pilgrim J, Brown J, Hanson D. Obtaining Peripheral Blood Cultures From Adults. CINAHL Nursing Guide, January 27, 2023. Database: Nursing Reference Center Plus.

Venipuncture
Knowles L, Mitchell M, Knowles A, Hanson D. Performing Venipuncture in Adults. CINAHL Nursing Guide, February 10, 2025. Database: Nursing Reference Center Plus.
Performing Venipuncture: Preparing the Vein (Video). CINAHL Nursing Guide, July 4, 2014. Database: Nursing Reference Center Plus.
Performing Venipuncture: Selecting a Vein. (Video). CINAHL Nursing Guide, July 4, 2014. Database: Nursing Reference Center Plus.
Performing Venipuncture: Inserting and Removing the Needle (Video). CINAHL Nursing Guide, 2014 Jul 04.

Point-of-Care Blood Glucose Testing
Balderrama D, Morales N, Constantine L, Hanson D. Performing Point-of-Care Blood Glucose Testing. CINAHL Nursing Guide, October 6, 2023. Database: Nursing Reference Center Plus.

Blood Glucose Testing - Obtaining a Blood Sample (Video). CINAHL Nursing Guide, February 12, 2016. Database: Nursing Reference Center Plus.**

Applying a Condom Catheter

Applying a Condom Catheter (Video). CINAHL Nursing Guide. February 12, 2016. Database: Nursing Reference Center Plus.

Removing a condom catheter (Video). CINAHL Nursing Guide. February 12, 2016. Database: Nursing Reference Center Plus.

Inserting an Indwelling Urinary Catheter

Inserting an Indwelling Urinary Catheter: Female Adult (Video). CINAHL Nursing Guide, 2016 February 12. Database: Nursing Reference Center Plus.

Smith N, Schub T, Hanson D. Urinary Catheter Use and Prevention of Infection. CINAHL Nursing Guide, July 19, 2024. Database: Nursing Reference Center Plus.

Schub T, Seeber-Combs C, Hanson D. Inserting an Indwelling Urinary Catheter in Adults With a Vulvar Urethra. CINAHL Nursing Guide, February 1, 2023. Database: Nursing Reference Center Plus.

Seeber-Combs C, Hanson D. Inserting an Indwelling Urinary Catheter in Adults With a Penile Urethra (con Video). CINAHL Nursing Guide, February 16, 2023. Database: Nursing Reference Center Plus.

Collecting Urine Specimen

Balderrama D, Seeber-Combs C, Hanson D. Collecting a Urine Specimen From an Indwelling Urinary Catheter in Adults (con Video). CINAHL Nursing Guide, March 2, 2023. Database: Nursing Reference Center Plus.

Collecting a Midstream Urine Specimen (Video). CINAHL Nursing Guide, August 07, 2015. Database: Nursing Reference Center Plus.

Collecting a Urine Specimen: Intermittent Catheterization (Video). CINAHL Nursing Guide February, 12, 2016. Database: Nursing Reference Center Plus.

Accidental Falls: risk assessing and prevention

Schub T, Hanson D. Falls, Accidental: Risk Assessment. CINAHL Nursing Guide, November 29, 2024. Database: Nursing Reference Center Plus.

Skucek C. How to Prevent Falls. Health Library: Evidence-Based Information, December 1, 2023. Database: Nursing Reference Center Plus.

Schub T, Woten M, Hanson D. Fall Prevention in Hospitalized Patients. CINAHL Nursing Guide, July 12, 2024. Database: Nursing Reference Center Plus.

Pilgrim J, Longo M, Constantine L, Hanson D. Using a Fall Risk Assessment Tool. CINAHL Nursing Guide, December 13, 2023. Database: Nursing Reference Center Plus.

Vital Signs

Measuring Oxygen Saturation: Continuous Pulse Oximetry (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Measuring Oxygen Saturation: Intermittent Pulse Oximetry (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Taking Tympanic (Ear) Temperature (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Taking Rectal Temperature: Adult Patient (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Taking an Axillary Temperature (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Taking an Apical Pulse (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Taking an Arterial (Radial) Pulse (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Assessing Respiratory Rate in Adults (Video). CINAHL Nursing Guide, July 04, 2014. Database: Nursing Reference Center Plus.

Assessing Pain Level (Video). EBSCO Nursing and Allied Health. Database: Nursing Reference Center Plus.

IN DEPTH TEXT for the schools in Lecco, Monza Brianza and Sondrio:
Ausili D, Baccin G, Bezze S, Bompan A, Macchi B, Alberio M, Sironi C, Di Mauro S (2018) Il Modello assistenziale dei processi umani 2018: un quadro teorico per l'assistenza infermieristica di fronte alla sfida della complessità. Milano: CNAI. Link per il reperimento della terminologia ICNP®
Disponibile da: https://www.icn.ch/what-we-do/projects/ehealth/icnp-browser

IN DEPTH TEXT for the school in Bergamo:
Herdman TH, Kamitsuru S, Takáo Lopes C (2024) Nanda International. Diagnosi infermieristiche-Definizioni e Classificazione 2024-2026. XIII edizione. Rozzano (MI): CEA.

Semester

Second semester.

Assessment method

The details are available in the Syllabus of Metodologia clinica nelle scienze infermieristiche.

Office hours

By appointment.

Sustainable Development Goals

GOOD HEALTH AND WELL-BEING | GENDER EQUALITY | REDUCED INEQUALITIES | PEACE, JUSTICE AND STRONG INSTITUTIONS | PARTNERSHIPS FOR THE GOALS