NIGHTINGALE
Nursing Times
A WINDOW FOR HEALTH IN ACTION
NNT
Vol XVIII No 8 ◆ November 2022
Rs. 200 (IND)

Diabetes: education to protect tomorrow

More than 90% of diabetes care is self-care.
Do you have the knowledge to make informed decisions?

Take charge of your diabetes care

Access free diabetes education:
worlddiabetesday.org/understandingdiabetes

#WorldDiabetesDay #EducationToProtect

International Diabetes Federation

world diabetes day
14 November

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Shri Yogi Adityanath

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08 October - 2022

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Secretary UP State Medical Faculty

Smt. Shruti Singh
Director General of Medical Education

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Ashok Jain

EDITOR-IN-CHIEF
S.S. Prabhudeva
Former Principal, M. S. Ramaiah
Institute of Nursing Education, Bangalore

EDITOR
Ajay Sunder

DESIGN
Nadeem Ahmad

SALES & MARKETING
A. P. Jain & Co.
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Ph: 011-22321465,
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18 YEARS OF NNT 2004-2022

EDITOR'S NOTE

World Diabetes Day, World Toilet Day

World Diabetes Day (WDD) aims to promote the importance of coordinated and concerted action to confront diabetes as a critical global health issue.

Education to protect tomorrow is the theme of World Diabetes Day 2022, the second year of the 2021–23 focus on access to diabetes care.

This year's campaign focuses on the need for better access to quality diabetes education for health professionals and people living with diabetes.

One in 10 adults around the world now live with diabetes, an estimated 537 million people. Almost half do not know they have it. This is putting added strain on healthcare systems.

The rising number of people affected by diabetes is putting added strain on healthcare systems. Healthcare professionals must know how to detect and diagnose the condition early and provide the best possible care; while people living with diabetes need access to ongoing education to understand their condition and carry out the daily self-care essential to staying healthy and avoiding complications.

World Toilet Day celebrates toilets and raises awareness of the 3.6 billion people living without access to safely managed sanitation. It is about taking action to tackle the global sanitation crisis.

The theme of World Toilet Day 2022 is **'Sanitation and Groundwater'.**

We face a global sanitation crisis. Today, 3.6 billion people are still living with poor quality toilets that ruin their health and pollute their environment. Every day, more than 800 children die from diarrhoea linked to unsafe water, sanitation and poor hygiene.

This year, World Toilet Day focuses on the impact of the sanitation crisis on groundwater.

Inadequate sanitation systems spread human waste into rivers, lakes and soil, polluting the water resources under our feet. However, this problem seems to be invisible. Invisible because it happens underground. Invisible because it happens in the poorest and most marginalized communities.

World Antimicrobial Awareness Week 2022 is **"Preventing antimicrobial resistance together".** AMR is a threat to humans, animals, plants and the environment. It affects us all. That is why this year's theme calls for cross-sectoral collaboration to preserve the efficacy of these important products.

To curb AMR effectively, all sectors must use antimicrobials prudently and adopt other preventive measures.

Prabhudeva S. S.

S.S.Prabhudeva

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world diabetes day
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WORLD DIABETES DAY: Education to protect tomorrow

World Diabetes Day (WDD) is marked every year on November 14.

Launched in 1991 by the International Diabetes Federation (IDF) and World Health Organization (WHO), WDD aims to promote the importance of coordinated and concerted action to confront diabetes as a critical global health issue.

The event unites a global audience of more than one billion people across more than 160 countries to raise awareness of the need for care, education and resources to support those with diabetes.

Education to protect tomorrow is the theme of World Diabetes Day 2022, the second year of the 2021–23 focus on access to diabetes care.

This year's campaign focuses on the need for better access to quality diabetes education for health professionals and people living with diabetes.

One in 10 adults around the world now live with diabetes, an estimated 537 million people. Almost half do not know they have it. This is putting added strain on healthcare systems.

Healthcare professionals must know how to detect and diagnose the condition early and provide the best possible care.

People living with diabetes need access to ongoing education to understand their condition and carry out the daily self-care essential to staying healthy and avoiding complications.

- Millions of people with diabetes around the world do not have access to diabetes care.
- People with diabetes require ongoing care and support to manage their condition and avoid complications.

We cannot wait any longer for

- Medicine, technologies, support and care to be made available to all people with diabetes that require them.
- Governments to increase investment in diabetes care and prevention.

The centenary of the discovery of insulin presents a unique opportunity to bring about meaningful change for the more than 530 million people living with diabetes and the millions more at risk.

Education to protect tomorrow

The rising number of people affected by diabetes is putting added strain on healthcare systems. Healthcare professionals must know how to detect and diagnose the condition early and provide the best possible care; while people living with diabetes need access to ongoing education to understand their condition and carry out the daily self-care essential to staying healthy and avoiding complications.

Key messages for people living with diabetes and the public

- More than 90% of diabetes care is selfcare and requires 24/7 management
- Do you have the knowledge to make informed decisions about your condition?
- Take charge of your diabetes care and protect tomorrow with free diabetes education at www.worlddiabetesday. org/understandingdiabetes

Key messages for healthcare professionals and policymakers

- One in nine people will have diabetes by 2030. This is putting more pressure on healthcare professionals to provide the best possible diabetes care
- When did you last update your diabetes knowledge?

Those whose diabetes coverage targets set the standard that, by 2030:

- 80% of people living with diabetes are diagnosed
- 80% of people with diagnosed diabetes have good control of glycaemia
- 80% of people with diagnosed diabetes have good control of blood pressure
- 60% of people with diabetes of 40 years or older receive statins
- 100% of people with type 1 diabetes have access to affordable insulin and blood glucose self-monitoring ■

UN WATER
19 November
WORLD TOILET DAY
2022 Sanitation and Groundwater

Making the invisible visible

Safely managed sanitation systems protect groundwater.
We must ensure safe toilets for all by 2030.

UN WATER
19 November
WORLD TOILET DAY
2022 Sanitation and Groundwater

World Toilet Day : Sanitation and Groundwater

World Toilet Day has been an annual United Nations Observance since 2013. It was first celebrated in 2001 by the World Toilet Organization.

World Toilet Day celebrates toilets and raises awareness of the 3.6 billion people living without access to safely managed sanitation. It is about taking action to tackle the global sanitation crisis and achieve Sustainable Development Goal 6: water and sanitation for all by 2030.

Every year, UN - Water — the United Nations' coordination mechanism on water and sanitation — sets the theme for World Toilet Day. In 2022, the theme is **'Sanitation and Groundwater'.**

Ahead of the day, UN - Water launches a global campaign at www.worldtoiletday.org and on social media with the hashtag #WorldToiletDay. Individuals, organizations, governments, companies, schools and many other actors support the day by using the official messages and assets, or by organizing their own World Toilet Day activities.

The theme of World Toilet Day 2022 is **'Sanitation and Groundwater'.**

The title of the World Toilet Day 2022 campaign is 'Making the invisible visible'. Please use and adapt the following narrative when talking about World Toilet Day 2022.

Making the invisible visible

We face a global sanitation crisis. Today, 3.6 billion people are still living with poor quality toilets that ruin their health and pollute their environment. Every day, more than 800 children die from diarrhoea linked to unsafe water, sanitation and poor hygiene.

This year, World Toilet Day focuses on the impact of the sanitation crisis on groundwater.

Inadequate sanitation systems spread human waste into rivers, lakes and soil, polluting the water resources under our feet. However, this problem seems to be invisible. Invisible because it happens underground. Invisible because it happens in the poorest a nd most marginalized communities.

Groundwater is our most abundant source of freshwater. It supports our drinking water supplies, sanitation systems, farming, industry and ecosystems. As climate change worsens and populations grow, groundwater is vit al for our survival.

Safely managed sanitation protects groundwater from human waste pollution. Sustainable Development Goal 6.2 is the world's promise to ensure safe toilets for all by 2030. This means everyone having access to a toilet connected to a sanitation system that effectively removes and treats human waste. But, we are seriously off track to meet this target.

We must work on average four times faster to ensure everyone has a safe toilet by 2030. The connection between sanitation and groundwater cannot be overlooked. Time is running out. We must make the invisible visible.

Key messages

Safe sanitation protects groundwater. Toilets that are properly sited and connected to safely managed sanitation systems,collect, treat and dispose of human waste, and help prevent human waste from spreading into groundwater.

Sanitation must withstand climate change. Toilets and sanitation systems must be built or adapted to cope with extreme weather events, so that services always function and groundwater is protected.

Sanitation action is urgent. We are seriously off track to ensure safe toilets for all by 2030. With only eight years left, the world needs to work four times faster to meet our promise.

The global sanitation crisis

Nearly half the world's population still lives without a "safe toilet". A "safe toilet" is shorthand for a safely managed sanitation system, which means a toilet not shared with other households, that either treats or disposes of human waste on site, stores it safely to be emptied and treated off - site, or connects to a functioning sewer and treatment plant.

People living without access to safely managed sanitation systems use shared facilities or those that do not safely dispose of human waste. Almost 500 million people relieve themselves outside ('open defecation') and 3.6 billion people – nearly half of the global population –

Continued on page 8

WORLD DAY OF REMEMBRANCE

World Day of Remembrance for Road Traffic Victims 2022

The World Day of Remembrance for Road Traffic Victims (WDR) is commemorated on the third Sunday of November each year.

It is a high-profile global event to remember the many millions who have been killed and seriously injured on the world's roads and to acknowledge the suffering of all affected victims, families and communities – millions added each year to countless millions already suffering: a truly tremendous cumulative toll.

This Day has also become an important tool for governments and all those whose work involves crash prevention or response to the aftermath of crashes, since it offers the opportunity to demonstrate the enormous scale and impact of road deaths and injuries, call for an end to the often trivial and inappropriate response to road death and injury and advocate for urgent concerted action to stop the carnage.

On World Day, we too pay tribute to the dedicated emergency crews, police and medical professionals, who deal daily with the traumatic aftermath of road crashes.

As every year, the objectives of WDoR 2022 are to provide a platform for road traffic victims and their families to:

- remember all people killed and seriously injured on the roads;
- acknowledge the crucial work of the emergency services;
- draw attention to the generally trivial legal response to culpable road deaths and injuries and advocate for an appropriately serious response;
- advocate for better support for road traffic victims and victim families;
- promote evidence-based actions to prevent and eventually stop further road traffic deaths and injuries

Every year, millions more road victims are added to the current toll of over 50 million killed and hundreds of millions injured since the first road death 125 years ago last August – a disaster that continues day in and day out in all countries of the world.

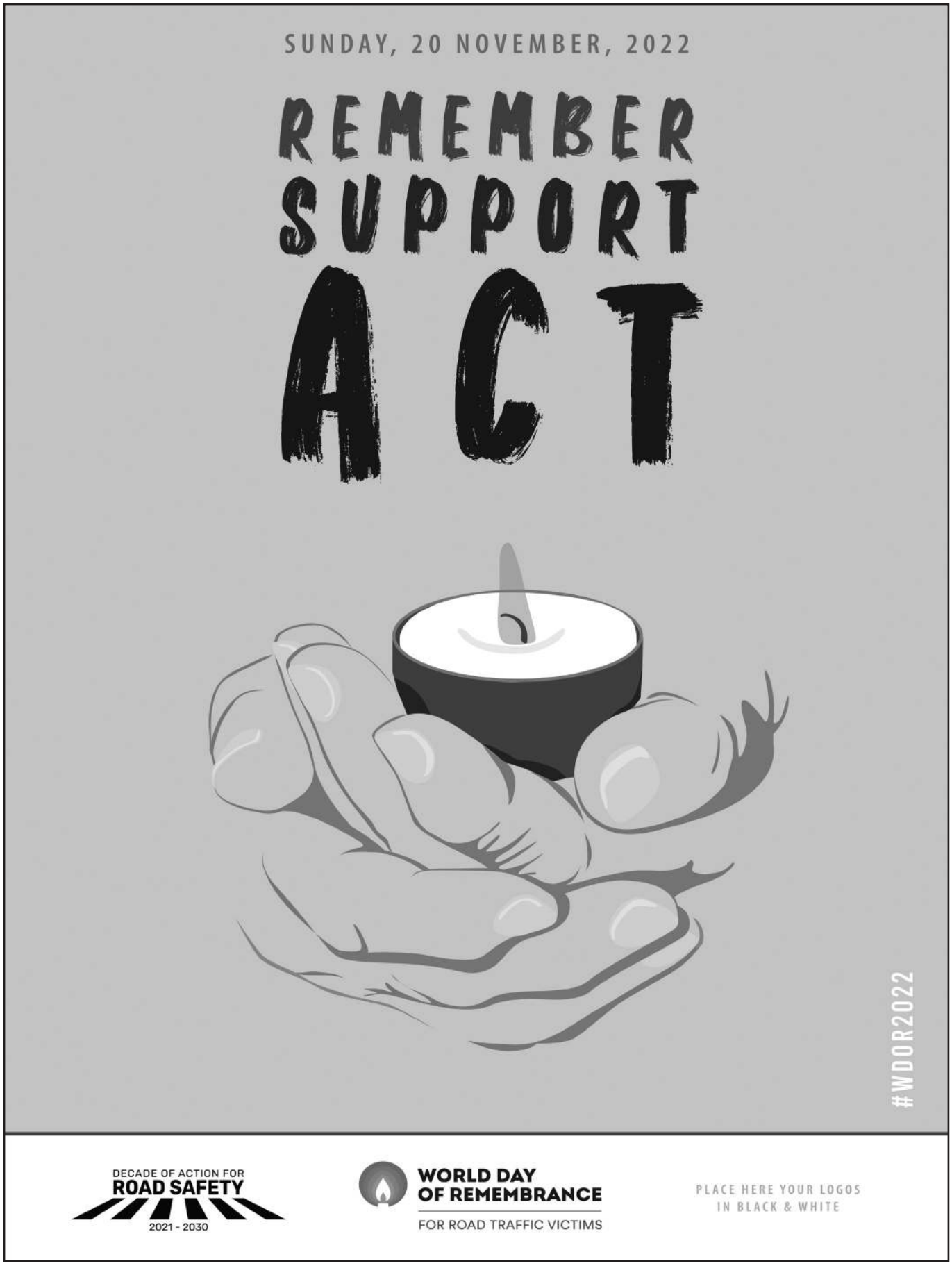
It is an actual pandemic, affecting primarily our vulnerable and our young, which in addition to the trauma of injury and bereavement has also a devastating economic impact for countries, communities and families.

Therefore, during the new Decade of Action 2021-2030 the World Day will have the important role of helping to achieve the 50% road casualty reduction target.

WDoR 2022 puts the spotlight on JUSTICE

Traffic law enforcement, thorough investigation after a crash to find out if a crime was committed and to prevent recurrence, criminal prosecution where appropriate and civil compensation are all part of the justice system.

When carried out seriously, fairly and consistently, such a system is what road crash victims who have been injured or had a family member killed as the result of someone's law–breaking or negligence deserve and wish for, since it also represents a main factor of prevention and this would mean that lessons are learnt from their tragedies so that they may not be repeated. ■


SUNDAY, 20 NOVEMBER, 2022
REMEMBER
SUPPORT
ACT
#WDOR2022
DECADE OF ACTION FOR
ROAD SAFETY
2021 - 2030
WORLD DAY
OF REMEMBRANCE
FOR ROAD TRAFFIC VICTIMS
PLACE HERE YOUR LOGOS
IN BLACK & WHITE

World Antimicrobial Awareness Week 2022

Preventing Antimicrobial Resistance Together 18 - 24 November 2022

The theme of WAAW 2022 is **"Preventing antimicrobial resistance together".** AMR is a threat to humans, animals, plants and the environment. It affects us all. That is why this year's theme calls for cross-sectoral collaboration to preserve the efficacy of these important products.

To curb AMR effectively, all sectors must use antimicrobials prudently and adopt other preventive measures. The following actions can help reduce the need for antimicrobials and minimize the emergence of AMR:

- Strengthen infection prevention and control in health facilities, farms and food industry premises;
- Ensure access to clean water, sanitation and hygiene, and vaccines;
- Implement best practices in food and agricultural production; and
- Minimize pollution and ensure proper waste and sanitation management.

The overall slogan for raising awareness on AMR during WAAW remains the same as in previous years - **Antimicrobials: Handle with care**

Key messages

Did you know?

- In 2019, nearly 5 million human deaths worldwide were associated with bacterial AMR, of which 1.3 million human deaths were directly attributable to bacterial AMR.
- Releases from unused drugs disposed of in toilets, bins or waste dumps contribute to exacerbate AMR.
- In a high-impact scenario, AMR will reduce global annual GDP by 3.8 percent by 2050. Left unchecked, in the next decade, AMR could result in a GDP shortfall of US$ 3.4 trillion annually and push 24 million more people into extreme poverty.
- Human-induced pollution exacerbates AMR in the environment. The treatment of waste streams of municipal, agricultural, and industrial origin are important preventive measures.
- The development of a new antibiotic can take 10-15 years and cost more than USD 1 billion.
- Keeping animals healthy is an important measure to reduce the need for antimicrobial treatment in the first place.
- When preparing food, washing hands before cooking and keeping food preparation areas clean can help prevent the spread of drugresistant microbes.
- Access to safe water, sanitation and hygiene (WASH) in homes and health facilities can reduce the need for antibiotics to treat diarrhoea by up to 60 percent. WASH helps prevent drugresistant infections, saves lives and reduces health care costs. ■

World Toilet Day

Continued from page 5

are not connected to safely managed sanitation systems, leaving human waste untreated and contaminating communities and water used for drinking, hygiene, recreation and food production.

Urban and rural areas face different challenges. In densely populated urban settings, pit latrines and septic tanks sited close to waterpoints that draw from a shallow aquifer create a potentially serious health risk.

In rural settings, mainly due to there being more space, pit latrines and septic tanks can be more easily sited at a safe distance from waterpoints.

This crisis has a profound impact on public health, educational attainment , economic productivity and environmental integrity.

For women and girls in particular, the indignity, inconvenience and danger of not having access to safely managed sanitation is a barrier to their full participation in society.

Groundwater is water found underground in aquifers, which are geological formations of rocks, sands and gravels that hold water. Groundwater is by far the most abundant source of freshwater globally, supporting drinking water and sanitation systems, food production, industrial processes and the healthy functioning of ecosystems . In many areas, aquifers are close to the surface, making them particularly vulnerable to human - made pollution from the soil

Continued on page 10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Language here.
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World Health Organization
HANDLE ANTIMICROBIALS WITH CARE
Antibiotics
Antivirals
Antifungals
Antiparasitics

World Toilet Day

Continued from page 8

and surface water above.

Impact of inadequate sanitation on ground water

Groundwater utilization for drinking water is endangered by the uncontrolled disposal of human excreta, especially in densely populated urban settlements, and the absence of sustainable sanitation systems in fast -growing cities and peri-urban areas. These are five areas of concern.

Pit latrines and septic tanks: In a densely populated community, pit latrines as well as poorly constructed and managed septic tanks can result in significant pollution of shallow aquifers and nearby water bodies. This can lead to disease outbreaks via contaminated waterpoints and harmfully high nutrient loading in water supplies and nearby lakes.

Faecal sludge disposal by landfill: Where human waste is taken from pit toilets and septic tanks and disposed of with other solid waste in landfill sites without impermeable layers and good effluent management, the potential for groundwater pollution is high.

Irrigation with untreated wastewater: Farms and municipal authorities sometimes use untreated wastewater for irrigation. This poses a major health risk for farmers and consumers of leafy vegetables irrigated with this untreated wastewater, as well as when practised near unprotected public water wells and human settlements.

Sewerage outfall: In towns and cities where sewers are used to take away effluent, the arrangements for wastewater disposal and reuse are often inadequate, with significant pollution risks for the aquifers under land or rivers where the sewage is dumped.

Climate change impacts: In areas with intensifying rainfall, pit latrines, septic tanks and open sewers can get flooded, spreading human waste into soil and surface water. Conversely, in areas with worsening drought, sanitation systems such as pour - flush latrines may become unusable, forcing people torelieve themselves outside.

How do sanitation solutions protect groundwater?

Safely managed and properly sited sanitation protects humans and groundwater from the pathogens in faecal waste. A safe and sustainable sanitation system begins with a toilet that effectively captures human waste in a safe, accessible and dignified setting. Either, the waste then gets sto red in a tank, which can be treated on - site where liquid waste infiltrates to soil and solids may be emptied later by a collection service. Or, it is transported away by a sewer connected to a treatment plant and then safely disposed of or reused. Safe reu se of treated human waste can capture greenhouse gas emissions for energy production and provide agriculture with a reliable source of water and nutrients.

Sustainable sanitation systems need to be able to withstand more frequent floods, droughts, changes in water availability and sea level rise brought on by climate change, so that services always function and groundwater is protected. In areas experiencing water scarcity and decreasing groundwater availability treated wastewater can be used to recharge aquifers and replenish groundwater supplies.

Groundwater protection zones are vital, as part of a context - specific, integrated approach to ensuring sanitation systems, land use planning and water abstraction do not adversely impact the quality and quantity groundwater resources, particularly in areas where aquifers are close to the surface.

Why should we care about groundwater pollution?

Remediation of groundwater pollution caused by humans is often a long and difficult process. This increases the costs of processing groundwater, and sometimes evenprevents its use. Exploring, protecting and sustainably using groundwater will be central to surviving and adapting to climate change and meeting the needs of a growing population.

Having access to safely managed sanitation services, in combination with safely managed drinking water services and good hygiene facilities and behaviours, is the foundation of public health and therefore essen tial for the realization of all other human rights.

Toilets drive improvements in health, gender equality, education, economics and the environment. Par-

ticularly for women and girls, toilets at home, school and at work help them fulfil their potential and play their full role in society, especially during menstruation and pregnancy.

Role of decision - makers

The connection between groundwater and sanitation has always been critically important but not fully recognized. We must protect groundwater from pollution and use it sustainably, balancing the needs of people and the planet.

Groundwater's vital role in water and sanitation systems must be reflected in policymaking. Furthermore, under the SDG 6 Global Acceleration Framework, particularly in the areas of governance, capacity building, data and information,the link between groundwater and sanitation needs to be strengthened through inclusive policy and its coordinated implementation.

In order to achieve that, groundwater -and sanitation specialists, policymakers and practitioners must all increase their cooperation.

Action on sanitation – why is it urgent?

Sustainable Development Goal 6 is to ensure availability and sustainable management of water and sanitation for all by 2030.

SDG target 6.2 is to "achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations."

At present, the world is seriously off track to meet SDG 6.2. Today, 3.6 billion people still live without safely managed sanitation services.

The latest data show that, on average, governments must work four times faster to meet the promise of SDG 6.2 within the next eight years. UN - Water is encouraging the world to take action through the SDG 6 Global Acceleration Framework and the specific accelerators for sanitation set out in the *State of the World's Sanitation*.

The World Toilet Day 2022 campaign calls on decision - and policymakers to accelerate progress on sanitation and to ensure the connection between sanitation and groundwater is reflected in legislation and related guidelines at all administrative levels, from international and national to local.

Who calls on countries to "Act Local to Go Global"

By 2050, nearly 7 out of 10 people globally will live in cities and other urban settings. While cities face many health challenges, on World Cities Day 2022 WHO and partners examine how city leaders are uniquely positioned to understand local needs and respond rapidly to changing conditions to safeguard health.

Although living in cities brings many advantages, rapid and unplanned urbanization can have negative social and environmental health impacts. These include not only issues linked to climate change, pandemics and noncommunicable diseases, but also to malaria and other vector-borne diseases. While the burden of malaria is currently still higher in rural areas, current trends in urbanization mean that in a few years most people living in malaria-endemic countries will reside in urban areas.

In this regard, and on the occasion of World Cities Day 2022, WHO and UN Habitat have produced the *Global framework for the response to malaria in urban areas*. The Framework provides guidance to city government officials, health professionals and urban planners for a comprehensive malaria response specifically in urban areas, where the dynamics of transmission and burden of vector-borne diseases can be different from that of rural areas. The Framework acknowledges that the global fight against malaria and other vector-borne diseases requires strong action from local governments, in areas such as health, housing and infrastructure.

"By offering specific guidance to local officials, this new Framework can help ensure that malaria control forms an integral part of the broader urban planning, policy-making and budgeting processes," explains Dr Abdisalan Noor, Head of the Strategic Information for Response Unit in the WHO Global Malaria Programme. "For each urban context, the strategic use of data can inform effective, tailored responses and help build resilience against the threat of malaria and other vector-borne diseases."

On World Cities Day 2022, WHO is also launching the Urban health research agenda, a comprehensive strategy to help cities build better evidence around what works to address urban health challenges. The agenda calls for building evidence on the environmental, economic and social impacts of urban health policies, so that they can be addressed through a coordinated approach that involves the different sectors working together to improve the health of their residents.

"We desperately need to get ahead of the challenges that are impacting the health and well-being of people living in cities," notes Dr Etienne Krug, Director of the Department of Social Determinants of Health at WHO. "Strong urban policies must prioritize health, to ensure resilient and vibrant communities for people to live, work, go to school and play, all while protecting those who are most vulnerable." ■

Assessing effectiveness of structured teaching programme on care of patients undergoing radiotherapy for breast and cervical cancer among III year B.Sc. Nursing students at a selected Nursing College



Sivasakthi.T *, Annie Mary.G** and Priyadharshini.G***

Cancer is emerging as a major public health crisis in South Asia. This dramatic escalation in cancer incidence is parity due to South Asia's exploding population- specifically, India's population of one billion which accounts for a substantial percentage of South Asia's total population.

Cervical and breast cancer combined constitute 54 percent of all cancers in Indian women. The highest absolute numbers of cervical cancer cases occur in Asia. In India, an estimated 132,000 new cases, or more than one-fourth of cases are reported annually.

Reports on cervical cancer incidence have the highest rates-typically above 25 per 100,000 women- in Sub-Saharan Africa, Latin America , the Caribbean, and South East Asia. Studies also show that one in four women with the diseases in Uganda are still alive five years after diagnosis, with 30-50% in India - 50-60% in Thailand and china 60-75% in the developed world as a whole. In Kampala, Uganda there has been doubling of breast cancer incidence from the late 1960's to late 1990's. In Africa, only 20% of patients have access to radiotherapy.

Radiotherapy is a major modality in the treatment of cancer. It involves using high - energy ionizing radiation to treat malignancies. It is estimated that 60% of individuals with cancer receive radiation at some point during the course of their disease. Radiation is used at all phases of the cancer trajectory. As a primary therapy, radiation is used with curative intent in early stage.

Need for the study

The nurse is the primary caregiver of the patients and plays an important role in identifying, reporting and helping patients deal with the side effects of radiation . The investigator is interested in providing educational programme to the nursing students to improve their knowledge regarding care of patients undergoing radiotherapy for breast cancer and cervical cancer.

Statement of the problem

A study to assess the effectiveness of structured teaching programme on care of patients undergoing radiotherapy for breast and cervical cancer among the III year B.Sc. Nursing students studying at a selected Nursing college, Tamil Nadu.

Objectives

1. To assess the existing knowledge on care of patients undergoing radiotherapy for breast and cervical cancer among the III year B.Sc. Nursing students.
2. To assess the effectiveness of structured teaching programme on care of patients undergoing radiotherapy for breast and cervical cancer among the III year B.Sc. Nursing students using traditional method of teaching (lecture).
4. To associate the pre-test knowledge on care of patients undergoing radiotherapy for breast and cervical cancer with selected demographic variables.

Assumptions

- The students may have inadequate knowledge regarding care of patients undergoing radiotherapy for breast and cervical cancer.
- Education will improve the knowledge of students on care of patients undergoing radiotherapy for breast and cervical cancer.
- Adequate knowledge will help the students to manage care of patients undergoing radiotherapy for breast and cervical cancer in a more intelligent way.

Research methodology

Research approach: The research approach used for this study was quantitative approach.

Research design: The research design adopted for this study was the true experimental approach, one

*Asso. Professor, **Principal and ***Lecturer, Mahendra College of Nursing, Salem, Tamil Nadu.

group pre test and post test.

Variables in the study

Independent variables: STP on care of patients undergoing radiotherapy for breast and cervical cancer.

Dependent variables: Knowledge of the students about the care provided to the patients undergoing radiotherapy for breast and cervical cancer.

Extraneous variables: The extraneous variables are the interest of students in learning during teaching and clinical experience.

Population: III year B.Sc. Nursing students studying at selected Nursing college.

Sample: III year B.Sc. Nursing students studying at selected Nursing College.

Sample size: The sample selected for the present study was decided to be 88 III year B.Sc. Nursing students.

Sampling technique: Convenient sampling has been followed to form groups.

Criteria for sample selection

Inclusion criteria: Students who were studying in III year B.Sc. Nursing • Students who were willing to participate in this study

Exclusion criteria: Students who were not willing to participate in this study • Students who were not well/ absent were excluded.

Description of the tool: This instrument used for data collection was structured questionnaire which consisted of 3 sections.

Section – A: It assessed the demographic variables of samples such as age, religion, educational status of the parents, percentages or marks scored in Higher secondary examination, marks or percentage obtained during I and II year B.Sc. Nursing examination using structured questions.

Section - B: It was a multiple choice questions and semi structured questionnaire with 21 items to assess the students' knowledge regarding radiotherapy. The items were related to the purposes, types, measurement and recent advances in radiotherapy.

Comparison of the pre-test and post-test mean knowledge score on care of radiotherapy among students in lecture group

N=88

Group	Pre-test		Post-test		Paired 't'	'P' value
	Mean	SD	Mean	SD		
Lecture group	5.705	2.141	18.727	5.346	-14.700	< 0.000 (S)

S- Significant Maximum score =32

Section – C

It was multiple choice questions, semi structured and close ended questionnaire with 19 items to assess the students' knowledge care of patients undergoing radiotherapy for breast cancer and cervical cancer. The items were related to the side effects, techniques, principles, and nursing care before, during and after intervention & complications.

Content validity: The tool was validated by 3 experts in the field of nursing and medicine. The experts offered suggestions regarding simplifying the terms and scoring were incorporated and modified as per experts.

Reliability: The reliability of the tool was estimated by using intra-class correlation co- efficient and the value was 0.88. The tool was found to be highly reliable.

Data collection procedure: Pre-test was given to the students and STP on care of patients undergoing radiotherapy for breast and cervical cancer. After 7 days post-test was conducted for students.

Plan for data analysis: The data were analyzed based on the objectives of the study using descriptive and inferential statistics.

- Frequency and percentage for analysis of the demographic data.
- Mean and standard deviation used for assessing the knowledge level.
- Computing Kruskal Wallis test / Mann Whitney "U" test to determine the association between selected demographic variables with pre-rest knowledge score.

Table – 2 shows the average pre-test knowledge score on care of radiotherapy the students found to be 5.705. After traditional lecture method of teaching, there was improvement in the mean post- test knowledge score on care of radiotherapy which was improved to 18.727. Thus, the increase in level of the knowledge on radiotherapy was confirmed by the 't' value (-14.700), which was significant (p<0.000).

Table 3 shows the result where there was significant relationship between previous percentages of the higher secondary and there was no significant relationship between previous percentages of the first year and second year marks and students mean knowledge score on care of radio therapy.

Major findings

1. The study showed that students had inadequate knowledge during pre-test.
2. After attending the structured teaching programme the student's mean knowledge scores

Table – 3: Association of pre-test level of knowledge and care on radiotherapy with previous academic performance among students

Demographic variables	NO	Mean	SD	Kruskal wallis	P Valve
Percentage of the student marks					
Higher secondary					
50-60%	22	11.045	3.525	7.514	0.023 (S)
61-70%	44	10.864	2.800		
Above 80%	22	12.955	12.955		
First year					
50-60%	40	11.775	3.230	0.845	0.655 (NS)
61-70%	39	11.205	3.062		
71-80%	9	10.889	3.333		
Second year					
50-60%	40	11.700	3.391	1.053	0.591 (NS)
61-70%	42	11.333	2.791		
71-80%	6	10.333	4.082		
NS- Non Significant, S - Significant					

improved to 34.068.

3. There was a statistically significant association between percentage of marks scored in higher secondary examination with mean knowledge score. But there was no statistically significant association between percentage of marks scored in I year and II year B.Sc. Nursing examination.

Nursing implications

Nursing service: The students should be included in the care of patients undergoing radio therapy for breast and cervical cancer team which help them to improve their skills.

The students should be motivated to give education to patients regarding before, during and after the care of radio therapy.

Nursing education: This study emphasizes the need of conducting mock drills to improve students' knowledge on care of patients undergoing radio therapy for breast and cervical cancer.

This study emphasizes the importance of conducting educational programmes regarding care of radio therapy for breast and cervical cancer to improve the knowledge and skills of students.

Nursing administration: The nurse administrator must plan formal training programme for all health personnel in achieving the objectives of reducing the mortality rate and promoting the care of patients undergoing radio therapy for breast and cervical cancer.

Nursing research: More research can be conducted by the researchers using randomised study based on effectiveness of radiotherapy

Similar study can be done on large group.

An explorative study can be done to identify the effect of radio therapy, reducing the risk in breast and cervical cancer.

Recommendations

- The study can be replicated by using a large sample to generalize the findings.
- A follow–up study can be conducted to evaluate the effectiveness of educational programme.
- Provision of more practical hours in ward setting which helps to improve their skills in care of radiotherapy in breast and cervical cancer.
- Studies can be conducted to assess the knowledge of care of radiotherapy for breast and cervical cancer.
- More research can be conducted by the reseachers using randomised study based on effectiveness of radiotherapy in reducing the risk.

References

1. Aldelaijan, S., Mohammed, H., Tomic N., & Liang L.H., et al. (2011). Radiochromic film dosimetry of HDR (192)Ir source radiation fields. Journal of Radiation oncology, 38(11): 6074-6083.
2. Battista, J.J., Clark,B.G., Patterson, M.S., & Beaulieu, L., (2012). Medical physics staffing for radiation oncology: a decade of experience in Ontario,Canada. Journal of National institutes of health, 13(1): 370-374.
3. Biswal, B.M., Zakaria, A., Baba, A.A., Ja'afar, R., (2004). Assessment of knowledge, attitude and exposure to oncology and palliative care in undergraduate medical students. Journal of US National Library of Medicine National institutes of health, 59(1): 78-83.
4. Buekers, T.E., Kao, M.S., Phillips NJ., & Xynos, F.P., (2007). The treatment of early stage cervical cancer: an assessment of pre-operative factors. Journal of obstetrics and gynecology. 104(3): 665-659.
5. Castroromero, J.I., Hemandez Giron, C., & Madrid marina V., (2011).Hormonal contraception as a risk factor for developing cervical cancer:biological, epidemiological and immunological evidence. Journal of Obstetrics and Gynecology. 79(9): 533-9
6. Dennis, KE., & Duncan,G., (2010). Radiation oncology in undergraduate medical education: a literature review. Journal of US National Library of Medicine National institutes of health,76(3): 649-655. ■

Effectiveness of structured teaching programme on knowledge and practice of menstrual hygiene among adolescent girls

P. Prabha*

Adolescence has been defined by the period between 10 years to 19 years of age. This has been recognized as a turbulent period which signifies the transition from girlhood to womanhood and considered as a landmark of female puberty.

This transitional period is marked with the onset of "Menarche " which is generally accepted by young girls as a sign of maturity.

Need for study

Most of the adolescents tend to be extremely unaware of their own body, their physical well being and psychological change. Menstrual cycle has come to occupy an increasingly important place in discussions of woman's health and attention is again being given on the impact of the onset of menarche.

Objectives

- To assess the existing level of knowledge on menstrual hygiene among adolescent girls.
- To assess the existing level of practice on menstrual hygiene among adolescent girls .
- To assess the effectiveness of structured teaching program on knowledge and practice regarding menstrual hygiene among adolescent girls .
- To find association between mean pretest knowledge and practice score on menstrual hygiene among adolescent girls in a selected school with their selected demographic variables.

Hypothesis

H_1: The mean post test knowledge score on menstrual hygiene among adolescent girls age will be higher than mean pre test knowledge score.

H_2: The mean post test practice score on menstrual hygiene among adolescent girls age group will be higher than mean pre test practice score.

H_3: There will be significant association between mean pretest knowledge score on menstrual hygiene with selected demographic variables.

H_4: There will be significant association between mean pretest practice score on menstrual hygiene with selected demographic variable.

Assumptions

Adolescent girls may have inadequate knowledge and practice regarding menstrual hygiene.

Structured teaching programme will be an effective tool for creating awareness on knowledge and practice on menstrual hygiene.

Methodology

Research approach: Evaluative research approach was used in this study.

Research design: Quasi experimental one group pretest and post test design.

Study setting: Selected Higher Secondary School, Karur.

Population: Adolescent girls.

Sample size: 30

Sampling technique: Convenient sampling technique

Inclusion criteria

- Adolescent girls who were studying in selected higher secondary school.
- Adolescent girls who were willing to participate in the study.
- Adolescent girls who were present during data collection procedure.

Exclusion criteria

- Adolescent girls who had previous exposure to any other teaching methods.
- Adolescent girls who were not willing to participate in the study.
- Adolescent girls who were not available during the period of data collection.

Discription of the tool

Section A: Demographic variables

Section B: Structured knowledge questionnaire regarding menstrual

** Assistant Professor, Mahendra College of Nursing, Salem.*

hygiene

Section C: Structured observational checklist on practice of menstrual hygiene.

Scoring procedure

Knowledge scoring

1. Inadequate knowledge-0-8
2. Moderate-9-16
3. Adequate-17-25

Practice scoring

1. Poor Practice-0-3
2. Inadequate-4-6

Table: 1 Frequency and percentage distribution of demographic variables of menstrual hygiene among adolescents girls

N=30

Demographic variables	No	%
Age in years		
13 yrs	7	23.3
14 yrs	23	76.6
Education		
9th standard	30	100
Religion		
Hindu	30	100
Family income		
Less than Rs, 5,000	2	6.7
Rs 5,001 to 10,000	13	43.3
Rs 10,001 to 15,000	8	26.7
Above 15,001	7	23.3
Residence		
Rural area	7	23.4
Urban area	21	70
Semi urban	2	6.6
Birth order		
First	16	53.3
Second	13	43.3
Third	1	3.4
Fourth	0	0
Source of information		
Parents and family	27	90
Mass media	3	10

3. Moderate-7-10

Plan for data analysis: The data obtained in this study was planned to be analyzed on the basis of objectives and hypothesis of the study. Collected data was organized in master sheet for demographic variables which were analyzed using frequencies and percentages. The effects of study were evaluated by using t test,chi square. The result was presented in the form of tables, graphs and diagrams.

The table shows that majority 23 (76.6%) were in the age group of 14 years,with respect to education status of the adolescents, majority 30 (100%) were educated at higher secondary school. Regarding religion of the adolescents, majority 30 (100%) were Hindus. The family income of majority 13 of (43.3%) have a family income of more than Rs.5001 to 10,000. Considering residential area, majority 21 (70%) were from urban area. Considering the birth order 16 (53.3%) were the first child. Analyzing the source of information 27 (90%) were parents and family members.

N=30

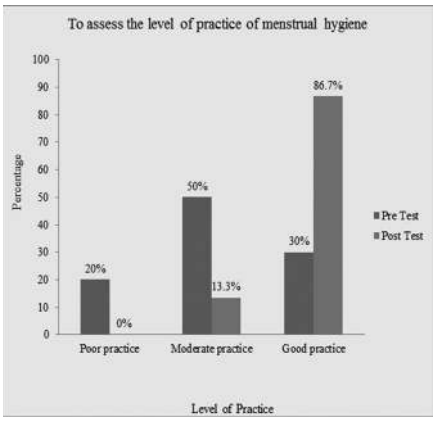

Fig.1: Percentage distribution of pretest and post test level of practice on menstrual hygiene among adolescent girls .

Fig.1 shows that in the pre test ,majority 15 (50%) had moderate practice and 9 (30%) had good practice, 6 (20%) had poor practice, whereas in the post test, majority 26 (86.7%) had good practice, 4 (13.3%) had moderate practice of menstrual hygiene among adolescent girls.

Table 2. shows that in the pretest, the mean score of knowledge was 12.00 with S.D 2.600 and the mean score of practice was 6.37 with S.D 1.388. The calculated Karl persons correlation value of r = 0.129 shows a positive correlation but was not found to be statistically significant.

Tab. 2: Correlation between pretest and post test knowledge and practice score on menstrual hygiene among adolescent girls (13 to 17 Yrs)

N=30

Variables	Mean	S.D	'r' Value
Pretest			
Knowledge	12.00	2.600	r =0.129 P=0.0001,S**
Practice	6.37	1.388	
Posttest			
Knowledge	21.50	1.548	r =0.5 P=0.0001,S**
Practice	8.93	944	
*P<0.05, S= Significant			

Whereas in the post test, the mean score of knowledge was 21.50 with S.D 1.548 and the mean score of practice was 8.93 with S.D .94, the calculated Karl Pearson's correlation value of r = 0.5 shows a positive correlation and was found to be statistically significant at $p < 0.05$ level. This clearly indicates that when the knowledge level increases in the post test, practice level also increases.

Table 3 shows with demographic variable residence had shown statistically significant association with pretest level of knowledge on menstrual hygiene among adolescent girls at $P < 0.05$ level and the other demographic variables had not shown statistically significant association with pre test level of knowledge.

Result

Objective 1: The overall knowledge score was 73.3%. After STP post test knowledge was assessed by using

Tab.3: Association between pretest knowledge with residence among adolescent girls with their demographic variable

Variable	Category	Knowledge						Chi Square Value
		Inadequate		Moderate		Adequate		
		No.	%	No.	%	No.	%	
Age	13 Yrs.	5	22.7	3	28.6	0	0	x2=0.714 P=0.950 d.f =4 NS
	14 Yrs.	16	76.6	5	57.1	1	0.1	
Education								
	9th Standard	22	100	7	100	1	0.1	NA
Religion	Hindu	22	100	7	100	1	0.1	NA
Monthly income	Below Rs. 5,000	2	9.2	0	0	0	0	x2= 5.124 P =0.150 d.f=6 NS
	Rs. 5,001 to 10,000	12	54.5	1	14.3	0	0	
	Rs. 10,001 to 15,000	5	22.7	2	28.6	1	0.1	
	Above Rs. 15,000	3	18.6	4	57.1	0	0	
Residence	Rural	6	27.3	1	14.3	0	0	x2=30.946 P=0.0001* d.f=6
	Urban	15	65.2	6	85.7	0	0	
	Semi urban	1	4.5	0	0	1	0.1	
Birth order	First	12	54.5	3	42.9	1	0.1	x2=1.693 P=0.792 d.f=4 NS
	Second	9	40.9	4	57.1	0	0	
	Third	1	4.6	0	0	0	0	
Menstrual hygiene	Parents & Family Members	20	90.9	6	85.7	0	0	x2=0.274 P=0.872 d.f=2 NS
	Mass Media	3	9.1	1	14.3	0	0	

same questionery the result knowledge was 83.3%.

Objective 2: The overall pretest practice score was good practice 30% (9). Moderate practice (50%) & poor practice 20% (6). After post test practice was assessed by using same checklist. The result of practice score good practice 86.7% (26), Moderate practice 13.3% (4).

Objective 3: The mean score of knowledge 12.00 with S.D 2.600 and the post test mean score of knowledge was 21.50 with S.D 1.548. The student 't' test score was 18.259. The calculated paired P value of 0.001 was found to be statistically significant at $P < 0.05$. The pretest , mean score of practice was 6.37 with S.D 1.388 and in the post test mean score of practice was 8.93 with S.D 0.944. The student 't' test score was 10.418. The calculated paired P value f 0.001 was found to be statistically significant at $P < 0.05$.

Objective 4: Post test the mean score of knowledge was 21.50 with S.D 1.548 and the post test mean score of practice was 8.93 with S.D 0.944.

Objective 5: The demographic variables residence had shown statistically significant association with pretest level of knowledge on menstrual hygiene among adolescent girls at $p < 0.05$ level .

Nursing implications

Nursing practice: Nurses must take advantage of time to spend with the adolescent girls group to engage them in reproductive health teaching and to prevent further complication.

The findings of the study can be used to improve reproductive health by providing structured teaching program on knowledge and practice of menstrual hygiene among adolescent girls.

Nursing education: Nurse educator should motivate the adolescent girls to follow a good menstrual practices during their reproductive age.

Nursing administration: Developing protocols and policies , framing guidelines regarding menstrual hygiene.

Nursing research: The obstetrics nurses should be motivated in doing small research studies on this content

Appropriate utilization of research helps nurses to make evidence based decision.

Limitations

The study was limited to 30 adolescent girls.

The study was limited only with the adolescence age group .

Conclusion

The findings of the study showed

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Assessing effectiveness of nursing intervention package on the functional status among elderly residing at selected area

R.Manjula*

Old age is the closing period of the life span. It is a period when people 'move away' from previous more desirable periods or times of 'usefulness'.

Old age is considered as a curse, being associated with deterioration of all physical, psychological factors, isolation from social, economic, and other activities. Socially, this stage is considered as the sum total of one's lived experiences.

Ageing is a normal, physiological, biological and universal phenomenon that happens in all the living beings. It is commonly understood as the process of maturing or becoming older.

The old age is defined as population aged 60 years and above. It is a stage of life, distinct from the rest by physiological, psychological and social changes and is characterized by a general reduction in functional capacities as well as structural changes in the body.

Need for the study

Aging is a natural process which universally affects all the human beings in the society. As the geriatric population is quiet vulnerable, they might suffer from mental and physical disabilities which consequently threatens their independence.

Quality of life among the geriatric population is a global concern as it reflects the status of health and the wellbeing among the set population.

Study objectives

1. To assess the pre test level of functional status among elderly in control group and experimental group.
2. To assess the post test level of functional status among elderly in control group and experimental group.
3. To assess the effectiveness of nursing intervention package on the functional status among elderly in experimental group.
4. To find the association between post test level of functional status, and the selected demographic variables among elderly in control group and experimental group.

Hypothesis of the study

H_1: There is a significant difference in the pre and post test level of functional status among elderly in control group and experimental group.

H_2: There is a significant relationship between the level of functional status and among elderly in control group and experimental group.

H_3: There is a significant association between the post test level of functional status, and the selected demographic variables among elderly in control group and experimental group.

Development of tool: The study methods used to collect data are intended to allow the researcher to construct a description of the meaning of the variables under study. (Carol L. Macne, 2010)

The researcher constructed the tool based on the literature review and opinion from experts. The tool used in this study had three parts as follows:

Part 1: Demographic variables proforma.

Part 2: Modified lawton–brody instrumental activities of daily living Scale (I.A.D.L)

Data collection procedure

Phase 1: The main study was conducted in Palayakottai and the data collection period was four weeks in the month of April 2021. The researcher obtained written permission from the local authorities of the village.

Phase II: Based on the inclusion criteria, the participants for control group and experimental group, were assigned. After selection of samples to the particular group each group was allotted with 30 samples.

On the first day, pre test was done by structured interview method. The average time taken for one participant was around 30 minutes. Modified lawton–brody Instrumental Activities of Daily Living scale (I.A.D.L.) was used to assess the functional status.

Phase III : After the nursing intervention, on 9th day post test was done using modified lawton–brody Instru

**Nursing Tutor, Mahendra College of Nursing, Salem,Tamil Nadu.*

mental Activities of Daily Living scale (I.A.D.L.), demographic variables proforma. Tool was checked and verified for the completion.

Data analysis and interpretation

Section I: Data on selected demographic variables of elderly in control and experimental group

It was inferred that among control group, majority 9 (30%) were in the age group 66-70 years,16 (53%)were females,14 (47%) were illiterates,14 (47%) were married, 14 (47%) were coolie, 19 (63%) had the income of Rs.5001-10000, 23 (77%) were living in joint family, 16 (53%) had more than two children, 13 (43%) were Hindus, 18 (60%) had specific leisure activities.

Among experimental group, majority 10 (33%) were 60-65 years,18 (60%) were female, 11 (37%) were illiterates, 13 (43%) were married, 11 (37%) were coolie, 17 (57%) had the income of Rs. 5001-10000, 20 (67%) were living in joint family, 12 (40%) had more than two children, 13 (43%) were Hindus, 21 (70%) had specific leisure activities.

Section II : Data on comparison of functional status, among elderly in experimental and control group

N=60

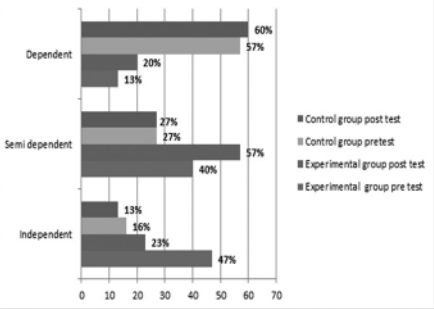


Figure 3 compares the percentage distribution of pretest and posttest level of functional status among elderly in experimental groupand control group.

Table 1: Frequency and percentage distribution of demographic variables of elderly in control and experimental group

Demographic Variables	Control group (n=30)		Experimental group (n=30)	
	F	%	f	%
Age in years				
60-65	8	23	10	27
66-70	9	27	8	30
71-75	6	23	7	20
76-80	7	17	5	23
Gender				
Male	14	47	14	40
Female	16	53	16	60
Educational status			12	
Illiterate	14	47	12	40
Primary school	8	26	9	30
High school	6	20	4	13
Higher secondary	2	7	5	17
Diploma and degree	0	0	0	0
Marital status				
Married	14	47	13	43
Unmarried	0	0	0	0
Widow/widower	12	40	10	33
Divorced	4	13	7	24
Previous occupation				
Skilled worker	8	27	7	23
Semi-skilled worker	4	13	5	17
Private employee	4	13	4	13
Government employee	0	0	3	10
Coolie	14	47	11	37
Monthly income of the family				
Below Rs.5000/-	6	20	9	30
Rs.5001-10000/-	19	63	17	57
Rs.10001-15000/-	5	17	4	13
Above Rs.15000/-	0	0	0	0
Type of family				
Joint	23	77	20	67
Nuclear	5	17	7	23
Extended	2	6	3	10
Number of children				
Nil	0	0	0	0
One	5	17	8	27
Two	9	30	10	33
More than two	16	53	12	40
Religion				
Hindu	15	50	13	43

Christian	9	30	8	27
Muslim	6	20	9	30
Others	0	0	0	0
Do you follow any specific leisure activities				
Yes	18	60	21	60
No	12	40	9	40

In experimental group , during pretest majority of the elders 14 (47%) were found with independent level of functional status, 12 (40%) had semi-dependent level of functional status and the least 4 (13%) had dependent level of functional status .

After the intervention, most of the participants, 17 (57%) of them had attained semi-dependent level of functional status, 7 (23%) of them reached independent level of functional status and 6 (20%) were found with dependent level of functional status.

Among elderly in control group pretest, it was found that, majority of the participants, 17 (57%) were found with dependent level of functional status, 8 (27%) had semi-dependent level of functional status and 5(16%) were found with independent level of functional status whereas in posttest, most of the control group participants, 18 (60%) were found with dependent level of functional status, 8 (27%) had semi-dependent level of functional status and 4 (13%) were found with independent level of functional status.

Comparison of posttest level of functional status among elderly in control and experimental group

In experimental group, obtained overall posttest mean was 9.4 with the SD of 3.2 whereas in control group overall posttest mean was 6.07,SD 2.95.

The calculated 't' value 4.19 .The calculated value was more than the table value and found to be significant at 0.01 level.

Level of functional status	Mean	SD	MD	Unpaired 't' value
Experimental group	9.4	3.2	3.33	4.19 Table value:2.66 P<0.01 S
Control group	6.07	2.95		

On effectiveness of nursing intervention package on level of functional status among elderly in experimental group.

Among experimental group, in pretest level of functional status overall mean score was 6.46 ,SD 2.8 and in posttest obtained mean score was 9.4 with the SD of 2.1.The mean difference found was 2.94 and the obtained 't' value was 14.20 .

The calculated 't' value 14.20 was more than the table value and found to be highly significant at 0.01 level.

Experimental group	Mean	SD	MD	Paired 't' value
Pre test	6.46	2.8	2.94	14.20 df= 29 t=2.76 P<0.01 S
Post test	9.4	2.1		

On association between posttest level of functional status and the selected demographic variables among elderly in experimental group and control group

There was a significant association between the functional status in the experimental and the specific leisure activities (χ^2=8.63) at p <0.05 level among elderly but other selected demographic variables such as age (χ^2=9.9), gender (χ^2=0.14), educational status (χ^2=0.14), marital status (χ^2=1.98),previous occupation (χ^2=3.31), monthly income of the family (χ^2=0.17), type of the family (χ^2=3.98), number of children (χ^2=3.77), religion (χ^2=2.6 were not significant at p>0.05 level.

There was a significant association between the functional status in the control group and the age (χ^2=13.18) and educational status ((χ^2=17.21) at p <0.05 level among elderly but other selected demographic variables such as gender (χ^2=1.59), educational status (χ^2=0.14), marital status (χ^2=3.21), previous occupation (χ^2=2.71), monthly income of the family (χ^2=2.11), type of the family (χ^2=5.38), number of children (χ^2=7.99), religion (χ^2=2.72),specific leisure activities (χ^2=0.54) were not significant at p>0.05 level.

Implications

The present study has got implications in the field of nursing: nursing administration, nursing research and nursing service. The nurse as a health care provider should be able to make significant contribution to reduce stress and enrich the positive coping strategies regarding functional status and quality of life of elderly people to lead life with comfort.

Implication for nursing practice: As a member of health team, nurses should understand the importance of aging to promote the level of QOL and functional status of elderly.

Psychiatric nurses can develop a structured program for the hospitalized elderly in order to improve their QOL which might be deteriorated due to some illness which can be utilised by the community nurse.

Continued on page 53

Assessing prevalence of internet gaming addiction among higher secondary school students

Frank J. C.*

Abstract: *Gaming behaviour has emerged as a common leisure habit among people. Internet gaming addiction is gaining more attention due to its negative aspect and the potentially serious pathological problems that it can cause such as promoting violence, aggressiveness, physical problems, deterioration of reality perception, social decline and high level of addiction. This study aimed to estimate the prevalence of Internet gaming addiction among higher secondary school students. The present study was conducted at BSF Senior Secondary School, Palloura, Jammu. The purposive sampling technique was used to select 100 higher secondary school students. Pontes & Griffiths (2015) internet gaming disorder scale was used to diagnose internet gaming addiction among higher secondary school students. The study findings revealed that among 100 higher secondary school students, 19 (19%) of the students have internet gaming addiction and 81 (81%) of the students didn't have internet gaming addiction.*

India is the second largest internet user in the world. In our country, around 933 million people are accessing internet via any device. Adolescents are more fascinated towards the usage of internet due to online learning through applications like Byju's & Unacademy etc, social media, gaming and entertainment. Increase in the internet addiction amongst the adults is alarming sign for impending psychological and physical problems.

Recently students were addicted to live streaming games like clash of clans, clash royal, mini militia, PUBG. While certain video games like Blue whale, Pokemon 'n' momo etc., have claimed lives of people who were playing them, PUBG Mobile game has 50 million daily active users and has been downloaded over 400 million times.

Need for the study

Students are the responsible citizens of tomorrow. They are the active fundamental, structural, and functional units of the society. Behavioural addictions like internet gaming addiction lead to the development of anger, hostility, social isolation, poor memory, impaired cognition, loss of interest from the studies and daily activities.

Students are more exposed to get addicted to internet games due to readily accessible gadgets and internet facility. The danger of internet gaming addiction is knocking very hard at the doors of future of children of our society. So in this context, this study has been conducted to know the prevalence of Internet gaming addiction among higher secondary school students in Jammu.

Statement of the study

"A descriptive study to assess the prevalence of Internet gaming addiction among higher secondary school students at B.S.F Senior Secondary School, Palloura , Jammu".

Objectives

1. To estimate the prevalence of Internet gaming addiction among higher secondary school students.
2. To determine the association between the prevalence of Internet gaming addiction among higher secondary school students with selected socio demographic variables.

Assumption

- Internet gaming addiction is more prevalent among Higher

*Principal, Bee Enn College of Nursing, Jammu.

secondary school students.

- Students use Internet excessively for gaming, entertainment and social networking.
- The knowledge regarding Internet gaming addiction and its consequences will be minimal among adolescents.

Delimitations

The study was limited to assess the prevalence of Internet gaming addiction among the higher secondary school students in Jammu.

The study was limited to higher secondary school students studying in BSF Senior Secondary School, Palloura, Jammu.

Methodology

Research approach: Quantitative research approach was adopted for this study.

Research design: Non experimental, descriptive research design was used in this study.

Setting: The study was conducted at BSF Senior Secondary School, Palloura, Jammu.

Accessible population: Higher secondary school students of BSF Senior Secondary School, Palloura, Jammu.

Sample and sample size: In this study, sample comprised of 100 higher secondary school students at BSF Senior Secondary School, Jammu.

Sampling technique: In this study non probability, purposive sampling technique was used to select the samples.

Criteria for sample selection

Inclusion criteria

The study included

- Students who were studying in 11th and 12th standard at BSF Senior Secondary School.
- Students who were available at the time of data collection.
- Students who were willing to participate in this study.

Exclusion criteria

The study excluded students who were not able to read or write English due to any defect.

Tool for data collection: The investigator used Pontes & Griffiths (2015) IGDS9-SF internet gaming addiction psychometric tool to assess the prevalence of Internet gaming addiction among higher secondary school students.

Description of tool

Section-A

It contains data related to demographic variables of higher secondary students such as age in years, sex, religion, type of family, area of residence, educational status of parents, occupation of the head of the family, monthly income, previous knowledge regarding internet gaming addiction and source of information.

Section – B

It consists of nine criteria regarding gaming activity behaviour among higher secondary school students. Pontes & Griffiths (2015) internet gaming disorder scale was used to diagnose internet gaming addiction among higher secondary school students.

Scoring procedure: Total scores can be obtained by summing up all responses given to all nine items of the IGDS9-SF and can range from minimum of 9 to maximum of 45 points, with higher scores being indicative of higher degree of internet gaming disorder. The items will be measured on a 5 point Likert scale from never to very often.

1- Never

2- Rarely

3- Sometime

4- Often

5- Very often

The score has been interpreted as

9-35 – No Internet Gaming Addiction

36- 45 – Internet Gaming Addiction Disorder

Pilot study The pilot study was conducted in S.D. Memorial Higher Secondary School, Karwanda, Jammu with prior permission from the authorities. Informed consent was obtained from 10 samples, who fulfilled the inclusion criteria by using purposive sampling method.

Data collection procedure: Data collection was done after getting the formal permission from the Principal of B.S.F Senior Secondary School, Palloura, Jammu. The purpose and the duration of the study were explained. The samples were selected and their consent was obtained. The study was conducted for a period of one week. The sample was selected by using non probability purposive sampling technique. Data was collected from 100 adolescents studying in 11th and 12th standard.

Data analysis and result: Descriptive and Inferential statistics were used for data analysis. The collected data was organized, tabulated and analysed by using descriptive statistics. The chi-square test was used to find out the association between demographic variables and prevalence of Internet gaming addiction.

Table 1: Frequency and percentage distribution of socio demographic variable

Demographic variables	Frequency	Percentage (%)
Age		
<16 years	14	14%
16 years	37	37%
17 years	33	33%
17 years	16	16%
Sex		
Male	60	60%
Female	40	40%
Residence		
Urban	70	70%
Rural	30	30%
Religion		
Hindu	73	73%
Muslim	10	10%
Sikh	16	16%
Christian	1	1%
Type of family		
Nuclear	71	71%
Joint	29	29%
Education status of mother		
Professional degree	14	14%
Graduate or post graduate	18	18%
Intermediate or post high school diploma	05	05%
High school certificate	41	41%
Middle school certificate	14	14%
Primary school certificate	04	04%
Illiterate	04	04%
Education status of father		
Professional degree	28	28%
Graduate or post graduate	24	24%
Intermediate or post high school diploma	07	07%
High school certificate	37	37%
Middle school certificate	04	04%
Primary school certificate	0	0%
Illiterate	0	0%
Monthly income of family in rupees		
≥52,734	32	32%
26,355-52,733	45	45%
19,759-26,354	11	11%
13,161-19,758	04	04%
7,887-13,160	04	04%
2,641-7,886	03	03%
≤2,640	01	01%
Occupation of head of family		
Professional	52	52%
Semi professional	16	16%
Clerical, shop owner/farm	09	09%
Skilled worker	16	16%
Semi skilled worker	03	03%
Unskilled worker	02	02%
Unemployed	02	02%
Do you have accessibility to mobile phone?		
Yes	67	67%
No	33	33%
How much time do you spend playing internet games		
≤1 hour	35	35%
1-2	33	33%
2-4	13	13%
≥4 hours	19	19%
Which device do you use to play games?		
Mobile phones	64	64%
laptops/personal computer	21	21%
Gaming consoles	04	04%
Others	11	11%
Do you have any previous knowledge regarding gaming addiction?		
Yes	74	74%
No	26	26%
If yes, means,source of information		
Health personnel	05	05%
School	26	26%
Mass media	36	36%
Any other	07	07%

The table 1 depicted that the sample was distributed according to socio demographic variables such as age, sex, religion, residence, type of family, educational status of father, educational status of mother, monthly income, occupational status of head of the family, accessibility to mobile phone, time duration for gaming, device use to play games, previous knowledge regarding game addiction.

Continued on page 54

Assessing knowledge of causes, management and prevention of cor pulmonale

M.Parvathamma*

Abstract: *A descriptive study was undertaken to assess the knowledge regarding causes, management and prevention of Cor pulmonale among B.Sc. (N) 3rd year students at Government College of Nursing, Kurnool. The study was conducted by Mrs. M. Parvathamma at the Government College of Nursing, Kurnool. This study was conducted as a part of curriculum and partial fulfillment of the requirement for the degree of B.Sc Nursing from the N.T.R University of Health science, Vijayawada 2005. Statement of the problem: A study to assess the knowledge regarding causes, management and prevention of Cor pulmonale among B.Sc Nursing 3rd year students at Government College of Nursing, Kurnool. The objective of study. To assess the knowledge of 3rd year students regarding causes, management and prevention of Cor pulmonale. To find out the association between the causes, management and prevention of Corpulmonale among B.Sc Nursing 3rd year students with selected demographic variables. To develop information module regarding the management and prevention of Cor pulmonale. The study was conducted in Government College of Nursing Kurnool. The population for the present study was B.Sc 3rd year students, the size of the sample was 25 for the present study a structured knowledge Questionnaire was prepared after validating its content with various experts in the filed of nursing. It is used to assess the knowledge of 3rd year B.Sc students regarding causes, management and prevention of Cor pulmonale pilot study is conducted on 5 members of 2nd year B.Sc nursing students 2YDC at Government College of Nursing, Kurnool. Pilot study results revealed that study is feasible and tools are appropriate. The main study conducted on 18 August 2005. The data is analyzed with the help of descriptive and inferential statistics. Results Sample characteristics: The present study shows that 25 (100%) students are 3rd year B.Sc nursing for 4YDC with regard to religion out of 25 students 19 (76%) students belong to Hindu, 4 (16%) belongs to Muslim, 2 (8%) students are Christians, with regarded to marital status out of 25 students 25 (100%) are unmarried. Overall finding of knowledge score revels that 24% (6) scored below average knowledge and average knowledge 68% (17) and 8% (2) students scored above average knowledge regarding causes, management and prevention of Cor pulmonale Conclusion: The findings revealed that 24 percent of students have below average knowledge, 68 percent have average level of knowledge and 8 percent have above average knowledge regarding causes, management and prevention of Cor pulmonale. So there is need to upgrade the knowledge of nursing personnel to above average, so that patients can be benefited in the hands of knowledgeable and skilled professionals.*

Cor pulmonale is a condition in which the right ventricle of heart enlarges as a result of diseases that affect the structure or function of the lung or its vasculature. Cor pulmonale develops secondary to a wide variety of cardiopulmonary disease processes. Although cor pulmonale commonly has a chronic and slow progressive course, acute onset or worsening cor pulmonale with life threatening complications also can occur.

Definitions of cor pulmonale

"Pulmonary heart disease is an alteration in the structure or function of the right ventricle resulting from disease affecting lung structure or function or its vasculature.

"Lippin Cott, 2003"

"Corpulmonale is defined as right heart failure due to disease of the lungs and pulmonary arteries. It may be acute or chronic cor pulmonale".

"Luckman & Soren Son, 2004"

"Cor pulmonale is enlargement of the right ventricle secondary to diseases of the lung, thorax or pulmonary circulation."

"Harrison, 2004"

Etiology

There are multiple factors that causes cor pulmonale or pulmonary

Professor, Yashoda College of Nursing, Saroor Nagar, Hyderabad.

heart disease. These factors are divided into the three main categories namely.

- Agent factors
- Host factors
- Environmental factors.

Agent factors

Physical agents

Dust: Dust causes infection and irritates the bronchioles which leads to cor pulmonale.

Smoking: Cigarette smoking is one of the major causes that leads to cor pulmonale and other respiratory diseases.

Foreign bodies: Aspiration of foreign bodies, vomitus or material from the upper respiratory tract causes the disease.

Pharmacological agents: Such as aspirin, non steroidal anti-inflammatory agents, hair dye,

Acid fumes: Due to inhalation of acid fumes disease like asbestos develops.

Industrial dust: Industrial dust contains cor bonmonaxide and other harmful reagents that causes the disease.

Contraceptive pills: The use of contraceptive pills leads to changes in the airway and disease due to hormones.

Host factors

Age: After the age of 45 years, cor pulmonale is the most common cardiac disorder except for coronary and hypertensive heart disease.

Sex: Most common in males than females because of exposure to smoke and hard work.

Nutrition: High salt and high cholesterol diet.

Occupation: Industrial workers, coal mines, chemical factory workers and also laboratory workers have more chance to develop the disease.

Race: Black males have more chances for the development of disease.

Habits: Like drinking alcohol, tobacco chewing, cigarette smoking produce the disease.

Environmental factors

Physical environment: Poor environmental sanitation like unsafe water, contaminated soil, poor housing, lack of disposal facilities for human excreta and solid wastes.

Biological environment: Certain rodents and animals lead to pollution of environment.

Social environment: Lack of education, poor living standards and low socio economic status predispose to disease.

Air pollution: Inhalation of polluted air with industrial dust and smoke causes the disease.

Clinical manifestations

Clinical manifestations of cor pulmonale are often observed by the signs and symptoms of underlying disease and are closely related to the pulmonary disease or disorder.

Central nervous system

• Weakness • Headache • Fatigue • Sleep apnea • Hypotension shock • Respiratory muscle fatigue.

Cardiovascular system

• Chest pain • Tachycardia and hypertension • Systolic murmurs • Mild systemic hypertension • Barrel Chest • Arrhythmia.

Respiratory system

• Hypoxaemia • Tachypnoea • Hypercapnia • Dyspnea • Cyanosis. • Cough with wheezing respirations

Gastrointestinal system

• Abdominal pain • Palpable liver • Ascitis

Circulatory system

•Haemoptysis •Peripheral cyanosis •Ankle edema

Renal system

• Low urine output • Peripheral edema

Integumentary system:

• Sweating • Clubbing of fingers

Pathophysiology: Pulmonary disease produces pathophysiologic changes that affect the heart and causes the right ventricle to enlarge and eventually fail. Any condition that deprives the lungs of oxygen causes hypoxaemia and hypercapnia, resulting in ventilatory insufficiency.

Hypoxaemia and hypercapnia causes pulmonary arterial vasoconstriction and possibly reduction of the pulmonary vascular bed, as in case of emphysema and pulmonary emboli that leads to increased resistance in the pulmonary circulatory system, with a subsequent rise in pulmonary blood pressure of 45 mm Hg or more.

In cor pulmonale right ventricular hypertrophy results from pulmonary hypertension that causes the right side of the heart to enlarge because of the increased work required to pump blood against high resistance through the pulmonary vascular system.

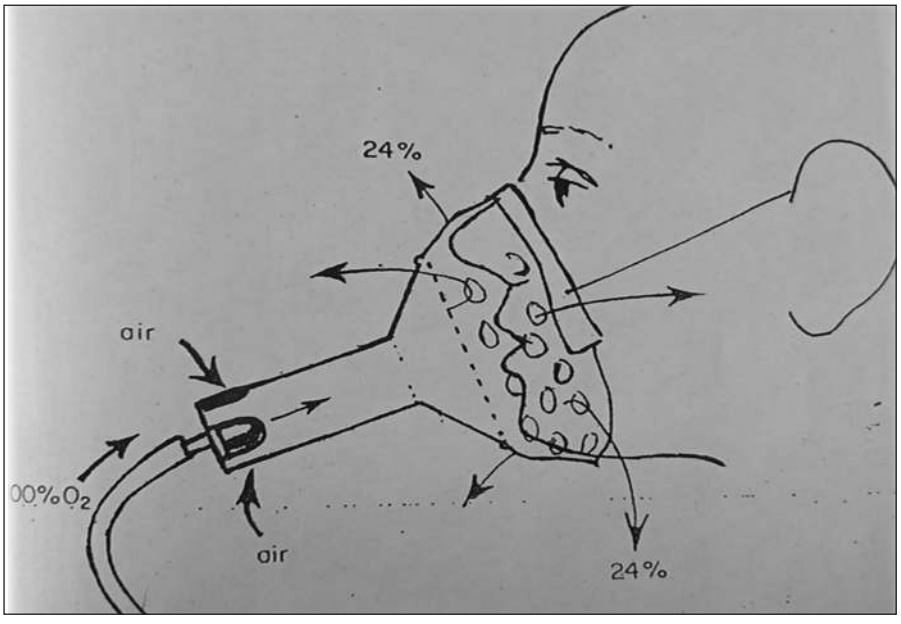
Medical management

The aim of medical management is to reduce the pulmonary hyperten-

sion and to treat the COPD.

The medical management of cor pulmonale:

1. Oxygen administration as stated for a minimum period of 12-18 hours per day in control manner as ordered.
2. Digitalis: e.g: Digoxin. Dose: 0.25-1.5mg daily.
3. Diuretics. e.g: Frusemide. Dose: Tab. 40mg. Inj. 20mg.
4. Broncho dilators. e.g: Theophyllin. Dose: 80-240mg tid.
5. Beta-Adrenergic antagonists. e.g: Propranolol. Dose: 10-40mg. 6. Vasodilators. Eg: Nifedipine. Dose: 30-60mg.
6. Corticosteroids. e.g: Prednisolone. Dose: Tab. 5-60mg. Inj. 25-100m
7. Postural drainage.



Oxygen administration-controlled low concentration

(Ventimask Mk. 1', Vickers Medical shown above; other masks employing the same principle are available). Suitable for patients with impaired ventilatory drive. Unsuitable for patients with arterial hypoxaemia in other situations.

A low concentration of oxygen is produced by the oxygen-driven air-entraining venturi and a high flow rate is maintained through the mask so that no room air or exhaled air is inspired. Note that masks are available which produce other higher concentrations (24 per cent, 28 per cent and 35 per cent).

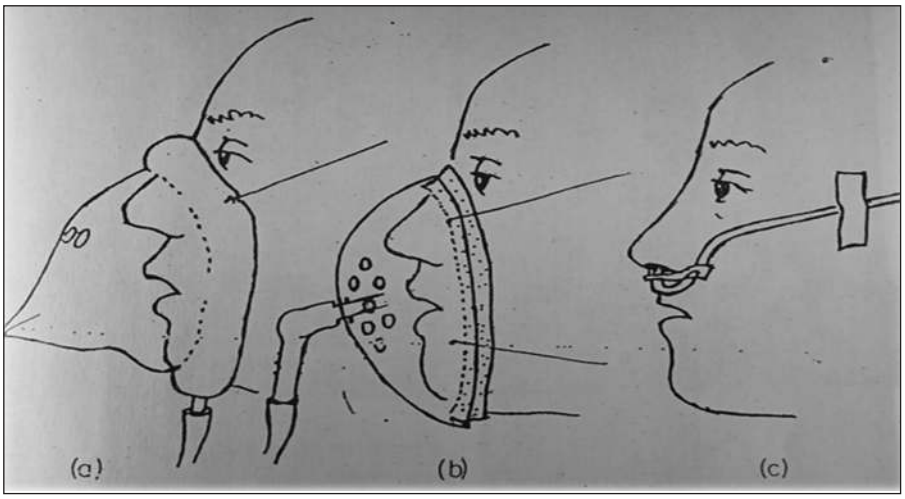
(a) Pneumask; (b) MC mask (Henleys Medical Supplies Ltd). These masks car deliver the equivalent of an inspired concentration of 40 to 60 per cent dependin on oxygen flow rate and a number of other factors. (c) Nasal catheters. A shor catheter is situated in each nostril penetrating only as far as the anterior nares.

Prevention

Levels of prevention

- Primordial prevention.
- Primary prevention
- Secondary prevention
- Tertiary prevention

Primordial prevention:



Oxygen administration-high concentration. For patients with good ventilatory drive

- In primordial prevention, health education is given to the patients to prevent the occurrence of disease. First obtain the history of the patient including his lifestyle, smoking, alcoholism, economic status.
- Teach the patients and family members about importance of cor pulmonale, reduction of salt in diet, avoidance of smoking, wearing of masks while working in chemical industries or while making beedi etc.
- Advise periodical check up of health.

Primary prevention

Primary prevention is an action taken prior to the onset of disease, which includes 1. Health promotion 2 Specific protection.

At this level protect the health by

following preventive measures.

- If the patient has history of smoking, explain the effect of cigarette smoking and advise to stop smoking.
- To the patients who have history of allergy to the particular substance like house dust, pet animals, specific foods, should be advised to avoid contact or exposure with that particular allergic agent.
- To the patients who can not avoid exposure to that particular allergic agents (for example occupational workers, laboratory, workers. farmers) are instructed to take specific protective measures like wearing of masks, gloves etc.
- People must be educated regarding advantages of control measures along with importance of maintenance of healthy living environment.
- Teach about importance of immunization schedule to children to protect them from diseases like measles and tuberculosis.
- Advise to take immediate and necessary measures for treating upper respiratory tract infections.
- Advise to do moderate exercises, avoid emotional stress.

Secondary prevention

- Secondary prevention is an action which halts or slows the progress of a disease and its incipient stage and prevents complications. It includes 1) Early diagnosis, 2) Prompt treatment.
- By routine blood examination elevated serum levels and case finding programmes are to be carried out to detect disease prognosis.
- Sputum examination and radiological tests are helpful to identify the lung diseases and to put the patient on correct treatment.
- By use of correct drugs and regular check-ups complications are prevented.

Diet

- Nutrition as a component of health promotion has become the focus of considerable attention and publicity.
- Some persons are allowed to eat regular diet but are told to eat in moderate, because large meals increase the work of heart during the process of digestion.
- If the person is over weight a controlled fat diet and a medium restricted diet be ordered
- Explain to the patient about the diet restriction and its importance.
- Explain to take the food in adequate amount but avoid large meals and hurrying while eating
- Demonstrate how to prepare acceptable meals plan.
- Teach to avoid high fatty foods and restrict caffeine-containing beverages.

Activity

Instruct the patient regarding activities that are appropriate to regain and maintain good health in order to participate in activities of daily living

- Emphasize to adopt work simplification techniques so that energy expenditure is reduced.
- Instruct alternate activity with rest period.
- Advise daily walk including distance and time as prescribed. Teach to monitor pulse during physical activities until the maximum level of activity is attained.
- Encourage to participate in activities of daily living.
- Inform to do simple exercises and participate indoor games

Tertiary prevention

Tertiary prevention includes a) Health supervision, b) Vocational rehabilitation.

Health supervision

- Continuous health supervision, including periodical medical check-up and guidance in the home setting is carried out by community health nurse.
- The community health nurse supervises and gives necessary suggestions concerning modification of physical facilities in the home that will reduce the patient's energy expenditure and also assist the family in planning to implement required nursing care.
- She also assess the patient's response to medical regimen and clarifies the doubts regarding prescribed therapies.

Vocational rehabilitation

- When the person with cardiac transplantation is ready to return to work, the health service, should provide discharge instructions booklet regarding the limitations of activity performance.
- Most are allowed to return to work because the financial strain placed on the family is great.
- Every effort should be made to evaluate patient condition and to place him in a position where he will be employed within his limitations.

Complications

- Acute respiratory failure.
- Chronic respiratory failure.
- Pulmonary hypoventilation
- Right side heart failure.
- Infections.
- Hepatic enlargement
- Dysrhythmias.

Prognosis

- Prognosis is good in case of early

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Standards of psychiatry nursing

Nagothu Vijaya Prasanthi*

The phases of the nursing process is described by the Standards of Practice in Psychiatric–Mental Health Nursing: Scope and Standards of Practice are assessment, diagnosis, outcomes identification, planning, implementation, and evaluation.

Validation is part of each step, and all phases may overlap or occur simultaneously. The nursing conditions related to each of these phases are shown in. Each of these phases, as it applies to psychiatric nursing practice, is now described.

Standards of practice

1. Standard 1: Assessment
2. Standard 2: Diagnosis
3. Standard 3: Outcome identification
4. Standard 4: Planning
5. Standard 5: Implementation

   Standard 5A: Coordination of care

   Standard 5B: Health teaching and health promotion

   Standard 5C: Milieu therapy

   Standard 5D: Pharmacological, biological, and integrative therapies

   Advance Practice Interventions 5E to 5G

   Standard 5E: Prescriptive Authority and treatment

   Standard 5F: Psychotherapy

   Standard 5G: Consultation
6. Standard 6:Evaluation
7. Standard 7:Quality of practice
8. Standard 8:Education
9. Standard 9:Professional Practice Evaluation
10. Standard 10: Collegiality
11. Standard 11: Collaboration
12. Standard 12: Ethics
13. Standard 13: Research
14. Standard 14. Resource Utilization
15. Standard 15: Leadership

Standard 1: Assessment

The psychiatric–mental health registered nurse collects comprehensive health data that are pertinent to the patient's health or situation. A systematic, dynamic process by which the nurse, through interaction with the patient, significant others, and health care provides collectives & analyses data about the patient. Data may include the following dimensions – physical, psychological, socio-cultural, spiritual, cognitive functional abilities, developmental, economic and life style

Rationale

The assessment interview, which requires linguistically and culturally effective communication skills, interviewing, behavioral observation, record review, and comprehensive assessment of the patient and relevant systems, enables the psychiatric–mental health nurse to make sound clinical judgments and plan appropriate interventions with the patient.

Key elements

Identify the patient's reason for seeking help. Assess for risk factors related to the patient's safety, including potential for the following:

• Suicide or self-harm • Assault or violence • Substance abuse withdrawal • Allergic reaction or adverse drug reaction • Seizure • Falls or accidents • Elopement (if hospitalized) • Physiological instability •Complete a biopsychosocial assessment of patient needs related to this treatment encounter, including the following: •Patient and family appraisal of health and illness •Previous episodes of psychiatric care in self and family •Current medications •Physiological coping responses •Mental status coping responses • Coping resources, including motivation for treatment and functional • Supportive relationships • Adaptive and maladaptive coping mechanisms • Psycho-

Lecturer

social and environmental problems • Global assessment of functioning • Knowledge, strengths, and deficits.

In the assessment phase, information is obtained from the patient in a direct and structured manner through observations, interviews, and examinations. The nurse also should use the most appropriate behavioral rating scales. These can help define current pretreatment aspects of the patient's problems, increase the patient's involvement in treatment, document the patient's progress over time and the efficacy of the treatment plan, and compare the patient's responses with those of groups of people with the same illness. This information can help formulate diagnoses and treatment plans, as well as document clinical outcomes of care.

Interviewing is a goal-directed method of communication

It is required in a formal admission procedure and should be focused but open ended, progressing from general to specific and allowing spontaneous patient self-expression. The nurse's role is to maintain the flow of the interview and to listen to the verbal and nonverbal messages conveyed by the patient. Nurses also must be aware of their responses to the patient.

Although the patient should be regarded as the primary source of validation, the nurse should be prepared to talk with family members or other people knowledgeable about the patient. This is particularly important when the patient is unable to provide reliable information because of the symptoms of the psychiatric illness.

The nurse also might consider using a variety of other information sources, including the patient's healthcare record, nursing rounds, change-of-shift reports, nursing care plan, and evaluation by other health professionals, such as psychologists, social workers, or psychiatrists.

Standard 2: Diagnosis

The psychiatric–mental health registered nurse analyzes the assessment data to determine diagnoses or problems, including level of risk.

" Nursing diagnosis are clinical judgments about individual, family or community responses to actual are potential health problems/life processes. A nursing diagnosis provides the basis for selection of nursing intervention to achieve outcomes for which the nurse is accountable" NANDA-2005

Rationale

The basis for providing psychiatric–mental health nursing care is the recognition and identification of patterns of response to actual or potential psychiatric illnesses, mental health problems, and potential co morbid physical illnesses.

Key points: Diagnoses should reflect adaptive and maladaptive coping responses based on nursing frameworks such as those of NANDA International (NANDA-I). Diagnoses should incorporate health problems or disease states such as those identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association [APA],2000) and the International Classification of Diseases and Related Health Problems (World Health Organization [WHO], 1992). Diagnoses should focus on the phenomena of concern to psychiatric– mental health nurses

Structural parts: A nursing diagnosis has 3 structural components:

Problem (unmet need)

Etiology (probable cause)

Supporting data (signs and symptoms)

Problem: Problems are unmet needs describe the state of the patient at present. Problems that are within the nurse's domain to treat are termed as Nursing Diagnoses. The nursing diagnosis title states that what should change.For example - Hopelessness

Etiology: Etiology or probable cause is linked to the diagnostic title with the words ' related to' .Stating the etiology/probable cause tells what needs to be addressed to effect the change and identifies causes the nurse can treat through nursing interventions. For example- hopelessness related to multiple losses.

Supporting data: Supporting data or signs or symptoms state what the condition is like at present. It may be linked to the diagnosis and etiology with the words 'As evidenced by'.

Supporting data (defining characteristics) that validate the diagnosis includes:- the patients statement e.g. it's no use, nothing will change.

Lack of involvement with family and friends.

Lack of motivation to care for self or environment.

A complete nursing diagnosis must be hopelessness related to multiple losses, as evidenced by lack of motivation to care for self.

Format of nursing diagnosis: Two –part statements

Risk problem

Part 1-Nursing diagnosis risk for other directed violence

Part 2-Risk factors • History of violence •Hyperactivity secondary to manic stage •Low impulse control

Three-part statements • Actual problem • Part 1-Nursing diagnosis • Post trauma syndrome.

Part 2-Etiologic factors (related to)
• ·Overwhelming anxiety secondary to: 1.Rape or assault 2. Catastrophic illness 3. Disasters 4. War.

Part 3 - Defining characteristics
• Re experience of traumatic event
• Repetitive dreams or nightmares
• Excess verbalization of traumatic event

Risk diagnoses

" Problems at risk for becoming actual"

A risk diagnosis refers to an individual's vulnerable health status. It means that a person is exposed to factors that increase chance of injury or illness. If the risk is not addressed by the preventable efforts of the nurse the potential problems may become actual, and an actual diagnosis will replace the risk diagnosis.

There are no defining characteristics in a risk diagnosis as the actual problem has not been manifested. Thus a risk diagnosis has two-part statement and an actual diagnosis has three-part statement.

Examples of a risk diagnosis

Part 1-nursing diagnosis-risk for constipation Part 2-Risk factors-

Tricyclic antidepressant medications

Refusal to drink water, juice.

Guidelines for health promotion/wellness dignosis

"Readiness for enhanced level of functioning"

A wellness diagnosis is a clinical judgment about an individual, family, community in transition from one level of wellness to a higher level. Most wellness diagnosis are one part statement .Examples are "Readiness for enhanced communication".

Phenomena of concern for psychiatric mental health nurse:

- Promotion of optimal mental and physical health and wellbeing and prevention of mental illness.
- Impaired ability to function related to psychiatric, emotional,and physiological distress.
- Alterations in thinking, perceiving, and communicating because of psychiatric disorders or mental health problems.
- Behaviors and mental states that indicate potential danger to self or others.
- Emotional stress related to illness, pain, disability, and loss.
- Symptom management, side effects to toxicities associated with self-administered drugs, psychopharmacological intervention, and other treatment modalities.
- The barriers to treatment efficacy and recovery posed by alcohol and substance abuse and dependence.
- Self-concept and body image changes, developmental issues, life process changes, and end-of-life issues.
- Physical symptoms that occur along with altered psychological status.
- Psychological symptoms that occur along with altered physiological status.
- Interpersonal, organizational, socio cultural, spiritual, or environmental.
- Circumstances or events that have an effect on the mental and emotional well-being of the individual and family or community.
- Elements of recovery, including the ability to maintain housing, employment, and social support, that help individuals reengage in seeking meaningful lives.
- Societal factors such as violence, poverty, and substance abuse

Standard 3: Outcomes Identification

The psychiatric–mental health registered nurse identifies expected outcomes for a plan individualized to the patient or to the situation.

Rationale

Within the context of providing nursing care, the ultimate goal is to influence mental health outcomes and improve the patient's health status.

Key elements

- Outcomes should be mutually identified with the patient.
- Outcomes should be identified as clearly and objectively as possible.
- Well-written outcomes help nurses determine the effectiveness and efficiency of their interventions.
- Before defining expected outcomes, the nurse must realize that patients often seek treatment with goals of their own.

Patient outcomes may include relieving symptoms or improving functional ability

Sometimes a patient cannot identify specific goals or may describe them in general terms. Translating nonspecific concerns into specific goal statements is not easy. The nurse must understand the patient's coping responses and the factors that influence them.

The patient may view a personal problem as someone else's behavior

This may be the case of a father who brings his adolescent son in for counseling. The father may view the son as the problem, whereas the adolescent may feel his only problem is his father. One approach to this situation is to focus help on the person who brought the problem into treat-

ment because he "owns" the problem at that moment. The nurse might suggest, "Let's talk about how I could help you deal with your son. A change in your response might lead to a change in his behavior also."

The patient may express a problem as a feeling, such as "I'm lonely" or "I'm so unhappy"

Besides trying to help the patient clarify the feeling, the nurse might ask, "What could you do to make yourself feel less alone and more loved by others?" This helps patients see the connection among their actions, thoughts, and feelings and increase their sense of responsibility for themselves.

The patient's problem may be one of lacking a goal or an idea of exactly what is desired from life

In this case it might be helpful for the nurse to point out that values and goals are not magically discovered but must be created by people for themselves. The patient can then actively explore ways to construct goals or adopt the objectives of a social, service, religious, or political group with whom the patient identifies.

The patient's problem may be a choice conflict

This is especially common if all the choices are unpleasant, unacceptable, or unrealistic. An example is a couple who wants to divorce but does not want to see their child hurt or suffer the financial hardship that would result. Although undesirable choices cannot be made desirable, the nurse can help patients use the problem-solving process to identify the full range of alternatives available to them.

The patient's goals may be inappropriate, undesirable, or unclear. However, the solution is not for the nurse to impose goals on the patient. Even if the patient's desires seem to be against self-interests, the most the nurse can do is reflect the patient's behavior and its consequences. If the patient then asks for help in setting new goals, the nurse can help.

Mutually identifying goals and expected outcomes is an essential step in the therapeutic process.

Expected outcomes can be documented using standardized classification systems, such as the Nursing Outcomes Classification (NOC) (Moorhead et al,2008). Long- and short-term goals should contribute to the expected outcomes. Following is a sample expected outcomeand long- and short-term goals:

Expected outcome: Patient will be socially engaged in the community.

Long-term goal: The patient will travel about the community independently within 2 months.

Short-term goals:

At the end of 1 week, the patient will sit on the front steps at home.

At the end of 2 weeks, the patient will walk to the corner and back home.

At the end of 3 weeks, the patient, accompanied by the nurse, will walk in the neighborhood.

At the end of 4 weeks, the patient will walk in the neighborhood alone.

At the end of 6 weeks, the patient will drive her car in the neighborhood.

At the end of 8 weeks, the patient will drive to the mall and meet a friend for dinner.

In writing goals, psychiatric nurses should remember that they can be classified into the "ABCs," or three domains, of knowledge:

Affective (feeling)

Behavioral (psychomotor)

Cognitive (thinking)

Correctly identifying the domain of the expected outcome is very important in planning nursing interventions. Some psychiatric nurses place all their emphasis on outcomes related to learning new information (cognitive). They forget about the equally important needs of patients to acquire new values (affective) and to master new skills (behavior).

Finally, it is important to explore with the patient the cost/ benefit effect of all identified goals, that is, what is being given up (cost) versus what is being gained (benefit) from attaining the goal. This can be thought of as exploring advantages, or positive effects, and disadvantages, or negative effects

Patients are not likely to commit themselves to a goal or to work toward attaining a goal if the stakes are too high or the payoffs too low.

Standard 4: Planning

The psychiatric–mental health registered nurse develops a plan that prescribes strategies and alternatives to attain expected patient outcomes.

Planning phase consists of the total planning of the patients overall treatment to achieve quality outcomes in a safe, effective, timely manner. Nursing interventions with rationales are selected in the planning phase based on the client's identified risk factors and defining characteristics.

The process of planning includes

- Collaboration by the nurse with patients, significant others, and treatment team members

- Identification of priorities of care.
- Critical decisions regarding the use of psychotherapeutic principles and practices
- Coordination and delegation of responsibilities according to the treatment team's expertise as it relates to client needs.

Rationale

A plan of care is used to guide therapeutic interventions systematically, document progress, and achieve the expected patient outcomes.

Key elements

- The plan of nursing care must always be individualized for the patient.
- Planned interventions should be based on current evidence in the field and contemporary clinical psychiatric–mental health nursing practice.
- Planning is done in collaboration with the patient, the family, and the health care team.
- Documentation of the plan of care is an essential nursing activity

One of the most important tasks for the nurse and patient is to assign priorities to the goals. Those goals related to protecting the patient from self-destructive impulses always receive top priority. Because the nursing care plan is dynamic, priorities are constantly changing.

If the focus is always on the patient's behavioral responses, priorities can be modified as the patient changes. If the goal answers the question of what, the plan of care answers the questions of how and why. Once again, the patient's active involvement leads to a more successful care plan.

After writing a tentative care plan, the nurse must validate this plan with the patient. This communicates to the patient a sense of self-responsibility for getting well. The patient can tell the nurse that the proposed plan is unrealistic based on financial status, lifestyle, value system, culture or, perhaps, personal preference. Usually several approaches to a patient's problem are possible. Choosing the one most acceptable to the patient improves the chances for success. Failure to reach a goal through one plan can lead to the decision to adopt a new approach or re-evaluate the goal.

The joint Commission (TJC) standards specify that the nursing plan of care must contain the six elements. They are

Essential elements of the nursing plan of care

1. Initial assessment and reassessment.
2. Nursing diagnosis or patient's care needs.
3. Interventions identified to meet the patient's nursing care needs
4. Nursing care provided.
5. Patient's response to and the outcomes of the nursing care provided.
6. Ability of the patient or significant others to manage continuing care needs after discharge.

Standard 5: Implementation

The psychiatric–mental health registered nurse implements the identified plan. Nursing interventions (also known as nursing orders or nursing prescriptions) are critical action components of the implementation phase and are the most powerful pieces of the nursing process. They make up the management and treatment approach to an identified health problem. Interventions are selected to achieve patients outcomes and to prevent or reduce problems.

Rationale

In implementing the plan of care, psychiatric–mental health nurses use a wide range of interventions designed to prevent mental and physical illness and to promote, maintain, and restore mental and physical health. Psychiatric–mental health nurses select interventions according to their level of practice.

At the basic level nurses may select counseling, milieu therapy, promotion of self-care activities, intake screening and evaluation, psychobiological interventions, health teaching, case management, health promotion and health maintenance, crisis intervention, community-based care, psychiatric home health care, telehealth, and a variety of other approaches to meet the mental health needs of patients.

In addition to the intervention options available to the basic level psychiatric–mental health nurse, at the advanced level the advanced practice registered nurse in psychiatric–mental health (APRN-PMH) may provide consultation, engage in psychotherapy, and prescribe pharmacological agents were permitted by state statutes or regulations.

Key elements

Nursing interventions should reflect a holistic, biopsychosocial approach to patient care. Nursing interventions are implemented in a safe, efficient, and caring. The level at which a nurse functions and the interventions implemented are based on the nursing practice acts in one's state, the nurse's qualifications (including education, experience, and certification), the caregiving setting, and the nurse's initiative.

Standard 5 a: Coordination of care

The psychiatric–mental health registered nurse coordinates care delivery.

Continued on page 37

Nightingale Institute of Nursing, Noida

Farewell and Get Together

Farewell and get together was organized by the students of GNM 2nd year under the guidance and support of Prof Lavanya Nandan, Director/Principal, Nightingale Institute of Nursing, and coordinated by Ms. Reena and Ms. Jaimika, Lecturers.

The programme started with the warm welcome address and felicitation of revered guests with flower bouquet by the students of GNM 2nd Year. On the occasion, choir group of GNM 1st year presented a heart warming prayer to give a perfect start to the program followed by a mesmerizing welcome dance performed by students group from GNM 2nd year.

Prof Lavanya Nandan, addressed the group and motivated the students to follow their dreams and to be more disciplined and humble as their seniors. Students from GNM 1st year gave a marvelous dance performance.

Mr. Ashok Jain Chairman, Nightingale Institute of Nursing, encouraged both students who were leaving the institute and the freshers who have joined.

The students of M.Sc. 1st year and P.B.B.SC 1st Year walked upon the stage and gave their introduction. Mrs. Tanvi Jain, Board member motivated the students in her speech to accept the future challenges.

Student of GNM 1st year gave an amazing dance

performance. To explain the real meaning of friendship a small video was presented for GNM 3rd year students followed by an electrifying dance performance was performed by the students of GNM 2nd year.

The students of GNM 3rd year walked down the aisle and were presented with a memento as token of love.

To keep the audience entertained the students of GNM 2nd year performed a dance.

To bring the memories of GNM 3rd year together, a memory video presentation was done by their juniors. Winners of Miss and Mr. Nightingale were announced from all three batches that is M.Sc, P.B.B.Sc and GNM 3rd year and were congratulated and awarded by Principal.

The programme came to an end with a vote of thanks proposed by student of GNM 2nd year.

Nightingale Institute of Nursing receives certificate of excellence, declared Mentor Institute by UP Govt

Nightingale Institute of Nursing, Noida received a Certificate of Excellence 'in recognition of maintaining the remarkable quality of Nursing Education'. The Institute was also declared Mentor Institute 'for other mentee institutes in the state to guide them in their development '.

The certificate and award were received by the Chairman of Nightingale Education Society ,Mr .Ashok Jain from the Chief Minister of UP ,Mr. Yogi Adityanath at a function held in Lucknow on October 8,2022.

Speaking on the occasion, the CM said nursing and paramedical sectors were the 'backbone' of the healthcare system and evergreen area for providing employment.

Launching the Mission Niramayah, the CM said this is one field which always remains in demand. Serving people right from their birth to death, these areas offer a chance to serve society while being a means of respect and self reliance.

Comparing the demand in the nursing and paramedical sector these days with the scenario in the 90s, the CM said there is no dearth of qualified and committed persons in the area.

Under the Mission, a series of reforms are being implemented to improve quality in nursing and paramedical education.

The reforms include a through assessment of existing nursing and paramedical colleges with the help of Quality Council of India besides initiating steps like building a mentor-mentee relationship between old colleges with the new ones, maintaining ideal student-teacher ratio, ensuring their attendance through biometric system, conducting free and fair examination and focus on practical rather than theoretical understanding of the subject.

Deputy CM Mr. Brajesh Pathak

Deputy CM Brajesh Pathak said Mission Niramayah would prove to be a game-changer in the field.

Mr. Pathak said the UP Government will soon recruit 52,000 nursing and paramedical staff to strengthen the healthcare facility. He said the vacancies will be advertised soon and most of the recruitment will be done by the UP Public Service Commission.

These nurses and paramedics will be deployed in government hospitals and medical institutions across the State. He also spoke about the UP Health Department's tie-up with the Board of Secondary Education to make the students aware about careers in nursing and paramedical streams.

Mr. Mayankeshwar Sharan Singh, State Ministers for Parliamentary Affairs, Medical Education, Medical and Health, Family Welfare, Mother and Child Welfare was also present on the occasion.

Mr. Mayankeshwar Sharan Singh

Speaking on the occasion, Chief Secretary Mr. Durga Shankar Mishra said Mission Niramayah would help us to get excellent nurses and paramedical staff.


Mr. Durga Shankar Mishra (IAS)

Principal Secretary Medical Education, Mr. Alok Kumar said while the number of medical seats in the State have doubled in the past five years, the corresponding seats for nurses and paramedical staff has not.


Mr. Alok Kumar (IAS)

Workshop on nursing

UP Government and UP State Medical faculty organised a workshop on October 8,2022 to appreciate the factors to enhance the quality of nursing education in Uttar Pradesh.The workshop was attended by Principals of Nursing schools and Nursing colleges , nursing educators, faculty members and owners of different nursing institutions.

During the sessions , groups were formed and topics were discussed to enrich the quality of nursing education, recruitment and retaining of nursing faculty, enhancing best clinical experience for nursing students. The topics focused on uplifting and enhancing the nursing standards and quality to the best level. During brainstorming, ideas were presented by the various groups to emphasise on improving the nursing education process and elevate the nursing skills.

The ideas that were illustrated by different members enabled the group to understand and work with enthusiasm and passion for present and future nursing. The end of the session was represented by executive members by using the Fish bone analysis method to categorize the issues and factors affecting the quality of nursing education in the state of Uttar Pradesh. The proceedings of the workshop were summarized by enumerating various solutions to enhance standards in nursing and paramedics education in the state of Uttar Pradesh.

Director/Principal, Lavanya Nandan and others

Prof. Lavanya Nandan, Director/Principal of Nightingale Institute of Nursing and Ms.Sushma Sharma, HOD, HR and Admin attended the workshop on behalf of the Institute.

The following institutions have been declared as Mentor Institutes:

1. **Nightingale Institute of Nursing - Noida**
2. **Guru Gorakshnath Institute of Nursing – Gorakhpur**
3. **Ruhelkhand College of Nursing - Bareilly**
4. **U.P.U.M.S Institute of Nursing – Saifai, Etawah**
5. **Sharda Institute of Nursing – G.B. Nagar**
6. **Baba Institute of Nursing – Lucknow**
7. **J.S.V.M College of Nursing – Kanpur**
8. **L.L.R.M Nursing Institute – Meerut**
9. **S.D.P.M College of Nursing – Gonda**
10. **Subharti University – Meerut**
11. **I.I.M.T College of Nurisng – Meerut**
12. **Hillary Clinton Nursing Institute - Saharanpur**

Nightingale Institute of Nursing, Noida

Nutrition Week

A nutritious diet protects one from chronic illness and leads towards a happy and long life. National Nutrition Week is celebrated from 1st to 7th September every year which aims at promoting the importance of a well-balanced diet, replete with all the necessary nutrients that our body requires for various functions and for the overall health. The theme of 2022 is "Celebrate a World of Flavours."

World Nutrition Day was celebrated at Nightingale Institute of Nursing, on September 22, organized by the students of BSc 1st year, G.N.M 1st year, and P.B.B.Sc. 1st year under the guidance and support of Prof. Lavanya Nandan, Director/Principal.

The event started in the morning with a warm welcome to all the dignitaries: Mr. Ashok Jain, Chairman, Nightingale Institute of Nursing, Prof. Lavanya Nandan, Director/Principal, Mrs. Sushma Sharma, HOD/ HR Admin, faculty members and students.

The students were very enthusiastic and full of energy while preparing the food in the nutrition lab as per the requirement of various groups like diet for preschoolers, diet during pregnancy etc.

Students also prepared charts, menus, decorated their respective stations and made it very eye catching. All the dignitaries visited the stations where the students spoke about the diet that they had prepared. ■

Audiovisual Exhibition

Audiovisual (AV) exhibition was organised in Nightingale Institute of Nursing, for MSc 1st year and GNM 3rd year students on September 22, 2022 under the guidance of Prof. Lavanya Nandan Director/ Principal and coordinated by Ms. Nishtha Thakur, Assistant Professor and Ms Ananya Sharma, Lecturer.

The dignitaries Prof. Lavanya Nandan, Mrs Sushma Sharma, HOD/HR Admin inaugurated the exhibition and were welcomed by a student of MSc 1st year Ms Jyotsna.

The students have prepared different types of AV AIDS such as PPT, OHP, Charts, Cartoon, working and non-working Models, puppets, flannel Boards, etc to enhance the depth of understanding of the students regarding use of Audio-Visual aids.

MSc 1st year and GNM 3rd year students explained the principles, uses, application and importance of AV aids. Principal along with the faculty members visited each

station and witnessed the AV aids prepared by the students. First year students of B.Sc (N) and GNM also visited the stations and witnessed the exhibition. Stimulating and enthusiastic words were shared by Prof. Lavanya Nandan, Director/Principal. The exhibition came to an end with a vote of thanks by a student. ■

Standards of psychiatry nursing

Continued from page 32

Measurement criteria

The psychiatric mental health registered nurse coordinates implementation of the plan and documents the coordination of care.

Additional Measurement Criteria for Psychiatric Mental Health Advanced Practice Registered Nurse:

Provides leadership in the coordination of multidisciplinary health care for integrated delivery of patient care services. Synthesizes data and information to prescribe necessary system and community support measures, including environmental modifications. Coordinates system and community resources that enhance delivery of care across continuums. Assists patients in getting financial assistance as needed to maintain appropriate care.

Standard 5b: Health Teaching and Health Promotion

The psychiatric–mental health registered nurse employs strategies to promote health and a safe environment.

Rationale

The psychiatric mental health registered nurse, through health teaching, promotes the patient's personal and social integration and assists the patient in achieving satisfying, productive, and health patterns of living.

Measurement criteria

The psychiatric mental health registered nurse:

- Uses health promotion and health teaching methods appropriate to the situation, patient's developmental level, learning needs, readiness, ability to learn, language preference and culture.
- Provides health teaching related to the patient's needs and situation that may include, but is not limited to, mental health problems and psychiatric disorders, treatment regimen, coping skills, relapse prevention, self-care activities, resources, conflict management, problem-solving skills, stress management and relaxation techniques, and crisis management. .
- Integrates current knowledge and research regarding psychotherapeutic educational strategies and content.
- Engages consumer alliances and advocacy groups, as appropriate in health teaching and health promotion activities.
- Identifies community resources to assist consumers in using prevention and mental health care services appropriately.
- Seeks opportunities for feedback and evaluation of the effectiveness of strategies utilized.
- Provides anticipatory guidance to individuals and families to promote mental health and to prevent or reduce the risk of psychiatric disorders.

Standard 5c: Milieu Therapy

The psychiatric–mental health registered nurse provides structures, and maintains a safe and therapeutic environment in collaboration with patients, families, and other health care clinicians.

Rationale

The therapeutic environment consists of the physical environment, social structures, and the philosophy of care and treatment that provides safety at points of crisis and supports the patient's ability to use new adaptive coping strategies and available resources.

Measurement Criteria

The psychiatric mental health registered nurse:

- Orients the patient and family to the care environment including the physical environment, the roles of different health care team providers in their care, how to be involved in the treatment and care delivery processes, schedules of events pertinent to their care and treatment, and expectations regarding behaviors.
- Orients the patient to their rights and responsibilities particular to the treatment or care environment.
- Conducts ongoing assessments of the patient in relationship to the environment to guide nursing interventions in maintaining a safe environment and patient safety.
- Selects specific activities that meet the patient's physical and mental health needs for meaningful participation in the milieu and promoting personal growth.
- Ensures that the patient is treated in the least restrictive environment necessary to maintain the safety of the patient and others.
- Informs the patient in a culturally competent manner about the need for the limits and the conditions necessary to remove the restrictions.

Standard 5d: Pharmacological, biological, and integrative therapies

The psychiatric–mental health registered nurse incorporates knowledge of pharmacological, biological, and complementary interventions with applied clinical skills to restore

the patient's health and prevent further disability.

Measurement Criteria

The psychiatric mental health registered nurse:

- Applies current research findings to guide nursing actions related to pharmacology, other biological therapies, and complementary therapies.
- Assesses patient's response to biological interventions based on current knowledge of pharmacological agents' intended actions, interactive effects, potential untoward effects and therapeutic doses.
- Includes health teaching for medication management to support patients in managing their own medications, and adherence to prescribed regimen.
- Educates on information about mechanism of action, intended effects, potential adverse effects of the proposed prescription, ways to cope with transitional side effects and other treatment options, including no treatment.
- Directs interventions toward alleviating untoward effects of biological interventions.
- Communicates observations about the patient's response to biological interventions and to other health clinicians.

Standard 5e: Prescriptive authority and treatment

The psychiatric–mental health advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations

Measurement criteria

The Advanced Practice Registered Nurse (APRN)

- Conducts a thorough assessment of past medical trials, side effects, efficacy and patient preference.
- Prescribes or recommends pharmacological agents based on research evidence and knowledge of psychopathology, neurobiology, physiology, expected therapeutic actions, anticipated side effects and courses of action.
- Prescribes or recommends psychotropic and related medications based on clinical indicators of patient status. Assesses a reasoned balance of risk and benefits, including results of diagnostic and lab tests as appropriate, to treat symptoms of psychiatric disorders and improve functional status
- Provides health teaching about mechanism of action, intended effects, potential adverse effects of the proposed prescription, ways to cope with transitional side effects and other treatment options, including no treatment.
- Educates and assists the patient in selecting the appropriate use of complementary and alternative therapies.
- Evaluates therapeutic and potential adverse effects of pharmacological and non pharmacological treatments.
- Evaluates pharmacological outcomes by utilizing standard symptom measurements and patient report to determine efficacy.
- Adjusts medications based on continual monitoring in collaboration with patient.

Standard 5f: Psychotherapy

The psychiatric–mental health advanced practice registered nurse conducts individual, couples, group, and family psychotherapy using evidence-based psychotherapeutic frameworks and nurse-patient therapeutic relationships.

The APRN

Uses knowledge of personality theory, growth and development, psychology, neurobiology, psychopathology, social systems small-group and family dynamics stress and adaptation, and theories and best available research evidence to select therapeutic methods based on the patient's needs.

Structures the therapeutic contract to include, but not limited to:

- Purpose, goals, and expected outcomes
- Time, place and frequency of therapy
- Participants involved in therapy
- Confidentiality and appropriate written release of information
- Availability and means of contacting therapist
- Responsibilities of both patient and therapist
- Fees and payment schedule
- Cancellations/alteration in schedule policy
- Utilizes interventions that promote mutual trust to build a therapeutic treatment alliance.
- Empowers patients to be active participants in treatment.
- Applies therapeutic communication strategies based on theories and research evidence to reduce emotional distress, facilitate cognitive and behavioral change and foster personal growth.
- Uses self-awareness of emotional reactions and behavioral responses to others to enhance the therapeutic alliance.
- Analyzes the impact of duty to report and other advocacy actions on the therapeutic alliance.
- Arranges for the provision of care in the therapist's absence.
- Apply ethical and legal principles to the treatment of patients with mental health problems and psychiatric disorders.
- Makes referrals when it is determined that the patient will benefit from a transition of care or consultation due to change in

clinical condition.

- Evaluates effectiveness of interventions is relation to outcomes using standardized methods as appropriate.
- Monitors outcomes of therapy and adjusts plan of care when indicated.
- Therapeutically concludes the nurse-patient relationship and transitions the patient to other levels of care, when appropriate.
- Identifies and maintains professional boundaries to preserve the integrity of the therapeutic process.

Standard 5g: Consultation

The psychiatric–mental health advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of other clinicians to provide services for patients, and effect change.

The standards of practice for implementation are detailed and explicit. The standards identify the range of activities psychiatric nurses. Implementation is the actual delivery of nursing care to the patient and the patient's response to that care.

Nursing interventions should be based on evidence of the effectiveness of the treatment. The use of a standardized classification system of interventions that nurses perform, such as the Nursing Interventions Classification (NIC) (Bulechek et al, 2008), is useful for clinical documentation, communication of care across settings, integration of data across systems, effectiveness research, productivity measurement competency evaluation, and reimbursement.

The psychiatric nurse helps the psychiatric patient do two things: Develop insight and change behavior. These two areas for nursing intervention correspond with the responsive and action dimensions of the nurse–patient relationship.

Insight is the patient's development of new emotional and cognitive understandings. However, knowing something on an intellectual level does not necessarily lead to a change in behavior. Another step is needed. Patients must decide whether they will continue to use maladaptive coping mechanisms or adopt new, adaptive, and constructive approaches to life.

The first step in helping a patient translate insight into action is to build incentives to abandon old, maladaptive patterns of behavior. The nurse should help the patient see the negative consequences of current actions and that they do more harm than good. The patient will not learn new patterns until the motivation to change is greater than the motivation to stay the same. This is the idea behind motivational interviewing.

The nurse should encourage the patient's desires for mental health, emotional growth, and freedom from suffering. The nurse also should continue to motivate and support patients as they test new, adaptive behaviors and coping mechanisms. Many of the patient's maladaptive patterns have built up over years.

The nurse cannot expect the patients to change them in a matter of days or weeks. The nurse must help the patient evaluate these new patterns, integrate them into life experiences, and practice problem solving to prepare for future experiences.

A final issue for the psychiatric nurse to consider in the implementation process is that there are four possible treatment stages

1.Crisis

2.Acute

3.Maintenance

4.Health promotion

Standard 6: Evaluation

The psychiatric–mental health registered nurse evaluates progress toward attainment of expected outcomes.

Rationale

Nursing care is a dynamic process involving change in the patient's health status over time, giving rise to the need for data, different diagnoses, and modifications in the plan of care. Therefore, evaluation is a continuous process of appraising the effect of nursing and the treatment regimen on the patient's health status and expected outcomes.

Key elements

- Evaluation is an ongoing process.
- Patient and family participation in evaluation is essential.
- Goal achievement should be documented and revisions in the plan of care should be implemented as appropriate.

Evaluation is a mutual process based on the patient's and family's previously identified goals and their satisfaction with the processes and outcomes of care. Patients, families, and psychiatric nurses often have different views of treatment and the effectiveness of care. It is therefore critical that psychiatric nurses have a systematic and objective way to learn from patients and families which aspects of the nursing care provided were helpful and what additional nursing actions may have further helped them.

Often, progress with psychiatric patients is slow and occurs in small steps rather than dramatic leaps. Realizing that progress has been made can produce growth and inspire new hope in both the patient

and the nurse.

Standards of professional performance: The conditions and behaviors relate to each standard of professional performance. The Standards of professional performance apply to self-definition, self-regulation, accountability, and autonomy for practice by psychiatric nurses, both individually and as a group.

Standard 7: Quality of practice

The psychiatric–mental health registered nurse systematically enhances the quality and effectiveness of nursing practice.

Rationale

The dynamic nature of the mental health care environment and the growing body of psychiatric nursing knowledge and research provide both the impetus and the means for the psychiatric–mental health nurse to be competent in clinical practice, to continue to develop professionally, and to improve the quality of patient care.

Key elements

The nurse should be open to critically analyzing the caregiving process.

The patient and family should be partners with the nurse in the evaluation of care activities.

Improving the quality of care provided goes beyond discussion and analysis to actually implementing actions that will improve practice.

Psychiatric nurses participate in the organizational evaluation of overall patterns of care through a variety of quality improvement or process improvement activities. In these activities, the focus is not on the nurse but on the patient, the overall program of care, and health-related outcomes of care. Specific objectives include the following:

- Continuous improvement of customer satisfaction
- Continuous improvement of patient outcomes
- Efficient use of resources
- Adherence to professional and regulatory standards

Standard 8: Education

The psychiatric–mental health registered nurse attains knowledge and competency that reflect current nursing practice.

Rationale

The rapid expansion of knowledge pertaining to basic and behavioral sciences, technology, information systems, and research requires a commitment to learning throughout the psychiatric–mental health nurse's professional career. Formal education, continuing education, independent learning activities, and experiential and other learning activities are some of the means the psychiatric–mental health nurse uses to enhance nursing expertise and advance the profession.

Key elements

- Professional learning should be regarded as a lifelong process.
- The nurse should pursue a variety of educational opportunities.
- New knowledge should be translated into professional nursing practice.

Psychiatric nurses are expected to engage in a continuous learning process to keep up with emerging knowledge.

They may do this in the following ways:

- Formal educational programs
- Continuing education programs
- Independent learning activities
- Lectures, conferences, and workshops
- Credentialing
- Certification

Reading journals and textbooks and collaborating with colleagues are other important ways to remain current with expanding areas of knowledge. Journals that relate to psychiatric nursing practice include

- Archives of Psychiatric Nursing,
- Journal of the American Psychiatric Nurses Association,
- Journal of Psychosocial Nursing,
- Journal of Child and Adolescent Psychiatric Nursing,
- Issues in Mental Health Nursing,
- Perspectives in Psychiatric Care.

A major resource for psychiatric nurses is the Internet, which allows nurses access to information around the globe.

Standard 9: Professional practice evaluation

The psychiatric–mental health registered nurse evaluates one's own practice in relation to the professional practice standards and guidelines and relevant statutes, rules, and regulations.

Rationale

The psychiatric–mental health nurse is accountable to the public for providing competent clinical care and has inherent responsibility as a professional to evaluate the role and performance of psychiatric– mental health nursing practice according to standards established by the profession.

Key elements

- Supervision should be viewed as an essential and ongoing aspect of one's professional life.
- The nurse should strive to grow and develop professional knowl-

edge, skills, and expertise.

Professional practice evaluation for the psychiatric nurse is generally provided in two ways:

- Administrative
- Clinical.

Administrative performance appraisal involves the review, management, and regulation of competent psychiatric nursing practice. It involves a supervisory relationship in which a nurse's work performance is compared with role expectations in a formal way, such as in a nurse's annual performance evaluation. Administrative performance evaluations should identify areas of competency and areas for improvement.

Clinical performance appraisal is guidance provided through a mentoring relationship and clinical supervision with a more experienced, skilled, and educated nurse. Clinical supervision is a support mechanism for practicing professionals within which they can share clinical, organizational, developmental, and emotional experiences with another professional in a secure, confidential environment to enhance knowledge and skills.

Psychiatric nurses are aware of the need for ongoing mentorship to improve their nursing practice. Clinical supervision reviews one's clinical care and also can serve as a support system for the nurse.

In many ways the process of supervision parallels the nurse patient relationship. Both involve a learning process that takes place in the context of a meaningful relationship that facilitates positive change. Self-exploration is a critical element of both. The supervisor should provide the same responsive and action dimensions present in the nurse–patient relationship to help supervised nurses be most effective.

The common types of supervision are as follows:

- Dyadic, or one-on-one supervision, in which the supervisor meets individually with the nurse being supervised.
- Group supervision, in which several supervised nurses meet for a shared session with the supervisory nurse.
- Peer review, in which nurses meet with nurse colleagues without a supervisor to evaluate their clinical practice.

All have the same purpose of exploring problem areas and maximizing the strengths of those being supervised. Despite its intensity, supervision is not therapy. The essential difference between the two is a difference of purpose. The goal of supervision is to teach psychotherapeutic skills. The goal of therapy is to change a person's way of coping to help the person to function more effectively. Supervision or consultation is necessary for the practicing psychiatric nurse. Although it is essential for novices, it is equally important for experienced practitioners. Finally, supervision is only as helpful as the skill of the supervisor, the openness of the supervised nurse, and the motivation of both to learn and grow.

Standard 10: Collegiality

The psychiatric–mental health registered nurse interacts with and contributes to the professional development of peers and colleagues.

Rationale

The psychiatric–mental health nurse is responsible for sharing knowledge, research, and clinical information with colleagues, through formal and informal teaching methods, to enhance professional growth.

Key elements

The nurse should regard other nurses as colleagues and partners in care giving. Mentorship within nursing is important both to nurses as individuals and to the nursing profession as a whole.

Collegiality requires that nurses view their nurse peers as collaborators in the care giving process who are valued and respected for their unique contributions, regardless of educational, experiential, or specialty background. It suggests that nurses view themselves as members of an organized professional group or unit and that nurses trust, support, and demonstrate commitment to other nurses.

Nurses need to work together as colleagues to blend their various skills and abilities in creating a better health care system and enhancing the quality and quantity of psychiatric nursing services provided. One way to do this is for psychiatric nurses to join a professional nursing organization.

The largest psychiatric nursing organization that is open to nursing students and psychiatric nurses of all educational and experiential backgrounds is the American Psychiatric Nurses Association (APNA). Information about joining is available on their website: www.apna.org.

Standard 11: Collaboration

The psychiatric–mental health registered nurse collaborates with patients, family, and others in the conduct of nursing practice.

Rationale

- Psychiatric–mental health nursing practice requires a coordinated, ongoing interaction between consumers and clinicians to deliver comprehensive services to the patient and the community.
- Through the collaborative process, different abilities of health care clinicians are used to identify problems, communicate, plan and implement inter-

ventions, and evaluate mental health services.

Key elements

- Respect for other grows out of respect for self.
- Nurses should be able to clearly articulate their professional abilities and areas of expertise to others.
- Collaboration involves the ability to negotiate and formulate new solutions with others.

Collaboration is the shared planning, decision making, problem solving, goal setting, and assumption of responsibilities by individuals who work together cooperatively and with open communication. Three key ingredients are needed for collaboration:

1. Active and assertive contributions from each person
2. Receptivity and respect for each person's contribution
3. Negotiations that build on the contributions of each person to form a new way of conceptualizing the problem

Psychiatric nurses have many potential collaborators, including patients and families, interdisciplinary colleagues, and nursing peers Each of these groups allows the psychiatric nurse an opportunity to solve problems in new ways and thus better plan and implement nursing care.

Most organized mental health settings use an interdisciplinary or interprofessional team approach, which requires highly coordinated and often interdependent planning based on the separate and distinct roles of each team member.

It is important for nurses to maintain their professional identity and integrity when they collaborate with other professionals. Within the health care setting, psychiatric nurses must determine whether they as a group are ready to engage in collaborative practice. Questions that should be considered include the following:

- Can psychiatric nurses define, describe, and appropriately defend psychiatric nursing roles and functions?
- Is the psychiatric nursing leadership ready for collegial practice?
- Are psychiatric nursing roles and functions appropriate for nurses' education, experience, and expertise?
- Is nurse staffing appropriate in numbers, patterns, and ratios?
- Are the other disciplines prepared for and supportive of collaboration?
- Is the organizational climate conducive to collaboration?

Collaborative relationships for psychiatric nurses

Standard 12: Ethics

The psychiatric–mental health registered nurse integrates ethical provisions in all areas of practice.

Rationale

The public's trust and its right to humane psychiatric–mental health care are upheld by professional nursing practice. Ethical standards describe a code of behavior to guide professional practice. People with psychiatric– mental health needs are an especially vulnerable population. The foundation of psychiatric–mental health nursing practice is the development of a therapeutic relationship with the patient. Boundaries need to be established to safeguard the patient's well-being.

Key elements

- Nurses should be sensitive to the social, moral, and ethical environment in which they practice.
- Patient and family advocacy is a core aspect of nursing practice.
- Ethical conduct is essential to the nurse–patient relationship.

Ethical considerations combined with legal and therapeutic issues to affect all aspects of psychiatric nursing practice. The American Nurses Association (2001) has a code of ethics for nurses. It emphasizes that the nurse's primary commitment is to the patient and expands the ethical perspective of nurses to include the health care system and duties of the nurse to oneself.

The ANA House of Delegates approved these nine provisions of the new Code of Ethics for Nurses at its June 30, 2001 meeting in Washington, DC. In July, 2001, the Congress of Nursing Practice and Economics voted to accept the new language of the interpretive statements resulting in a fully approved revised Code of Ethics for Nurses With Interpretive Statements.

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks

consistent with the nurse's obligation to provide optimum patient care.

5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.

7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

Standard 13: Research

The psychiatric–mental health registered nurse integrates research findings into practice.

Rationale

Nurses in psychiatric–mental health nursing are responsible for contributing to the further development of the field of mental health by participating in research. At the basic level of practice, the psychiatric–mental health nurse uses research findings to improve clinical care and identifies clinical problems for research study. At the advanced level, the psychiatric–mental health nurse engages and/or collaborates with others in the research process to discover, examine, and test knowledge, theories, and creative approaches to practice.

Key elements

- Research links nursing theory and practice and is essential to the development of a profession.
- Outcome research helps to establish the value of nursing in an era health care reform.

The progression of observing from practice, theorizing, testing in research, and modifying practice is an essential part of psychiatric nursing. The clinical problems are many, and as nurses gain the skills and experience to validate their work scientifically, they can make a significant contribution to psychiatric theory and practice through research actively involving consumers and families in psychiatric research which can improve the quality of research and clinical outcomes. In this process the role of the nurse is one of patient advocate and educator.

Standard 14: Resource utilization

The psychiatric–mental health registered nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

Rationale

The patient is entitled to psychiatric–mental health care that is safe, effective, and affordable. As the cost of health care increases, treatment decisions must be made in such a way as to maximize resources and maintain quality of care. The psychiatric–mental health nurse seeks to provide cost-effective, quality care by using the most appropriate resources and delegating care to the most appropriate, qualified health care clinician.

Key elements

Nurses play a critical role in integrating and coordinating health care services.Nurses should be fiscally accountable for the care they provide. Resources should be allocated based on cost/benefit analyses and documented expected outcomes.

Resource use is one of the most important aspects of psychiatric nursing practice. Discussing the costs and benefits of treatment options with patients, families, providers, and reimburses is an essential part of the professional psychiatric nursing role.

To meet this performance standard, psychiatric nurses need to request and obtain both cost and outcome information related to tests, consultations, evaluations, therapies, and continuum of care alternatives. Nurses need to assume an active role in questioning, advising, and advocating for the most cost-effective use of resources.

Standard 15: Leadership

The psychiatric–mental health registered nurse provides leadership in the professional practice setting and the profession.

Rationale

Psychiatric nurses have a responsibility to demonstrate leadership by working for greater professional accountability and autonomy for nurses through a negotiated process with their peers, other health care providers, administrators, consumers, and society at large, with the ultimate goal of improving patient

care.

Key elements

- An inherent part of nurses' role should be focused on the growth and success of their profession, their peers, and the care provided in their practice setting.
- Mentorship and team building are skills to be cultivated.
- Advocacy and participation in key governance groups are the best way to effect change.

The standard of leadership is one of the most important, since it requires psychiatric nurses to think beyond their immediate care giving responsibilities to the way in which they can impact the broader health care environment. Their interactions with other nurses and providers, health care administrators, and the public define them and reflect on their profession.

Nurses who have a positive regard for themselves, their knowledge, and their skills will reach out to mentor and teach others, including new nursing students, trainees, and professional colleagues. They will be open to new ideas and see every problem as an opportunity for new learning.

They also will understand that true change comes about through active participation on influential committees, boards, and decision-making bodies. They will therefore be both active and proactive in sharing their understandings challenging existing ways of thinking, and demonstrating leadership on behalf of their profession and the patients whom they serve.

References

1. Elizabeth.M .Varcarolis; Foundations Of Psychiatric Mental Health Nursing;Saunders Publications ;6th Edition
2. Mary. C. Townsend; Concepts Of Care In Evidence Based Practise; Jaypee Publications; Fifth Edition page no;
3. Katherine .M.Fortinash, Patricia A.Holoday Worret; Psychiatric Mental Health Nursing; Mosby Publications; 3rd Edition; Page
4. K.P Neeraja;Essentials Of Mental Health And Psychiatric Nursing Vol-1;Jaypee publications ; 3rd edition
5. Neeraja Ahuja;Textbook Of Postgraduate Psychiatry; Jaypee Publications;3rd edition;
6. Gail W Staurt , Principles and pra ctice of psychiatric nursing, 10th edition Mosby Publications,

Teach your children by what you are, not just by what you say.
Jane Revell & Susan Norman

Teachers should guide without dictating, and participate without dominating.
C.B. Neblette

Effectiveness of cardiac rehabilitation programme during first phase to assess knowledge and practice among patients with myocardial infarction

Sunitha Begum R.*

Abstract: *Cardiac rehabilitation programme (CRP) is the process by which a person who has Myocardial infarction is encouraged to achieve their full potential health. The study was aimed to find out the effectiveness of Cardiac Rehabilitation Program (CRP) during phase I to assess the knowledge and practice among patients with Myocardial Infarction (MI). A quantitative, evaluative research approach with pre experimental one group pre test post test design was adopted. By using non probability convenient sampling technique, 30 subjects were selected from ICU. Tools used for data collection were structured knowledge questionnaire to assess the knowledge and self reported checklist to assess the practice. In pre test demographic variable and study variables were assessed. Cardiac rehabilitation program phase I was administered on day 2 in ICU and on day 6 in ward, for a period of 30 minutes by lecture cum discussion and demonstration method .CRP phase I included meaning, definition, components of CRP and its explanation. Followed by CRP phase I , Post test conducted On day 4 in ICU for the practice of CRP phase I , on day 8 in ward to assess the knowledge and practice of CRP phase I. The findings showed that the post- test mean score of knowledge and practice of CRP phase I is higher than the pre- test mean score. The calculated paired 't' test result for knowledge was 16.4 and for practice in ICU was 16 and in ward was 10.8 is higher than the table value 2.05 at p<0.05 level of significant. There was no significant association between the mean pre-test knowledge score on cardiac rehabilitation program during first phase among samples with their selected demographic variables (age, gender, educational status and hereditary). Hence the Cardiac Rehabilitation Program was effective to increase the knowledge and practice on cardiac rehabilitation phase I .*

Keywords: Effectiveness , cardiac rehabilitation phase I , practice.

Cardiac rehabilitation program has become recognised as a significant component in the continuum of care for person with MI. Cardiac rehabilitation program aims to optimize risk reduction, foster healthy behaviour and reduce disability and promote an active life style of patients with cardiovascular disease. AHA and AACVPR, (2000).

Statement

A study to evaluate the effectiveness of cardiac rehabilitation programme during first phase to assess knowledge and practice among patients with myocardial infarction in ICU .

Objectives

1 To prepare and validate the cardiac rehabilitation program phase I for patients with Myocardial Infarction.

2 To assess and compare the pre-test and post test knowledge score on cardiac rehabilitation program phase I among patients with Myocardial Infarction.

3 To assess and compare the pre-test and post test practice score on cardiac rehabilitation program Phase I among patients with Myocardial Infarction.

4 To find association between pre test level of knowledge score on cardiac rehabilitation program Phase I with their selected demographic variables (age, gender, education and hereditary).

Hypotheses

H_1: The mean post test knowledge score on cardiac rehabilitation program phase I is higher than the mean pre test knowledge score among samples.

H_2: The mean post test practice score on cardiac rehabilitation program phase I is higher than the mean pre test practice score among samples.

H_2 (a) : The mean post test practice

**HOD, Medical Surgical Nursing Dept, Mahendra College of Nursing, Salem.*

score on cardiac rehabilitation program phase I in ICU.

H_2 (b) : The mean post test practice score on cardiac rehabilitation program phase I in ward.

H_3: There is a significant association between the pre test level of knowledge score on cardiac rehabilitation program phase I among samples with their selected demographic variables **H3 (a)** -age, **H3 (b)** -gender, **H3 (c)** -education and **H3 (d)** -hereditary).

Operational definitions

Effectiveness: In the study, the effectiveness is the gained knowledge followed by the teaching program to the desired change brought or difference in the knowledge and practice measured by score level obtained in post test .

Knowledge on CRP phase I : The information known by the samples about cardiac rehabilitation program phase I for MI.

Practice on CRP phase I : It refers to the performance of the patients with myocardial infarction about cardiac rehabilitation to reduce the further risk of MI and promote cardiac health. It is assessed by using self reported check list both in ICU and ward.

Cardiac rehabilitation program (CRP)phase I for MI : It is a multi dimensional program assisting for the patients with Myocardial Infarction (MI) to reduce the future risk through prescribed exercise, education, life style modification and counselling related to phase I. It comments the period from patients get admitted in the ICU and shifted to ward till discharge. During this phase samples receive information about the recovery process to promote cardiac health and reduce further risk of cardiovascular disease.

Myocardial infarction (MI) / Heart attack: It means diagnosis confirmed by the cardiologist for the samples through diagnostics studies (ECG, troponin I).

Research approach: A quantitative evaluative research approach is considered as the best to evaluate the effectiveness of CRP among samples.

Research design: The research design adopted for present study is pre-experimental one group pre-test post-test design.

Description of variables under study

Independent variable: In this study independent variable refers to the teaching on cardiac rehabilitation program phase I for patients with MI.

Dependent variable: In this study dependent variable refers to knowledge and practice score on CRP phase I among patients with MI .

Extraneous variable: The extraneous variable in this study refers to the selected demographic variables such as age, gender and educational status of the samples.

Sample: In this study samples were patients with MI on phase I undergoing treatment in hospital, who fulfil the eligibility criteria during the period of study.

Sampling technique and sample: In this study non probability convenience sampling technique was used. The sample size was 30 patients with MI.

Findings

Demographic variables

The demographic variables used for the present study were age in years, gender, educational status, hereditary, modifiable and non modifiable risk factor and dietary pattern. The analysis of the study shows that, among samples most of them were 46-55 years (47%), males, 26% had secondary education and 53% had no hereditary of MI. Regarding modifiable and non modifiable risk factor maximum samples were present under the risk factor of smoking and age. Most of the samples were non vegetarians. Association significant was done with selected demographic variables like age, gender, educational status and hereditary. That found to be not significant association with pre test knowledge score on CRP phase I.

The following diagram represents the level of pre-test and post-test knowledge score on cardiac rehabilitation programme phase I among samples.

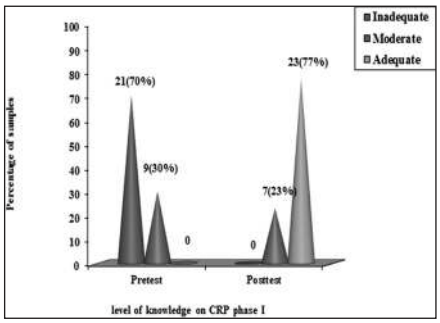

Fig- 1: Cone diagram on the level of pre-test and post-test knowledge score on cardiac rehabilitation program phase I among samples.

The mean percentage post-test knowledge score on cardiac rehabilitation phase I was 77% which is higher than the mean percentage pre-test knowledge score 70%. The paired 't' value was 16.4 and table value was 2.05 was significant at $p<0.05$ level.

The mean percentage post-test practice score on cardiac rehabilitation phase I was 100% both in ICU and ward. It was higher than the mean percentage pre-test practice score was 67% in ICU, 93% in ward. The paired 't' value was 16 in ICU and 10.8 in ward, table value was 2.05 was significant at $p<0.05$ level.

Table-1: Comparison of mean, standard deviation, range and mean score percentage, paired mean difference and paired 't' value of pre-test and post-test practice score on cardiac rehabilitation program on phase I among samples in ICU and Ward

n=30

Variable	Pre test					Post test				Difference in mean %	Paired 't' value
	Max	Mean	SD	Range	Mean %	Mean	SD	Range	Mean %		
Practice regarding CRP of phase I in ICU	15	11.1	1.2	9 -14	74	14.6	1.16	11- 15	97	23%	16*
Practice regarding CRP of phase I in ward	15	13	0.96	11-14	87%	14.8	0.4	14 -15	99	12%	10.8*

*Significant P<0.05 Level; Table Value=2.05; df= 29

Table-2: Chi-square value of the pre test level of knowledge score on cardiac rehabilitation program phase I among samples with their selected demographic variables

n=30

Demographic variable	Chi-square value	Df	P<0.05 level
Age	1.71 (N.S)	4	9.49*
Gender	1.70 (N.S)	2	5.99*
Education	13 (N.S)	10	18.31*
Hereditary	0.40 (N.S)	2	5.99*

*Significant P<0.05 Level; Table Value=2.05; df= 29

The association of mean pre-test knowledge score with selected demographic variables, age $x^2 = 1.71$ is less than the table value 9.49 and for the gender $x^2 = 1.70$ is less than the table value 5.99 , for the educational status $x^2 = 13$ is less than the table value 18.31 were for the hereditary $x^2 = 0.04$ is less than the table value 5.99. which indicates that there is no significant association between pre-test knowledge score on cardiac rehabilitation phase I among samples and their selected demographic variables.

Discussion

The study findings are supported by the following study, Dusseldorp, et.al, (1999), Linden, et.al, (1996), Heller, et.al. (1993),

Oldridge, et.al, (1988). Cardiac rehabilitation (CR) is proven benefit to people who have suffered with myocardial infarction, resulting in reduced morbidity and mortality. Heran BS, et.al, (2011) this study proven exercise-based cardiac rehabilitation to reduce the mortality, morbidity and health-related quality of life of patients with CHD. The present study shows that the level of knowledge and practice of cardiac rehabilitation program phase I among patients with MI found to be effective and useful . x^2

Implications

Nursing practice: The nurse plays a vital role in health care delivery system and emphasises more on self reliance and encourages patients to participate in health care system.

Nurse plays important role in educating the public and brings awareness towards importance of early CRP to save the patients from future complications.

Nursing education: The nursing curriculum should emphasize on imparting knowledge of health information to the care givers and public. They need to identify aspect of nursing care which was lacking and provide supportive education to prevent reoccurrence of MI.

Nursing administration: Nurse administrators should plan and organize continuing supportive education by conducting program to the primary care givers on home care management of cardiac rehabilitation after myocardial infarction. The nurse administrator should plan the activity in collaboration with other agencies in imparting normal life to the community.

Nursing research: Research is the strong foundation of evidence based nursing practice. This study help the nurse researcher for development of nursing care guide and material for cardiac rehabilitation among MI.

Limitations

(1) The sample size was small, so generalization is not possible.

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Applications of Self – Care Deficit Theory in Nursing

Pudota Anthony Lourdu Mary*

Dorothea Elizabeth Orem is one of the America's foremost nursing theorists and was born in Baltimore, Maryland. Orem began her nursing career at Providence Hospital School of Nursing in Washington, DC and also received diploma of nursing in early 1930s. She received a B.S.N.E from the Catholic University of America in 1939 and received her M.S.N.E .

During her professional career, she worked as staff nurse, private duty nurse, nurse educator and administrator and nursing consultant. She received honorary Doctor of Science degree in 1976·

Dorothea Orem, as a member of a curriculum subcommittee at Catholic University, recognized the need to continue in developing a conceptualization of nursing. She published first formal articulation of her ideas in nursing: Concepts of Practice in 1971, second in 1980, and finally in 1995.

Development of Theory

During 1949-1957 Orem worked for the Division of Hospital and Institutional Services of the Indiana State Board of Health. Her goal was to upgrade the quality of nursing in general hospitals throughout the state. During this time she developed her definition of nursing practice.

In the years of 1958-1960 she worked with Department of Health, Education and Welfare where she published "Guidelines for Developing Curricula for the Education of Practical Nurses" in 1959. Orem subsequently served as acting dean of the school of Nursing and as an assistant professor of nursing education at CUA.

She continued to develop her concept of nursing and self care during this time. Orem's nursing: Concept of Practice was first published in 1971 and subsequently in 1980, 1985, 1991, 1995, and 2001.Continues to develop her theory after her retirement in 1984.

Definitions of domain concepts

The definitions of main domain concepts in theory as given by Orem are:

Nursing is art, a helping service, and a technology. These are actions deliberately selected and performed by nurses to help individuals or groups under their care to maintain or change conditions in themselves or their environments and encompasses the patient's perspective of health condition ,the physician's perspective , and the nursing perspective.

Goal of nursing is to render the patient or members of his family capable of meeting the patient's self care needs that are:

- To maintain a state of health.
- To regain normal or near normal state of health in the event of disease or injury.
- To stabilize, control, or minimize the effects of chronic poor health or disability

Health and healthy are terms used to describe living things. It is when they are structurally and functionally whole or sound wholeness or integrity. includes that which makes a person human, operating in conjunction with physiological and psycho physiological mechanisms and a material structure and in relation to and interacting with other human beings.

Environment: Environment components are environmental factors, environmental elements, conditions, and developmental environment.

Human being has the capacity to reflect, symbolize and use symbols. Conceptualized as a total being with universal, developmental needs and capable of continuous self care.

A unity that can function biologically, symbolically and socially.

Nursing patient: A human being who has "health related /health derived limitations that render him incapable of continuous self care or dependent care or limitations that result in ineffective / incomplete care.

Principal of St.Mary's School of Nursing, Varanasi, U.P.

A human being is the focus of nursing only when a self –care requisites exceeds self care capabilities

Nursing problem: Deficits in universal, developmental, and health derived or health related conditions.

Nursing process: A system to determine (1) why a person is under care (2)a plan for care, (3) the implementation of care.

Nursing therapeutics: Deliberate, systematic and purposeful action.

Orem's general theory of nursing

Orem's general theory of nursing in three related parts:

- Theory of self care
- Theory of self care deficit
- Theory of nursing systems

Theory of self care

The practice of activities that maturing and mature persons initiate to perform within time frames, on their own and in interest of maintaining life and healthful functioning and continuing personal development and well being.

Self care agency: Is a human ability which is "the ability for engaging in self care" and conditioned by age developmental state, life experience, sociocultural orientation health and available resources·

Therapeutic self care demand: "Totality of self care actions to be performed for some duration in order to meet self care requisites by using valid methods and related sets of operations and actions "

Self care requisites: A formulated and expressed insight about actions to be performed that are known or hypothesized to be necessary in the regulation of an aspect(s) of human functioning and development, either continuously or under specified conditions and circumstances.

Categories of self care requisites are

- Universal
- Developmental
- Health deviation

Universal self care requisities

Universally required goals are to be met through self care or dependent care have their origin in what is validated or what is in the process of being validated about human structure l and functional integrity at various stages of the life cycle.

These associated with life processes and the maintenance of the integrity of human structure and functioning and common to all (ADL)

Orem identifies these requisites as:

- Maintenance of sufficient intake of air ,water, food.
- Provision of care assoc with elimination process.
- Balance between activity and rest, between solitude and social interaction.
- Prevention of hazards to human life well being and.
- Promotion of human functioning and development within social groups in accordance with human potential, human limitations and desire to be normal.

Develpomant self care requisites

Develpoment self care requisites promote processes for life and maturation and prevent conditions delirious to maturation or those that mitigate those effects.

Associated with developmental processes/ derived from a condition Or associated with an event e.g. adjusting to a new job, adjusting to body changes.

Health deviation self-care requisites

These self care requisites are required in conditions of illness, injury, or disease. These include:--

- Seeking and securing appropriate medical assistance.
- Being aware of and attending to the effects and results of pathologic conditions.
- Effectively carrying out medically prescribed measures.
- Modifying self concepts in accepting oneself as being in a particular state of health and in specific forms of health care.
- Learning to live with effects of pathologic conditions.

Theory of self care deficit

The central idea of the theory of self care deficit is that requirements of persons for nursing are associated with the subjectivity of mature and maturing persons to health related action limitation.

Self care deficit is the term that expresses the relation between the action capabilities of individuals and their demands for self care.

Theory of self care specifies when nursing is needed. Nursing is required when an adult (or in the case of a dependent, the parent) is incapable or limited in the provision of continuous effective self care.

Orem identifies 5 methods of helping:--

- Acting for and doing for others
- Guiding others
- Supporting anothers
- Providing an environment promoting personal development in relation to meet future demands

- Teaching another

Theory of nursing systems

It describes how the patient's self care needs will be met by the nurse , the patient, or both.

The theory of nursing systems purposes that nursing is human action, nursing systems are action systems formed by nurses through the exercise of their nursing agency for persons with health deviated or health associated limitations in self care.

Orem identifies 3 classifications of nursing system to meet the self care requisites of the patient:-

- Wholly compensatory system
- Partly compensatory system
- Supportive – educative system

Design and elements of nursing system define:

- Scope of nursing responsibility in health care situations
- General and specific roles of nurses and patients
- Reasons for nurses' relationship with patients and
- The kinds of actions to be performed and the performance patterns and nurses' and patients' actions in regulating patients' self care agency and in meeting their self care demand.

Orem recognized that specialized technologies are usually developed by members of the health profession which is a systematized information about a process or a method for affecting some desired result through deliberate practical endeavour, with or without use of materials or instruments.

Categories of technologies

- Communication adjusted to age, health status
- Maintaining interpersonal ,intragroup or intergroup relations for coordination of efforts
- Maintaining therapeutic relationship in light of psychosocial modes of functioning in health and disease
- Giving human assistance adapted to human needs ,action abilities and limitations
- Regulatory technologies
- Maintaining and promoting life processes
- Regulating psycho physiological modes of functioning in health and disease
- Promoting human growth and development
- Regulating position and movement in space

Major assumtons

Assumptions basic to the general theory were formalized in the early 1970s and were first presented at Marquette University School of Nursing in 1973.

Orem identifies the five premises underlying the general theory of nursing:

1. Human beings require continuous, deliberate inputs to themselves and their environments to remain alive and function in accordance with natural human endowments.
2. Human agency, the power to act deliberately, is exercised in form of care for self and others in identifying needs and making input needs.
3. Mature human beings experience privations in the form of limitations of action in care for self and others involving and making of life sustaining and function regulation inputs.
4. Human agency is exercised in discovering, developing and transmitting ways and means to identify needs and inputs of self and others.
5. Groups of human beings with structured relationships cluster tasks and allocate responsibilities for providing care to group members who experience privations for making required, deliberate inputs to self and others.

Orem's work and the characterictics of a theory

- Theories can interrelate concepts in such a way as to create a different way of looking at a particular phenomenon
- Theories must be logical in nature
- Theories must be relatively simple yet generalizable
- Theories are the basis for hypothesis that can be tested
- Theories contribute to and assist in increasing the general body of knowledge within the discipline through the research implemented to validate them
- Theories can be used by the practitioners to guide and improve their practice
- Theories must be consistent with other validated theories, laws and principles

Theory testing

- Orem's theory has been used as the basis for the development of research instruments to assist researchers in using the theory.
- A self care questionnaire was developed and tested by Moore (1995) for the special purpose of measuring the self care practice of children and adolescents.
- The theory has been used as a conceptual framework in assoc. degree programs (Fenner 1979) also in many nursing schools.

Orem's theory and nursing process

Orem's approach to the nursing process presents a method to determine the self care deficits and then to define the role of person or nurse to meet the self care demands. The steps within the approach are considered to be the technical component of the nursing process.

Orem emphasizes that the technological component "must be coordinated with interpersonal and social processes within nursing situations.

Comparison of Orem's nursing Process and the Nursing Process

Nursing Process

- Assessment
- Nursing diagnosis
- Plans with scientific rationale
- Implementation
- Evaluation

Orem's nursing process

- Diagnosis and prescription; determine why nursing is needed. analyze and interpret –make judgment regarding care
- Design of a nursing system and plan for delivery of care
- Production and management of nursing systems

Step 1-Collect data in six areas

- The person's health status
- The physician's perspective of the person's health status
- The person's perspective of his or her health
- The health goals within the context of life history ,life style, and health status
- The person's requirements for self care
- The person's capacity to perform self care

Step 2

Nurse designs a system that is wholly or partly compensatory or supportive-educative.

The 2 actions are

Bringing out a good organization of the components of patients' therapeutic self care demands

Selection of combination of ways of helping that will be effective and efficient in compensating for/ overcoming patient's self care deficits

Step 3

Nurse assists the patient or family in self care matters to achieve identified and described health and health related results. Collecting evidence in evaluating results achieved against results specified in the nursing system design

Actions are directed by etiology component of nursing diagnosis evaluation

Strenghts of the theory

- Provides a comprehensive base to nursing practice
- It has utility for professional nursing in the areas of nursing practice nursing curricula ,nursing education administration, and nursing research
- Specifies when nursing is needed
- Also includes continuing education as part of the professional component of nursing education
- Her self care approach is contemporary with the concepts of health promotion and health maintenance
- Expanded her focus of individual self care to include multiperson units

Limitations of the theory

- In general system, theory is viewed as a single whole thing while Orem defines a system as a single whole thing.
- Health is often viewed as dynamic and ever changing. Orem's visual presentation of the boxed nursing systems implies three static conditions of health.
- Appears that the theory is illness oriented rather with no indication of its use in wellness settings.

Application of the theory

Education

Some of the elements of Orem's theory have been mentioned in guides for developing curriculum for the education is of practical nurse.

Orem book of Foundation is of nursing and its practice which was published and used at Morris Harvey College.

Research

The research related to or derived from Orem's theory can be classified as relating to:

The development of research instruments for measuring the conceptual elements of the theory

- The first instrument to measure the exercise of self care agency (ESCA) was published in 1975.
- A self care questionnaire was developed and tested by Moore (1995) for the special purpose of measuring the self care practice of children and adolescents.
- Orem's theory of self care deficit was used in design of the Self – As-Carer Inventory(SCI)

Studies that test elements of the theory in specific population

- Orem's theory has been used as the conceptual framework

in the development ,design, selection and evaluation of appropriate written patient education materials for patients with low literacy skills. (Feleta L.Wilson,Darlene W. Mood,Joanna ,risk)

- Orem's self care deficit theory of nursing was used in developing an effective plan of self-care for an elderly women who underwent ileostomy.(Laurie A. Martinez)

- Using Orem's theory of self care nursing theory, 14 conditions were covered in the paediatric asthma literature that influence development of competency by parents.(Karen R. Cox,Susan G. Taylor)

- Orem's theory was used to build conceptual framework for the study to explore relationships among health promoting self care behaviours, self care efficacy and self care agency.(Donna M, Callaghan)

- Orem's theory was employed to determine self care and dependent-care operations children and parents perform to address self care requisites and to explore nursing interventions to promote operations.(Jean Burley Moore, Asher E. Beckwitt)

Summary

Orem's general theory of nursing is composed of three constructs. Throughout her work, she interprets the concepts of human beings, health, nursing and society, and has defined 3 steps of nursing process.

It has a broad scope in clinical practice and to lesser extent in research, education and administration.

References

1. Wills M.Evelyn, McEwen Melanie (2002). Theoretical Basis for Nursing Philadelphia. Lippincott Williams& Wilkins.pg 145-146

2. Sarah E. Allison(2007) Self care requirements for activity and rest: An Orem Nursing focus,Nursing Science Quaterly,vol 20,pg 68-76

3. Jean Burley Moore,Asher E. Beckwitt(2006) Self care operations and nursing interventions for children with cancer and their parents,nursing Science Quaterly,Vol 19,147-156

4. Donna M. Callaghan(2003) Health promating self care behaviours,self care efficacy and self care agency,Vol 16,247-254

5. Karen R. Cox,Susan g. Taylor,Orem's self care deficit nursing theory :pediatric asthma as exampler,Nursing Science Quaterly,Vol 18,249-257

6. Laurie A. Martinez(2005) Self care for stoma surgery: Mastering independent stoma self care skills in an elderly woman,Nursing Science Quaterly,Vol8,66-69 ■

Effectiveness of cardiac rehabilitation programme

Continued from page 47

(2) The study was limited only for cardiac rehabilitation program for phase I.

(3) Adequate reinforcement was not possible in all the samples.

Conclusion

The result highlights that the pre test knowledge score on CRP phase I was inadequate, in post-test knowledge score was adequate.

The pretest practice score on CRP phase I was inadequate in ICU, in posttest practice score was adequate. The pre test practice score on CRP phase I was moderate in ward, in posttest practice score was adequate.

This indicates that the CRP phase I was effective to improve the knowledge and practice among samples to promote cardiac health and prevent further risk of MI.

References

1. Black M. Joyce. Hawks Jane Hokanson. Medical and Surgical Nursing, Vol - 2. (7th ed), Missouri, Saunders Publishers. 2007. 1707-1729.

2. Brunner and Suddarth's., (2004). Medical Surgical Nursing (Revised Edition). New York : Lippincott Williams and Wilkins, 302

3. Lippincott. Lippincott Manual of Medical Surgical Nursing, (8th ed), Philadelphia, Mosby publishers, 2002, 816-836.

4. American Heart Association Journal, (1994), Cardiac rehabilitation circulation, volume 90(3), Pp.1602-1610.

5. Warner M.Mampuva, Cardiac Rehabilitation Past, Present and Future. Journal on cardiac diagnosis and therapy. 2012, 2(1): 56.

6. Dusseldorp, et.al, (1999), Cardiac rehabilitation program an interpretative phenomenological analysis, Coronary Health Care, Vol- 5(4), Pp.178-188

" Life is not just being well, it is being healthy". ■

Assessing knowledge of causes, management and prevention of cor pulmonale

Continued from page 27

detection and prompt treatment for the COPD and pulmonary hypertension by regular intake of medications, good diet and environment and avoidance of irritant. The prognosis is good.

- But in chronic or severe forms of disease the prognosis is poor.
- With the advancement in medical science and technology in case of lung transplantation 60%, and in heart transplantation, 80% achieved good prognosis.
- After the lung transplantation survival rate is 4 years to 5 years.
- After the heart transplantation, the survival rate is 5 years.

References:

1 Brunner and Suddartha. "A Text Book of Medical and Surgical Nursing. 9 Edition, J.B. Lippincott company, New York, Page No. 379-480.

2 Braunwald. "A Text Book of cardiovascular Medicine and Heart Disease." 5 edition. WB Saunders Company, Page No. 1604-1620.

3 Davidson's. "Principles and practice of Medicine," 19th edition, published by Edinburg London, New York, Philadephia Page No. 487-513.

4 Fraser and Pane et al. "Diagnosis of diseases of Chest, 4th edition, WB. Saunders Company Page No.525-530.

5 Fuster, Alexander Co Rourke. "A textbook of the Heart," 11th edition, published by Mc Grawhil, 2004, Page No. 695-696.

6 Harrisons. "Principles of Internal Medicine," 14" edition, Adivision of the M.C. Graw hill Company, Page No. 1327-1458.

7 Hinshaw & Murray. A Text Book of Diseases of the chest," 4" edition, W.B. Saunders Company Page No.697-703.

8 Lippin Cott. "Manual of Nursing practice," 3d edition Saunder company page No. 303-307.

9 M. Tierney. "A textbook of current Medical diagnosis and treatment," 4th edition, Published by United States of America, 2002, Page No. 366-369.

10 Watson. "A textbook of Medical and Surgical Nursing," 4th edition, 1999, Page No.726-736.

Journals

1 Dr. Chopra, K.L. "Chest Disease syndromes," Cardio Thorasic Journal, 2001,Vol. 1, PP. 10-15.

2 Dutta S.K." Prevention of Chest and Heart Disease," Journal of your health, Vol.42, No. 11 and 12 November & December 1999, P. No.130-137.

3 Janice, L. Hinkle "Treating cardiac diseases," 8" edition, the American Journal of nursing, 1986 Page No. 55-62.

4 Kamal G. Nath "Diet and Coronary Heart Disease," Journal of Swasth Hind, Vol.30, No.7, July 2003, Page No. 50-59.

5 Thomas Strasser, "Heart Health," Journal of World Health, Vol.9, P. No.20-25. ■

Assessing effectiveness of nursing intervention package

Continued from page 20

Health education programs can be conducted to create awareness among the public regarding elderly care.

Implication for nursing research: Findings of this study can be used as a basis for future evidence based care related to elderly QOL.

The nurse researchers should be aware of the various research aspects in improving QOL of elderly.

Recommendations

This study can be replicated on large scale.

This study can be conducted among elderly living with their family.

Limitations

- The study was limited to elderly population residing at selected community area.
- Nursing intervention package were given for 50 minutes for one week.
- Sample size was limited to 30 in each group.
- The period of data collection was limited to four weeks

Conclusion

Nowadays, the population of the elderly grows absolutely and relatively to the overall population worldwide. Concepts such as quality of life, wellbeing, social interaction and connectivity, functional status are of crucial importance, and are directly linked to the environment in which the elderly are living in.

References

Text Books

1. Basvanthappa B.T (2000) "Nursing Research" Jaypee brothers, Bangalore.
2. Garland(2001) "Life review in health &Social care" Hove ,East Susx Brunner –Routledge.
3. Helen .C. Anderson et.al(1971), "Geriatrics Nursing" The C.V.Mosby company ,5th edition .
4. Herbert Joyer ,Jave Oyer. "Aging and communication" London,university park publishers.
5. Hogstel MO (1990) . Geropsychiatric Nursing. St. Louis: Mosby.
6. Jenni Keith , (1985). "Old people as people" ,Canada,Little Brown company, publishers .
7. Lachs MS, Reinstein AR, Cooney LM et al. 1990. A simple procedure for general screening for functional disability in elderly. Ann Intern Med. 1990 May 1;112(9):699-706. [PubMed]
8. Lueckenotte AG (2000). Gerontologic Nursing. 2nd ed. St. Louis: Mosby.
9. Polit, D.F & Beck, C.T (2010). Nursing Research, (9th ed.) New Delhi; Elsevier publications. ■

Assessing prevalence of internet gaming addiction

Continued from page 23

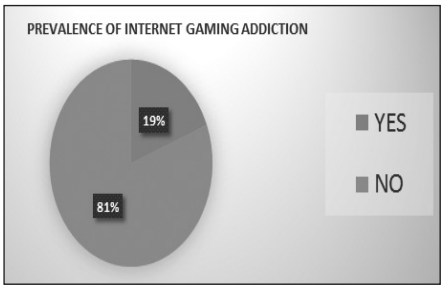


Figure 1: Prevalence of internet gaming addiction among higher secondary school students

Fig. 1 inferred that majority of higher secondary school students 81 (81%) did not have Internet gaming addiction and 19 (19%) had Internet gaming addiction.

The prevalence of Internet gaming addiction was higher among the age group of 16 years (11%), females (11%), urban residence (14%), Hindu religion (13%), nuclear family (13%), Graduate mother (6%), professional degree father (9%), upper class (10%), professional occupation (12%), mobile phone accessibility (17%), 1-2 hours duration for playing games (8%), using mobile phone for playing games (16%) and previous knowledge regarding internet gaming addiction (14%).

Demographic variables like education, status of mother, monthly income of family and accessibility to mobile phone were statistically associated with the prevalence of Internet gaming addiction.

Conclusion

The main study concludes that the prevalence of Internet gaming addiction among higher secondary school students was 19%.

The investigator observed that the Internet gaming behaviour among higher secondary school students looks at alarming stage.

Recommendations

A similar study can be conducted in larger group of higher secondary school students for generalization.

Interventions such as awareness program, various psychological therapies, counselling sessions, etc can be used to reduce psychological problems such as depression, anxiety, stress, loneliness and enhance coping.

The longitudinal study can be undertaken for assessing internet gaming disorder levels and its negative consequences.

References

1. P Prakash, " A Textbook of mental health and psychiatric Nursing, CBS publications, 1st edition, 2020.
2. Purnima Bairagi, Internet addiction and its effects on lifestyle of the adolescents, American journal of advances in Nursing research, Vol.6, 2019, Page No. 83-86.
3. Jayalakshmi G et al, online game addiction among adolescents in Pondicherry, Indian journal of addictive behaviours, therapy and rehabilitation, 2017, Page No. 1-4.
4. Undavalli VK et al, prevalence of internet gaming addiction disorder in india: A technological hazard among adolescents, International journal of community medicine and public health, vol.7, Page No: 688-693.
5. Nitin Anand et al, Prevalence of excessive internet use and its association with psychological distress among university students in south india, Indian psychiatry journal, 2018, Page No: 131-140.
6. Halley M. Pontes & Mark D. Griffiths, Measuring DSM-5 internet gaming disorder: Development and validation of a short psychometric scale, Computers in Human Behavior (45), 2015, Elsevier publications, Page No:137-143. ■

WHO highlights high cost of physical inactivity in first-ever global report

Almost 500 million people will develop heart disease, obesity, diabetes or other noncommunicable diseases (NCDs) attributable to physical inactivity, between 2020 and 2030, costing US$ 27 billion annually, if governments don't take urgent action to encourage more physical activity among their populations.

The *Global status report on physical activity 2022,* published recently by the World Health Organization, measures the extent to which governments are implementing recommendations to increase physical activity across all ages and abilities.

Data from 194 countries show that overall, progress is slow and that countries need to accelerate the development and implementation of policies to increase levels of physical activity and thereby prevent disease and reduce burden on already overwhelmed health care systems.

- Less than 50% of countries have a national physical activity policy, of which less than 40% are operational
- Only 30% of countries have national physical activity guidelines for all age groups
- While nearly all countries report a system for monitoring physical activity in adults, 75% of countries monitor physical activity among adolescents, and less than 30% monitor physical activity in children under 5 years
- In policy areas that could encourage active and sustainable transport, only just over 40% of countries have road design standards that make walking and cycling safer.

"We need more countries to scale up implementation of policies to support people to be more active through walking, cycling, sport, and other physical activity. The benefits are huge, not only for the physical and mental health of individuals, but also for societies, environments, and economies..." said Dr Tedros Adhanom Ghebreyesus, WHO Director-General, "We hope countries and partners will use this report to build more active, healthier, and fairer societies for all."

The economic burden of physical inactivity is significant and the cost of treating new cases of preventable noncommunicable diseases (NCDs) will reach nearly US$ 300 billion by 2030, around US$ 27 billion annually.

Whilst national policies to tackle NCDs and physical inactivity have increased in recent years, currently 28% of policies are reported to be not funded or implemented. Considered a "best buy" for motivating populations to combat NCDs, the report showed that only just over 50% of countries ran a national communications campaign, or organised mass participation physical activity events in the last two years.

Global status report on physical activity 2022

Overview

This Global status report on physical activity is WHO's first dedicated global assessment of global progress on country implementation of policy recommendations of the Global Action Plan on Physical Activity (GAPPA) 2018-2030. It also presents an estimate of the cost to health systems of not taking action to improve physical activity levels and reinforces the urgency to position physical activity as a shared, whole-of-government priority, and to strengthen coordination and partnerships to promote physical activity.

The COVID-19 pandemic has not only stalled these initiatives, but it also affected other policy implementation which has widened inequities in access to and, opportunities for, engaging in physical activity for many communities.

To help countries increase physical activity, WHO's Global action plan on physical activity 2018-2030 (GAPPA) sets out 20 policy recommendations – including policies to create safer roads to encourage more active transport, provide more programmes and opportunities for physical activity in key settings, such as childcare, schools, primary health care and the workplace.

Today's Global Status report assesses country progress against those recommendations, and shows that much more needs to be done. One critical finding in the Global status report on physical activity is the existence of significant gaps in global data to track progress on important policy actions – such as provision of public open space, provision of walking and cycling infrastructure, provision of sport and physical education in schools. The report also calls for weaknesses in some existing data to also be addressed.

"We are missing globally approved indicators to mea-

Continued on next page

WHO launches new campaign to amplify the lived experience of people affected by cancer

WHO has recently launched the first global survey to better understand and address the needs of all those affected by cancer. The survey is part of a broader campaign, designed with and intended to amplify the voices of those affected by cancer – survivors, caregivers and the bereaved – as part of WHO's Framework for Meaningful Engagement of People Living with Noncommunicable diseases (PLWNCDs).

This Framework is a commitment to respectfully and meaningfully engage PLWNCDs in co-designing policies, programmes, and solutions. The survey results will feed into the design of policies and programmes to offer better well-being in the context of a cancer diagnosis and co-create solutions for the future.

Nearly every family globally is affected by cancer, either directly – 1 in 5 people are diagnosed with cancer during their lifetime – or as caregivers or family-members. A cancer diagnosis triggers a broad and profound effect on the health and well-being of all those involved.

"For too long, the focus in cancer control has been on clinical care and not on the broader needs of people affected by cancer," said Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization. "Global cancer policies must be shaped by more than data and scientific research, to include the voices and insight of people impacted by the disease."

Recent studies have shown that nearly half of people diagnosed with cancer experience anxiety and loss of faith and may be abandoned by their intimate partners. In low- and middle-income countries, financial hardship and loss of assets can be experienced by 70% or more of those affected.

"When my daughter was diagnosed with cancer, our lives changed drastically and in ways that we did not expect. The effects of cancer last a lifetime," said Ruth Hoffman, President of the American Childhood Cancer Organization.

Understanding and amplifying the lived experiences of people affected by cancer can create more effective and supportive systems. Yet, the needs and preferences of people with cancer and their caregivers remain unknown to many providers and policy-makers.

"We are making a long-term commitment to place people affected by cancer properly at the center of the agenda, to co-create better solutions" explained Dr Bente Mikkelsen, Director of the Department of Noncommunicable Diseases at WHO. "This campaign will include four phases: releasing the global survey, hosting national consultations, presenting best practices and implementing community-led initiatives. We are ready to open a new chapter and improve the well-being of people affected by cancer."

The ambition of the global survey is to reach more than 100 000 responders from 100 countries, a majority of whom live in low- and middle-income countries. The survey results are expected in early 2023 and, thereafter, used to shape policies, programmes and services for people affected by cancer globally. ■

Continued from page 55

sure access to parks, cycle lanes, foot paths – even though we know that data do exist in some countries. Consequently, we cannot report or track the global provision of infrastructure that will facilitate increases in physical activity, "said Fiona Bull, Head of WHO Physical Activity Unit. "It can be a vicious circle, no indicator and no data leads to no tracking and no accountability, and then too often, to no policy and no investment. What gets measured gets done, and we have some way to go to comprehensively and robustly track national actions on physical activity."

The report calls for countries to prioritize physical activity as key to improving health and tackling NCDs, integrate physical activity into all relevant policies, and develop tools, guidance and training to improve implementation.

"It is good for public health and makes economic sense to promote more physical activity for everyone," said Dr Ruediger Krech, Director Department of Health Promotion, WHO. "We need to facilitate inclusive programmes for physical activity for all and ensure people have easier access to them. This report issues a clear call to all countries for stronger and accelerated action by all relevant stakeholders working better together to achieve the global target of a 15% reduction in the prevalence of physical inactivity by 2030." ■

Towards stronger food safety systems and global cooperation

Launch of WHO Global Strategy for Food Safety 2022-2030

WHO has launched the WHO Global Strategy for Food Safety 2022-2030, adopted by Member States at the 75th Session of the World Health Assembly - Resolution WHA75 (22). The launch marks a milestone in WHO work to promote health, keep the world safe and protect the vulnerable.

Every year, one in ten people globally fall ill due to foodborne diseases. Contaminated food can cause over 200 diseases, and the magnitude of public health burden is comparable to malaria or HIV AIDS. Children under five are at higher risk, as one in six deaths from diarrhoea are caused by unsafe food.

The updated WHO Global Strategy for Food Safety is a step towards a safer and healthier world, but also towards strengthening multisectoral collaboration and innovative public health approaches.

The Global Food Safety Strategy has been developed to guide and support Member States in their efforts to prioritize, plan, implement, monitor and regularly evaluate actions towards the reduction of the burden of foodborne diseases (FBD) by continuously strengthening food safety systems and promoting global cooperation.

The Strategy's vision is that all people, everywhere, consume safe and healthy food so as to reduce the burden of FBDs. This strategy gives stakeholders the tools they need to strengthen their national food safety systems and collaborate with partners around the world.

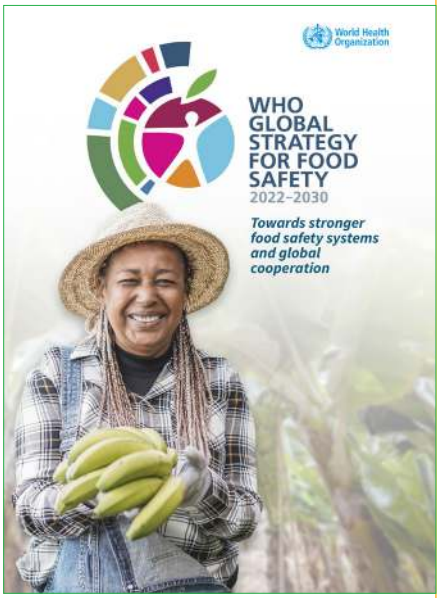
This new WHO Global Strategy for Food Safety 2022-2030 addresses current and emerging challenges, incorporates new technologies and includes innovative approaches for strengthening food safety systems.

It also reflects feedback received through a comprehensive consultation process with Member States and governmental institutions, United Nations agencies and other intergovernmental organizations, academic institutions, non-governmental organizations, private sector entities, and individuals working in public health and food safety.

The strategy also sets concrete targets and aims to reduce the burden of foodborne diseases by reducing 40% the number of cases of foodborne diarrheal diseases incidence that affects most the children under 5 and other vulnerable populations.

WHO global strategy for food safety 2022-2030: towards stronger food safety systems and global cooperation

Overview



The vision of the WHO Global Strategy for Food Safety 2022-2030 is to ensure that all people, everywhere, consume safe and healthy food so as to reduce the burden of foodborne diseases. The strategy was adopted by the 75th World Health Assembly. With five interlinked and mutually supportive strategic priorities, the strategy aims to build forward-looking, evidence-based, people-centred, and cost-effective food safety systems with coordinated governance and adequate infrastructures.

The WHO Secretariat has prepared the WHO Global Strategy for Food Safety with the advice of the Technical Advisory Group (TAG) on Food Safety: Safer food for better health. The current strategy reflects feedback received through a comprehensive consultation process with Member States and governmental institutions, United Nations agencies and other intergovernmental organizations, academic institutions, non-governmental organizations, private sector entities, and individuals working in public health and food safety.

It also has a target of 100% of functional coordination mechanisms to manage foodborne events and enhanced laboratory capacity for foodborne disease surveillance.

The strategy has identified five interlinked and mutually reinforcing strategic priorities with respective strategic objectives. Using the identified five strategic priorities and respective strategic objectives, the strategy aims to build

proactive, forward-looking, evidence-based, people-centred, and cost-effective food safety systems with coordinated governance and adequate infrastructures.

Strategic priorities:

- Strengthening national food control systems.
- Identifying and responding to food safety challenges resulting from global changes and food systems transformation.
- Improving the use of food chain information, scientific evidence and risk assessment in making risk management decisions.
- Strengthening stakeholder engagement and risk communication.
- Promoting food safety as an essential component in domestic, regional and international food trade.

WHO and the members of the Technical Advisory Group on Food Safety are working on tools to complement the existing sources from WHO, FAO and other organizations to support Member States in the implementation of the strategy over 2022-2030.

The collaboration among different sectors and stakeholders is key for the implementation of the strategy, and the implementation plan of the strategy is aligned with the FAO food safety strategic priorities through a joint coordination framework.

Background

In 2020, the Resolution 73.5 titled "Strengthening efforts on food safety" was adopted by the Seventy-third World Health Assembly. In the resolution, Member States requested WHO to update the WHO Global Strategy for Food Safety to address current and emerging challenges, incorporate new technologies and include innovative approaches for strengthening food safety systems.

In response to this request, the WHO Secretariat has prepared a WHO Global Strategy for Food Safety with the advice of the Technical Advisory Group (TAG) on Food Safety: Safer food for better health.

The current strategy reflects feedback received through a comprehensive consultation process with Member States and governmental institutions, United Nations agencies and other intergovernmental organizations, academic institutions, non-governmental organizations, private sector entities, and individuals working in public health and food safety.

WHO Global Strategy for Food Safety 2022-2030, adopted by Resolution 75(22) during the 75th World Health Assembly, is available here. ■

Effectiveness of structured teaching programme on knowledge

Continued from page 17

that there was a statistically significant in post test ,the mean score of knowledge was 21.50 with S.D 1.548 and the mean score of practice was 8.93 with S.D 944.

Hence, the structured teaching programme was effective. the post test knowledge level increases in the post test practice level also increases.

References

1. Knithar and menson S (1990) "Menstrual life education for girls in Bombay slums " Pride. Bombay.
2. Lathleen J.W.Wilson and Anne Waugh, (1999) Anatomy and physiology in health and illness ".8th edition, Churchill livingstone publication, New York, Pp 421-431
3. Kerlinger N.F.(1993) " Foundations of Menstrual Research " 7th edition, Lippincott Publisher New York, Pp. 222-223
4. Suresh k.sharma Nursing research &statistics,2nd edition, India. ELSEVIER Publications, pageno;182,416.

Journals

1. Abioye – Kuteyi EA. (2000) "The menstrual knowledge and practices amongst secondary school girls in Nigeria " Journal of school healthy, 120(1): 23-26
2. Abraham G.J.S (1982) " Our experiences with student participation in teaching learning process " The Indian journal ofmedical Education, 21(1):88-92
3. Ahuja et al (1995) "Awareness of pubertal changes among adolescent girls " The journal of family Welfare, 41:46-50. ■

The mind is not a vessel to be filled, but a fire to be ignited.
Plutarch

Launch of WHO's first blueprint for dementia research

Dementia is one of the greatest health challenges of our generation. "Although dementia is the 7th leading cause of death globally, dementia research accounts for less than 1.5% of total health research output" said Dr Soumya Swaminathan, WHO's Chief Scientist. "Sadly, we are falling behind implementing the *Global action plan on the public health response to dementia 2017-25*. Addressing dementia comprehensively requires research and innovation to be an integral part of the response."

Strategies are needed to better understand, prevent, and treat the underlying diseases that cause dementia and, at the same time, provide care and support for people with dementia and their carers.

Moreover, dementia research needs to be conducted within an enabling environment, where collaborations are fostered, and equitable and sustained investment is realized.

With these objectives, WHO developed *a blueprint for dementia research*, the first WHO initiative of its kind for noncommunicable diseases. The blueprint is designed to provide guidance to policy makers, funders, and the research community on dementia research, making it more efficient, equitable, and impactful.

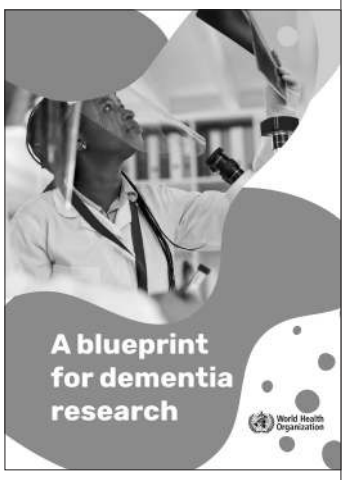
Specifically, the blueprint for dementia research

- builds on and applies lessons learned from WHO efforts to prioritize research and coordinate research activities for infectious diseases;
- considers the entire dementia research spectrum, incorporating diagnostics and therapeutics, as well as emerging scientific and technological advances such as artificial intelligence, multiomics, and biomarkers;
- encompasses epidemiology, health economics, care and carer research, risk reduction, and brain health across the life course; and
- provides insights on different drivers of research, such as sustainable funding, diversity and equity, and the involvement of people with lived experience of dementia throughout the research development process.

"We can achieve progress in dementia research by strengthening and monitoring the drivers of research highlighted in the Blueprint so that they become the norm for good research practice." said Dr Ren Minghui, WHO's Assistant Director General UHC/Communicable & Noncommunicable Diseases.

A blueprint for dementia research

Overview



Research and innovation are integral parts of the global response to dementia. Yet, the Global status report on the public health response to dementia shows that despite some encouraging efforts most countries are far from reaching the adopted targets of the Global action plan on the public health response to dementia 2017–2025.

This blueprint for dementia research summarizes the current state of dementia research across six broad themes, identifies existing knowledge gaps, and outlines 15 strategic goals with actions and timebound milestones to address these gaps.

The blueprint also outlines drivers of research that together create an enabling research environment that is essential for accelerating dementia research globally.

Going forward, the blueprint will guide policymakers, funders, and the research community on future activities in dementia research, and contribute to making dementia research more efficient, equitable, and impactful.

WHO encourages national and international research agencies, together with other funding bodies, to use this blueprint to inform upcoming funding streams and operationalize the drivers of research.

Civil society can ensure that advocacy efforts are likewise aligned, supporting the drive for a more equitable, efficient, and collaborative research landscape. Additionally, researchers can support the achievement of milestones and strategic goals of this blueprint by addressing the research gaps identified.

WHO will work with all stakeholders across relevant sectors to ensure that the actions outlined in the blueprint are implemented, milestones are achieved, and strategic goals are realized, with the ultimate aim of improving the quality of life of and support offered to people living with dementia, their carers, and families. ■

WHO issues a new framework to strengthen collaborative action on TB and comorbidities

The World Health Organization (WHO) is launching a new Framework for collaborative action on TB and comorbidities to address the limited uptake of collaborative activities to reduce the burden of TB and comorbidities and to support countries in enabling access to people-centred care.

The Framework is designed to stimulate action, recognising that addressing health-related risk factors and comorbidities among people with TB is essential to end the TB epidemic.

The Framework outlines the key steps to establish and strengthen collaboration across health programmes and across sectors for delivering people-centered services for TB and comorbidities, provides guidance on planning, implementation and evaluation of these services and is designed to facilitate scale-up of new WHO recommendations on TB, comorbidities and health-related risk factors.

"The Framework for collaborative action on TB and comorbidities aims to alleviate the burden of those affected along their pathway of care, and increase access to high quality prevention and care for people with TB and comorbidities, at the same place," said Dr Tereza Kasaeva, Director of WHO's Global Tuberculosis Programme. "We urge countries to use the framework to support the roll out of people-centric approaches to end TB suffering and save lives."

Evidence tells us that five key risk factors drive the TB pandemic: alcohol use disorder, diabetes, HIV, tobacco smoking and undernutrition. In 2020, these risk factors accounted for an alarming 45% of all TB episodes.

People with TB can also experience mental health disorders, drug use disorders and viral hepatitis, which can lead to poorer TB treatment outcomes and lowered quality of life.

While there has been a focus for TB-HIV collaborative activities for decades - with tangible results that have reduced deaths and suffering due to TB - action on TB and other co-morbidities has languished.

The Framework attempts to put the spotlight on TB and HIV as well as other comorbidities and multimorbidity - as a key concern for health programmes.

"As we move towards universal health coverage, a shift is needed towards health systems designed for people, with people. The Framework for collaborative action on TB and comorbidities aims to do just this to ensure people-centred services for people living with TB" stressed WHO's Assistant Director General for Universal Health Coverage/Communicable and Non-communicable diseases, Dr Ren Minghui.

The development of the Framework for collaborative action on TB and comorbidities has been informed by interviews with survivors of TB and comorbidities, focus group discussions with staff from health programmes and clinicians, and through consultation with key stakeholders, including civil society. ■

Framework for collaborative action on tuberculosis and comorbidities

Overview

Addressing comorbidities and risk factors for TB is a crucial component of Pillar one of the End TB Strategy, which focuses on integrated patient-centred care and prevention, including action on TB and comorbidities.

The Framework for collaborative action on TB and comorbidities aims to support countries in the evidence-informed introduction and scale-up of holistic people-centred services for TB, comorbidities and health-related risk factors, with the goal of comprehensively addressing TB and other co-existing health conditions. It should be used in conjunction with relevant WHO guidelines.

The Framework is intended for use by people working in ministries of health, other relevant line-ministries, policymakers, international technical and funding organizations, researchers, nongovernmental and civil society organizations, as well as primary care workers, specialist health practitioners, and community health workers who support the response to TB and comorbidities in both the public and private sectors.

The best teacher is the one who suggests rather than dogmatizes, and inspires his listener with the wish to teach himself.

Edward Bulwer-Lytton

Building climate resilient health services with sustainable energy

The World Health Organization (WHO) and over 20 leaders from governments and international organizations agreed and called for action to increase climate resilience of health-care facilities and increase indoor air quality through sustainable energy.

The *Call to Action*, focuses on 6 areas based on a Strategic Roadmap to promote healthier populations through clean and sustainable energy to address inequalities and health concerns caused by lack of access for clean cooking and electricity in health care facilities. Actions include: considering clean cooking and access to electricity in health-care facilities development priorities essential to protect public health; dramatically increasing public and private investments in electrifying health-care facilities and in clean cooking; and developing tailored policy and financing schemes to unlock the potential of clean and sustainable energy solutions.

An estimated hundreds of millions of people are served by health facilities lacking electricity. This limits access to essential, lifesaving medical devices and dramatically hampers the quality, accessibility and reliability of health services delivered.

"It is unacceptable that such a large portion of the population is unable to access adequate health services due to lack of electricity," said Dr Maria Neira, WHO Director, Department of Environment, Climate Change and Health. "A person's right to health should not be determined by where they were born, the right to universal health care is our global responsibility."

Around one third of the global population still relies on polluting fuels to meet their basic daily energy needs for cooking. The resulting household air pollution leads to 3.2 million premature deaths each year from noncommunicable disease and pneumonia. Households that rely on polluting fuels for cooking risk creating an environment that puts often the most vulnerable communities at great risks. Cooking with polluting fuels is also the largest source of black carbon, making it responsible for around half of black carbon emissions globally.

Unfortunately, lack of access to clean fuels and technologies starts at home. Women and children are exposed to polluted air when dirty fuels are used for cooking, as they spend the most time at home, and suffer additional risk when they have to travel far from home to gather the wood needed to cook. Accelerating access to clean cooking will not only save millions of lives, it will also reduce greenhouse gas emissions and therefore protect our planet.

When accelerating access to clean cooking and electrifying health-care facilities, COP27 offers a great opportunity to move forward in mitigating climate change and building the resilience of health systems, protecting public health now and in the future, while saving millions of lives. The High-Level Coalition stands ready to work with all partners at COP27 and beyond to accelerate action to ensure a healthy, clean and safe future for all.

Call to Action to increase climate resilience of health-care facilities & air quality through sustainable energy

Hundreds of millions of people globally are served by health facilities without electricity, limiting access to essential and lifesaving medical devices and dramatically hampering the quality, accessibility and reliability of health services delivered. In addition, the health sector overall is responsible for 4.4% of global carbon emissions.

At the same time, around one third of the population worldwide still rely on polluting fuels and technology combinations to meet their basic daily energy needs for cooking. The resulting household air pollution leads to 3.2 million premature deaths each year from noncommunicable disease and pneumonia and is the largest source of black carbon, responsible for around half of black carbon emissions globally.

COP27 offers a great opportunity to synergize efforts to protect public health while mitigating climate change and building the resilience of the health system, therefore saving millions of lives.

The High-Level Coalition on Health and Energy members urge the international community gathering at COP27 to make every effort to accelerate clean and sustainable energy access for health-care facilities and households.

During the Second Meeting on October 7, 2022, the High-level Coalition endorsed a call to action, based on the Strategic Roadmap to promote healthier populations through clean and sustainable energy and on the following actions:

1) consider clean cooking and access to electricity in health-care facilities two development priorities essential to protect public health;

2) dramatically increase public and private investments in electrifying health-care facilities and in

Continued on next page

World Mental Health Day is an opportunity for us to embrace our sense of community and normalize mental health

Devora Kestel, Director of Mental Health and Substance Abuse, World Health Organization

In 2022, WHO published its seminal mental health work, the *World Mental Health Report*. The Report provides a blueprint for governments, academics, health professionals, civil society and others with an ambition to support the world in transforming mental health.

One of the pervasive issues the report covers is stigma. Stigma, discrimination, and human rights violations against people with mental health conditions are widespread in communities and care systems everywhere. Recently published, Lancet Commission on Ending Stigma and Discrimination in Mental Health is therefore timely and well received but how will it make a difference?

Stigma wears many faces. We most commonly equate it with how we treat one other. However, that represents only part of the issue; personal shame, internalized through an individual's mental health suffering, is a silent problem.

We must normalize talking about mental health and its multitude of conditions because stigma is the chain onto which all mental health conditions link.

One strength of WHO's World Mental Health Report is that it includes diverse stories of people living with experience of mental health conditions. We are grateful to the more than 30 people who shared their stories of perseverance and survival.

Their courage in telling their story is laudable and humbling; it is by listening to more and more experiences like theirs that we can learn how to offer better support and normalize conversations.

The same is true of the recent *WHO guidelines on mental health at work*. With an estimated 12 billion workdays lost annually due to depression and anxiety, the new Guidelines recommend actions to tackle risks to mental health in the workplace such as heavy workloads, negative behaviours, and other factors that create distress at work.

Each week brings a new challenge to our personal and collective mental health – conflict, disease and climate call for a new type of resilience in our mental health. Without expressing and understanding it, we will continue to paper the cracks.

Reflecting on an ambition for this year's World Mental Health Day, there are four priorities WHO would like to see acted upon:

- Fund mental health services – it is estimated that countries spend less than 2% of their health care budget on mental health services. With approximately one billion people living with a mental disorder in 2019, services are radically under resourced.
- Upskill ourselves and our care-givers with an understanding of mental health, understand fully personal experiences and how to provide support. The WHO Quality Rights Mental Health e-training is a great place to start. This training was designed to improve the quality of care in mental health and related services and to promote the rights of people with psychosocial, intellectual and cognitive disabilities.
- Prioritize mental health through our own self-care, analyzing workplace practices to ensure employees thrive and ensuring there is strong community care for mental health.
- Listen to the voices of people with lived experience of mental health conditions. Their experience will teach us how best to support and care for them.

Mental health conditions are usually painful and unfortunately stigma only amplifies that distress. Let's embrace the wise words of this year's World Mental Health Day theme and make mental health and well-being for all a truly global priority. ■

Continued from page 61

clean cooking;

3) provide the necessary human and financial resources to design and implement clean energy plans and sustainable delivery models tailored to the needs of health sector and households;

4) develop tailored policy and financing schemes, able to unlock the potential of clean and sustainable energy solutions and to address the health sector needs;

5) increase cooperation between the energy and health sectors and collaboration with all relevant stakeholders; and

6) facilitate collaboration between private, public, and non-governmental actors. ■

WISH summit calls for sustainable mega sports event legacies which boost physical activity

Launched during the World Innovation Summit for Health (WISH), a new report, co-authored by WISH partners and the World Health Organization (WHO), calls on governments, sports authorities, and the wider sporting community to maximize the investment and excitement generated by sports mega events and leave behind more permanent health benefits for communities.

The report, *Playing the Long Game; A framework for promoting physical activity through sports mega-events,* recommends ways to strengthen mega sports event legacies so that they contribute more effectively to increasing physical activity, and improving the health of populations.

"Large-scale sport events are significant opportunities to promote the health and social benefits of physical activity and sport, and ensure a lasting health legacy for generations," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "But sports events are too often missed opportunities to produce sustainable change. The *Playing the Long Game* report underscores how learning from past events and better planning can lay the foundations for health and sustainable sports legacies."

Regular physical activity, including through playing sport, is proven to help prevent and treat noncommunicable diseases (NCDs) such as heart disease, stroke, diabetes and breast and colon cancer. It also helps to prevent hypertension, overweight and obesity and can improve mental health and well-being. Increasing sport and physical activity participation can save lives, improve health and support stronger, more resilient health systems and communities.

But one in four adults and four in five adolescents are not active enough; there has been little change in the average levels of physical activity over the last 15 years.

Global sports mega events attract millions of viewers and large investments, and can make an important contribution to promoting public health messages and increasing physical activity through effective event legacy programmes.

However, there is currently no global standard of what a sport event legacy should involve; requirements set by different organizing authorities for hosting events vary and there are no standard metrics to assess sport mega event legacy planning, delivery or long-term impact.

"Many cities that host sports mega-events have grand plans to leverage the momentum around these events to increase physical activity and improve health. But time and again, we can't seem to show any measurable impact – the data just isn't there," said Didi Thompson, Director of Research and Content, WISH.

For the first time, a framework has been presented for the design and implementation of such legacies to maximize the reach and impact on community participation in sports and physical activity. *Playing the Long Game* details 7 strategies to deliver meaningful sports mega event legacies which start with the planning and bidding process and extend 10 or 20 years after the event itself - promoting better health for years ahead.

One recommendation is to set common key performance indicators to measure the impact across its legacy lifecycle including the design, planning, delivery/implementation and evaluation.

The framework draws on the strategic objectives outlined by WHO in the *Global action plan on physical activity 2018–2030: More active people for a healthier world* (GAPPA) which charts a comprehensive approach to encourage participation and behavior change, and ultimately influence increased physical activity in all populations.

The impact of the pandemic

The COVID-19 pandemic has significantly reduced participation in physical activity and sport worldwide. It also increased depression and anxiety by 25%. COVID-19 has highlighted more than ever, the importance of increasing efforts to engage more people in regular physical activity and sport.

Globally, noncommunicable diseases cause 74 percent of deaths each year and will burden health systems and communities significantly if efforts to encourage sports and other forms of physical activity among their populations do not improve. Increases in NCDS are projected

Continued on next page

New global guidelines to curb motorcycle crash deaths

Nearly 30% of all road crash deaths involve powered two- and three-wheeled vehicles, such as motorcycles, mopeds, scooters and electrical bikes (e-bikes), and the numbers are rising

The World Health Organization [WHO] and partners launched an updated manual to help policy makers end the scourge of road traffic deaths and injuries involving motorcycles and other powered two- and three-wheelers.

Titled '*Powered two-and three-wheeler safety: a road safety manual for decision-makers and practitioners*' it includes guidelines on developing safer roads, ensuring safer mobility for all road users, vehicle safety standards and actions to improve emergency responses to crashes. It includes evidence and case studies from a range of low- and middle-income countries.

"Motorcycles dominate the roads in many low- and middle-income countries, where nine in ten road traffic deaths happen. It is vital that all relevant authorities put the laws, frameworks and actions in place to reduce deaths and injuries involving powered two- and three-wheelers, and ensure motorcyclists and other vulnerable road users are not left dangerously exposed. Grounded in successful actions and evidence, the latest manual should help policy makers take urgent action to save lives," said Dr Nhan Tran, Head of Safety and Mobility at WHO.

Key risk factors for motorcycle traffic injuries include drivers not wearing helmets, speeding, alcohol impairment, mixed traffic conditions, a lack of protection from the vehicle in a crash and a lack of safe infrastructure for powered two and three wheeled vehicles such as poor road surfaces and roadside hazards.

In the WHO South East Asian Region, deaths involving powered two- and three-wheelers account for 43% of all road traffic deaths. In Thailand and Cambodia, motorcycle deaths accounted for 73% and 74% of all road deaths in 2016.

Young adults aged 15–34 years account for over 60% of all powered two- and three-wheeler related deaths in low- and middle-income countries.

The manual was launched at the Global Regional Road Safety Observatories Dialogue on Motorcycle Safety, held at the Asian Development Bank in Manila, the Philippines. The event aims stimulate commitment and solutions to the road safety crisis with a focus on countries for which motorcycling is the dominant mode of road transport.

Powered two-and three-wheeler safety: a road safety manual for decision-makers and practitioners, 2nd ed

World Health Organization. (2022). Powered two-and three-wheeler safety: a road safety manual for decision-makers and practitioners, 2nd ed. World Health Organization

The publication is part of a series of manuals that are co-produced by WHO, the Global Road Safety Partnership (GRSP), the FIA Foundation and the World Bank, with financial support from Bloomberg Philanthropies.

In the 10 years since the first edition of the manual, the global landscape has changed significantly. The rapid increase in the use of powered two and three wheelers poses new challenges.

With the adoption of the United Nations Decade of Action for Global Road Safety 2021-2030 and the subsequent Political Declaration adopted by the UN General Assembly in July 2022, countries are adopting the Safe Systems approach, that recognizes that road transport is a complex system with interconnecting elements that all affect each other. ■

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to result in an estimated US $47 trillion loss to the global economy between 2010–2030.

WHO's Global action plan on physical activity 2018-2030 promotes active societies, people and environments to contribute to the global goal of increasing participation in physical activity by 15 percent by 2030.

Playing the Long Game, released at the Sport for Health Conference, builds on the World Innovation Summit for Health (WISH) 2020 publication, *Stepping up to the plate*: Planning for a lasting health legacy from major sporting events, and focuses on the opportunity of *sports mega event legacy* to improve health by increasing participation in physical activity locally and globally.

Authors of the Report: Fiona Bull, Paul Simpson, Didi Thompson, Abdulla Saeed Al-Mohannadi, Ravinder Mamtani, Javaid Sheikh, Mohammed Bin Hamad Al-Thani. ■

One Health Joint Plan of Action launched to address health threats to humans, animals, plants and environment

A new One Health Joint Plan of Action was launched by the Quadripartite – the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the World Health Organization (WHO), and the World Organisation for Animal Health (WOAH, founded as OIE).

This first joint plan on One Health aims to create a framework to integrate systems and capacity so that we can collectively better prevent, predict, detect, and respond to health threats. Ultimately, this initiative seeks to improve the health of humans, animals, plants, and the environment, while contributing to sustainable development.

The One Health Joint Plan of Action, developed through a participatory process, provides a set of activities that aim to strengthen collaboration, communication, capacity building, and coordination equally across all sectors responsible for addressing health concerns at the human-animal-plant-environment interface.

The One Health Joint Plan of Action (OH JPA)

The five-year plan (2022-2026) focuses on supporting and expanding capacities in six areas: One Health capacities for health systems, emerging and re-emerging zoonotic epidemics, endemic zoonotic, neglected tropical and vector-borne diseases, food safety risks, antimicrobial resistance and the environment.

This technical document is informed by evidence, best practices, and existing guidance. It covers a set of actions which endeavour to advance One Health at global, regional and national levels. These actions notably include the development of an upcoming implementation guidance for countries, international partners, and non-State actors such as civil society organizations, professional associations, academia and research institutions.

The plan sets out operational objectives, which include: providing a framework for collective and coordinated action to mainstream the One Health approach at all levels; providing upstream policy and legislative advice and technical assistance to help set national targets and priorities; and promoting multinational, multi-sector, multidisciplinary collaboration, learning and exchange of knowledge, solutions and technologies. It also fosters the values of cooperation and shared responsibility, multisectoral action and partnership, gender equity, and inclusiveness.

Why One Health?

One Health is the main approach for addressing the complex health challenges facing our society, such as ecosystem degradation, food system failures, infectious diseases and antimicrobial resistance.

"Using a One Health lens that brings all relevant sectors together is critical to tackle global health threats, like monkeypox, COVID-19 and Ebola." WOAH Director General Dr Monique Eloit highlights the need for enhanced disease prevention capacity in all sectors. "It all starts with ensuring the health of animals. Animal health is our health, it is everyone's health.

FAO Director-General QU Dongyu adds, "One Health should start from proper land management and stopping deforestation, which will help people and their animals in the surrounding environment. We need all sectors working closely together to identify and implement adaptation and mitigation measures.""

UNEP Executive Director Inger Andersen says that "Everyone has the right to a clean and healthy environment - the foundation of all life on Earth. The current pandemic unequivocally demonstrates that the degradation of nature is driving up health risks across the board." Efforts by just one sector or specialty cannot prevent or eliminate infectious disease and other complex threats to One Health. She continued: "Vulnerable populations of all species, including the most poor and marginalized humans, bear the heaviest costs. The Joint Plan of Action will drive down health risks through an integrated approach to human, animal and environment health." ■

One health joint plan of action (2022 - 2026): working together for the health of humans, animals, plants and the environment

Overview

The Quadripartite Organizations – the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the World Organisation for Animal Health (WOAH, founded as OIE), and the World Health Organization (WHO) – collaborate to drive the change and transformation required to mitigate the impact of current and future health challenges at the human–animal– plant–environment interface at global, regional and country level.

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