The Theme for last year nurse's day was a force for change, a vital resource for health. In this year world health day theme is "Food safety: Farm to plate", which is based on prevention of non-communicable diseases and promotion of health., As these are the basic principles of nursing, and we are the changing agent, it may be taken as warfoot action by nurses to improve the health status of our nation.

All of us aware that the production of food and grains now a days became commercial. Marketing on health drinks and ready to eat preparations attract all our citizens and predisposing to systemic, metabolic syndromes like diabetes mellitus, hypertension and related systemic failures.

Obesity is one among the risk factors, which is caused by faulty food habits which can be prevented by nurses only. To achieve our goals in this year, let us start a movement to prevent the chronic diseases by good food habits.

As the part of our health education and bundle care system model, nurses can come forward to create awareness and get rid of obesity and return to our cultural foods to lead a healthy life.

*Indira. S, Ph.D.,
Nursing Principal*
01. Quality of working life for nurses in a healthy work environment - An overview  
   
   Mrs. Ch. Roja Rani

02. Emotional Self Regulation (ESR)  
   
   Ms. Rajeswari. H

03. Respiratory distress syndrome  
   
   Mrs. Radhika.M

04. Workplace Violence  
   
   Mrs. B. Vanaja Kumari

05. A Study to Assess the Effectiveness of Mentha Spicata paste on Dysmenorrhea among adolescent girls in Narayana College of Nursing, Nellore.  
   
   Mrs. A. Latha

06. A study to assess effectiveness of structured teaching programme on knowledge regarding prevention of leg cramps among antenatal mothers at maternal child health center, Tirupathi.  
   
   Ms. Radhika

07. Maternal - Fetal Medicine (MFM)  
   
   Ms. P. Mogileeswari

08. Promotion of Health  
   
   Mrs. B. Kalpana

09. A Quasi Experimental Study to Assess The Effectiveness Of Structured Teaching Programme on the knowledge Regarding the Ill Effects Of Alcoholism Among Labourers  
   
   Mrs. BM. Madhavi

10. Patient Care Technology and Safety  
    
    Mrs. R. Kanakalakshmi

11. Benefical effects of virgin coconut oil serum cholesterol  
    
    Ms. S. Chan Mubeena

12. Geriatric Health In India Concerns and Solutions  
    
    Mrs. A. Mercy Rani

13. Spirulina the Best Food for future  
    
    Mrs. K. Kantha

14. Transcultural Nursing Theory  
    
    Ms. M. Ruth Grace
Quality of working life for nurses in a healthy work environment - An overview

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“An educated nurse workforce in a healthy work environment results in High Quality care”

Adequately trained and motivated health professionals in sufficient numbers are essential for Global Health. Nurses have a great responsibility to improve the health of the population, as the only available health professionals to the people. We are facing a global workforce crisis. Many Countries are finding the challenge of underemployed and unemployed nurses along with nurses shortage. The reasons for this problem are multiple, but key among them are unhealthy work environment and poor organization climate. The underinvestment in the health sector, along with poor employment conditions and policies are resulted in deterioration of working conditions. Such policies are like, discrimination physical and psychological violence, insufficient remuneration, unreasonable work load, limited career development opportunities etc. It is clearly understood that this has a serious negative impact on the productivity and performance of health facilities, recruitment and retention, ultimately on quality of patient care. Just adding more nurses is not the solution. Improving the work environment is a key aspect of improving patient safety and quality of health care.

Maintaining a healthy working environment is a challenge. It is the responsibility of the administrators at different levels to explore and promote the quality of working life of employees by assessing their work environment and adopt appropriate actions to promote healthy environment. The results of certain studies on quality of working life of nurses indicated dissatisfaction of nurses in terms of heavy workload, poor staffing, lack of autonomy to make patient care decisions, increase in performing non-nursing activities. On the other hand, the work context i.e. policies and procedures relationship with co-workers, career growth opportunities and the work environment do influence the quality.

➢ The Policies and procedures which lead to dissatisfaction include lack of participation in decision making related to patient care and organization development, lack of recognition for their accomplishments and best deeds, lack of respect by co-workers and top administrators etc.

➢ Some studies shows the results as the nurses are dissatisfied with their co-workers especially physicians, where they experienced low respect, appreciation and support career development and growth for nurses is hardly available in both Government and private sectors towards promotions, higher education, in service trainings or continuing Nursing education.

➢ In terms of work environment, nurses are concerned about safety in workplace. In addition to inadequacy of patient care supplies and equipment, lack of minimum facilities for storage, rest, safe drinking water and toilets are also triggering unrest in nurses.

Adhikari and Gautham (2010) stated the measures of quality of working life which includes adequate pay and benefits, job security, safe and healthy working conditions, meaningful job and autonomy in job. The organization need to establish certain measures for
1. Increase in employee engagement
2. Increase the emphasis on employee skill development.
3. Increase in autonomy for action and decision making at employee level.
4. Reduce the status distinctions among employees hierarchy.

Healthy working environment strives to ensure health, safety and personal well-being of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organization as a whole.

**CHARACTERISTICS OF HEALTHY WORKING ENVIRONMENT:** Healthy working environment is characterized by
- Wellness policies that address workplace hazards, discrimination, physical and psychological violence and issues pertaining to personal security.
- Health and safety at workplace
- Fair and manageable work load and job demands.
- Leadership practices, peer support, supervision
- Worker participation in decision making and shared values
- Decent pay and benefits
- Equal opportunity and respect
- Career advancement, professional development and capacity building.
- Professional identity, autonomy and control over practice.
- Job security
- Safe staffing levels
- Open communication and Transparency
- Recognition programs
- Access to adequate supplies and support staff.

**STANDARDS FOR HEALTHY WORKING ENVIRONMENT:** Six standards for establishing and sustaining healthy work environment have been identified globally.

1. **Skilled communication:** Nurses must be as proficient in communication skills as they are in clinical skills. The health care organization provides team members with support and access to develop critical communication skills including self awareness, conflict management, listening, advocacy, ethical decisions, soft skills etc.

2. **Collaboration:** Nurses must be relentless in pursuing and fostering collaboration. Interdisciplinary approach in patient care is focused which reduces the stress levels of nurses, results in retention. The physicians shall recognize the need for assessment and knowledge that only nurses can provide. Education and clinical competence help in this process.

3. **Effective decision making:** Nurses must be valued and committed partners in making policy, directing and evaluating clinical care and for organizational development.

4. **Appropriate staffing:** Staffing must ensure the effective match between patient needs and nurses competencies. Nurse managers are positioned to assess and recommend for adequate staffing.

5. **Meaning full recognition:** The efforts and achievements of nurses must be recognised which promotes life along motivation to learn.

6. **Authentic leadership:** Nurses leaders must completely embrace the imperative of a healthy work environment. The nurses leaders must authenticate for allotment of resources, to create opportunities for growth and policy making or health work environment.

There are many nurses who spend their life to serve the patients without expecting any benefit (There is an urgent need to make better working environment to improve quality services) Healthy work environment is essential to ensure patient safety, enhance staff recruitment and retention and sustainability of organization. Nurses must take all necessary steps to develop and maintain healthy work environment for self and patients.

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EMOTIONAL SELF REGULATION (ESR)

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Emotions are normal and everyone experiences them. Sometimes, particularly when one have had persistent distressing experiences during their lives, one can emotionally react more often to situations (that others may not find distressing) where it is felt threatened. The distress can be very intense and it’s difficult to manage our self and situations when things are feeling so over-whelming.

Emotion is an affective state of consciousness in which joy, sorrow, fear, hate, or the like, is experienced, as distinguished from cognitive and volitional states of consciousness.

HEALTHY PERSPECTIVES ON EMOTION:
➢ Emotions are neither good or bad, right or wrong. Feelings just are. They exist.
➢ There is a difference between having an emotion and doing something or acting on the emotion.
➢ Emotions don’t last forever. No matter what we are feeling, eventually, it will lift and another emotion will take its place.
➢ When a strong emotion comes, we do not have to act on the feeling. All to be done is to recognize the emotion and feel it.
➢ Emotions are not facts. When emotions are very powerful they feel just like “the truth”.
➢ Emotions can’t be get rid because they serve important survival functions. Must be willing to radically accept the emotions as they arise.

TYPES OF EMOTION: Individual is born with the emotions wired into the brain. That wiring causes the body to react in certain ways and to have certain urges when the emotion arises.

a) Primary emotions: Anger, Sorrow, Joy, Fear, Disgust, Guilt, Shame, Interest are the primary emotion. All other emotions are made up by combining these basic 8 emotions
b) Secondary emotion: An emotional reaction to an emotion.

Emotions have 3 “jobs”
1. Communication :
➢ Emotions are communicated most powerfully by faces, voice, tone and volume, our posture, and our gestures. Often, other people can tell what we are feeling; even if we’re trying to hide it.
➢ Non-verbal communication is very rapid. If we need to communicate alarm, we can do it with our faces and don’t have to provide a lengthy explanation to someone.

2. Motivation :
➢ Emotions tell us to “ACT NOW!” and “STAY FOCUSED”
➢ It gives us motivation to change a situation.
➢ Emotions save the time in important situations.
➢ Strong emotions help to overcome obstacles-in the mind and in the environment
3. Validation :
➢ Emotions can be information about a situation.
➢ There are sometimes we have a “gut instinct” in a situation.
➢ Emotions can be SIGNALS or ALARMS.
➢ When this is carried to extreme, emotions are treated as facts

UNIQUE RESPONSES: Research shows us that the 8 primary emotions cause a common reaction in all human beings,
✓ Every person is unique. When the emotion is felt the tension is felt on any part of the body. Some people feel anger in their chest, others in their stomachs.
✓ Urges to DO SOMETHING are a natural part of having any emotion.
✓ Urges have a particular emotion may or may not be the same as someone else’s urges.
✓ Some emotions are hard to feel. Most of us try to avoid painful or uncomfortable emotions. These uncomfortable emotions can be regulated sometimes without DOING anything to change them.
Learning Emotion Regulation skills will help an individual to learn effectively manage and change the way to feel and cope with situations. Emotions, thoughts and what we do or feel an urge to do (behaviours) are all linked and become vicious cycles. Changing one part of the cycle will help improve the situation and help you feel better.

**EMOTION REGULATION:**
Emotion regulation is the conscious or unconscious control of emotion, mood, or affect.

**Conscious control** is an active thought process or a commitment to a behavior to control the emotion, also known as a coping mechanism.

**Unconscious control** is thoughts and behaviors you don’t control, like temperament and how some people are just not very emotional.

**Emotions** are single emotions that are easy to define but rarely occur in isolation, like anger or sadness.

**Mood** is an emotional state, and something which affect and emotions are built on. Sort of like when an individual in a bad or good mood and everything else is built off that.

**Affect** is a description of a person’s immediate emotional state, such as angry, ashamed, or flustered.

**A. REDUCING VULNERABILITY:**

I. Staying STRONG

- Sleep as much as needed—not too much, not too little.
- Take medications as doctor prescribed.
- When sick take care of self.
- Resist using street drugs or alcohol.
- Once a day, do something that gives a feeling of being in control, mastering the world.
- Nutrition - eat a balanced diet, don’t over or under eat. Don’t make decisions about food based upon the emotional state at the time (I’m too upset to eat). Keep the blood sugar balanced.
- Get exercise - try to do 20 minutes a day. Research shows that exercise helps people improve their mood.

II. Suggestions for Good Sleep

1. Sleep only as much as needed to feel refreshed during the following day. Restricting the time in bed helps to deepen the sleep. Excessively long times in bed lead to fragmented and shallow sleep. Get up at regular time the next day, no matter how little is slept.
2. Get up at the same time each day, 7 days a week. A regular wake time in the morning leads to regular times of sleep onset, and helps to set the “biological clock”.
3. Exercise regularly. Schedule exercise times so that they do not occur within three hours of when it is intended to go to bed. Exercise makes it easier to get to sleep and to sleep deeply.
4. Make sure that the bedroom is comfortable and free from light and noise.
5. Make sure that the bedroom is at a comfortable temperature during the night.
6. Eat regular meals and do not go to bed hungry. A light snack at bedtime (especially carbohydrates) may help sleep, but avoid greasy or “heavy” foods.
7. Avoid excessive liquids in the evening.
8. Cut down on all caffeinated beverages and foods (coffee, tea, cola, chocolate) can cause difficulty falling asleep, awakening during the night, and shallow sleep. Even caffeine early in the day can disrupt nighttime sleep.
9. Smoking may disturb sleep as nicotine is a stimulant.
10. Don’t take the problems to bed. Plan some time earlier in the evening for working on the problems or planning the next day’s activities. Worrying may interfere with initiating sleep and produce shallow sleep.
11. Train self to use the bedroom only for sleeping. This will help to condition the brain to see bed as the place for sleeping. Don’t read, watch TV, or eat in bed.
12. Do not try to fall asleep. This only makes the problem worse. Instead, turn on the light, leave the bedroom, and do something different like reading a book. Don’t engage in stimulating activity. Return to bed only when feeling sleepy.
13. Put the clock under the bed or turn it so that it is not seen. Clock watching may lead to frustration, anger, and worry, which interfere with sleep.
14. Avoid naps. Staying awake during the day helps to fall asleep at night.

**B. MASTERING MY WORLD:**
A sense of accomplishment is a gift which one can give for self. Make a list of things that can be done in order to gain a sense of mastery. Make sure that the tasks are realistic goals for each mood state. Remember that it is harder to do everything when we are depressed, so pick small tasks for when the mood is low.

I. Steps for Increasing Positive Experiences

(i) Build Positive Experiences Short Term:

- Do pleasant things that are possible NOW.
Make a list of joyful experiences that you can have every day.
Do at least one or two of these experiences MINDFULLY each day and record on your diary card.

(ii) Long Term:
Make changes in your life so that positive events will occur more often.
Build a “life worth living.”
Work toward goals:

(iii) Accumulate positives
Make a list of positive events you want.
List small steps toward goals.
Take first step.

(iv) Attend to relationships
Repair old relationships.
Reach out for new relationships.
Work on current relationships.

(v) Avoid avoiding
Avoid giving up.

(vi) Be Mindful of Positive Experiences
FOCUS attention on positive events that happen (even very small ones)!
REFOCUS when your mind wanders to future worries, past regrets, current distractions and other thoughts while you PARTICIPATE mindfully in the joyful experience.
Make a list of things that interrupt enjoyment for you and be prepared to TURN the MIND when these things appear.

(vii) Be Unmindful of Worries DISTRACT from:
Thinking about when the positive experience will end
Thinking about whether you deserve this positive experience.
Thinking about how much more might be EXPECTED of you now.

C.LETTING GO OF EMOTIONAL SUFFERING:
Mindfulness of Your Current Emotion

(i) Observe the emotion
NOTE its presence.
Step BACK.
Get UNSTUCK from the emotion.

(ii) Experience the emotion fully
As a WAVE, coming and going.
Try not to BLOCK emotion.
Try not to PUSH the emotion AWAY.
Don’t try to KEEP the emotion around.
Don’t try to INCREASE the emotion.
Just be a WITNESS to the emotion.

(iii) Remember: You are not your emotion
Do not ACT on the sensation of urgency.
Remember when you have felt DIFFERENT.
Describe your emotion by saying “I have the feeling of _______”, rather than, “I am ____.”
Notice OTHER feelings that you have at the same time you feel the strong emotion.

(iv) Practice respecting, loving your emotion
Don’t JUDGE your emotion.
Practice WILLINGNESS with your emotion.
Radically ACCEPT your emotion.

D.CHANGING EMOTIONS BY ACTING OPPOSITE TO THE CURRENT EMOTION

(i) Fear
Do what you are afraid of doing …OVER and OVER
APPROACH events, places, tasks, activities, people you are afraid of.
Do things to give yourself a sense of control and MASTERY.
When overwhelmed, make a list of small steps or tasks you can do.
Do the first thing on the list.

(ii) Guilt or shame
When guilt or shame is JUSTIFIED (the emotion fits the wise mind values)
REPAIR the transgression. Say you’re sorry. Apologize.
Make things better: do something nice for the person you offended (or for someone else, if that is not possible).
COMMIT to avoiding that mistake in the future.
ACCEPT the consequences gracefully.
Then LET IT GO. When guilt or shame is UNJUSTIFIED (emotion does not fit your wise mind values).
Do what makes you feel guilty or ashamed OVER and OVER.

APPROACH, don’t avoid.

(iii) Sadness or Depression
Get ACTIVE. APPROACH, don’t avoid.
Do things that make you feel COMPETENT and SELF-CONFIDENT.

(iv) Anger
Gently AVOID the person you are angry with rather than attacking. (Also avoid thoughts about that person, rather than dwelling on them).
Do something NICE rather than mean or attacking.
Imagine SYMPATHY AND EMPATHY for the other person.
<table>
<thead>
<tr>
<th>Taking Charge of My Feelings and Behaviors</th>
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</thead>
<tbody>
<tr>
<td><strong>Taking Charge:</strong></td>
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<tr>
<td>I am checking how I feel right now.</td>
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<tr>
<td></td>
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<tr>
<td><strong>Do I need to do something to help me feel ok or be safer?</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>How do I feel now?</strong></td>
</tr>
</tbody>
</table>

| Write down my thoughts                      |
| Ask for help to take a break card          |
| Give teacher help                           |
| Sit and count to 30                         |
| Think about a safe place                    |
| Think about my strengths (what I do well)  |

**What will make me feel better or safer?**

- Put my head down
- Draw a picture
- Squeeze my hands
- Breathe in and out slowly
- Stretch my body
- Help a friend
- Ask for help
- Wait
- Say, sing, or press down on something
rather than blame.

E. STRATEGIES FOR EMOTIONAL REGULATION

(i) Situation selection: If a person selects to avoid or disengage from an emotionally relevant situation, he or she is decreasing the likelihood of experiencing an emotion.

(ii) Situation modification: Situation modification refers specifically to altering one’s external, physical environment. Altering one’s ‘internal’ environment to regulate emotion is called cognitive change.

(iii) Attentional deployment: Attentional deployment involves directing one’s attention towards or away from an emotional situation. Following are the strategies of attentional deployment.

a. Distraction: Distraction, an example of attentional deployment, is an early selection strategy, which involves diverting one’s attention away from an emotional stimulus and towards other content.

b. Rumination: Rumination, an example of attentional deployment, is defined as the passive and repetitive focusing of one’s attention on one’s symptoms of distress and the causes and consequences of these symptoms.

c. Worry: Worry, an example of attentional deployment, involves directing attention to thoughts and images concerned with potentially negative events in the future. By focusing on these events, worrying serves to aid in the downregulation of intense negative emotion and physiological activity.

d. Thought suppression: Thought suppression, an example of attentional deployment, involves efforts to redirect one’s attention from specific thoughts and mental images to other content so as to modify one’s emotional state.

(iv) Cognitive change: Cognitive change involves changing how one appraises a situation so as to alter its emotional meaning.

a. Reappraisal: Reappraisal, an example of cognitive change, is a late selection strategy, which involves reinterpreting the meaning of an event so as to alter its emotional impact. Reappraisal is generally considered to be an adaptive emotion-regulation strategy.

b. Distancing: Distancing has been shown to be an adaptive form of self-reflection, facilitating the emotional processing of negatively-valenced stimuli, reducing emotional and cardiovascular reactivity to negative stimuli, and increasing problem-solving behavior.

c. Humor: Humor, an example of cognitive change, has been shown to be an effective emotion regulation strategy. Specifically, positive, good-natured humor has been shown to effectively upregulate positive emotion and downregulate negative emotion.

(v) Response modulation: Response modulation involves attempts to directly influence experiential, behavioral, and physiological response systems.

a. Expressive suppression: Expressive suppression, an example of response modulation, involves inhibiting emotional expressions. Expressive suppression is generally considered to be a maladaptive emotion-regulation strategy. Compared to reappraisal, it is correlated positively with many psychological disorders, associated with worse interpersonal outcomes, is negatively related to wellbeing, and requires the mobilization of a relatively substantial amount of cognitive resources.

b. Drug use: Drug use, an example of response modulation, can be a way to alter emotion-associated physiological responses.

c. Exercise: Exercise, an example of response modulation, can be used to downregulate the physiological and experiential effects of negative emotions. Regular physical activity has also been shown to reduce emotional distress and improve emotional control.

CONCLUSION: Regulating emotion by self leads a way to get away from distress, suffering and to have a good interpersonal relationship with others. Benefits of these strategies can be achieved only when it becomes a part of the life.

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RESPIRATORY DISTRESS SYNDROME

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**Abstract:** Respiratory distress syndrome (RDS), also referred to as hyaline membrane disease (HMD), is common in premature babies whose lungs lack the maturity to adapt to extra-uterine life. It is most common in babies born before 28 weeks of gestation and rarely seen in full term babies (at 40 weeks). RDS is mostly caused by a lack of surfactant, a lipoprotein. Surfactant must be present in the lungs to keep the alveoli from collapsing. Some babies die from RDS and others may develop long term complications.

**KEY WORDS:** Apnea, Respiratory distress, Surfactant deficiency.

**INTRODUCTION:** Neonatal respiratory distress syndrome (RDS) remains one of the major causes of neonatal mortality and morbidity despite advances in perinatal care. Infant respiratory distress syndrome (IRDS), also called neonatal respiratory distress syndrome, respiratory distress syndrome of newborn, or increasingly surfactant deficiency disorder (SDD) and previously called hyaline membrane disease (HMD), is a syndrome in premature infants caused by developmental insufficiency of surfactant production and structural immaturity in the lungs. It can also result from a genetic problem with the production of surfactant associated proteins. IRDS affects about 1% of newborn infants and is the leading cause of death in preterm infants. The incidence decreases with advancing gestational age, from about 50% in babies born at 26-28 weeks, to about 25% at 30-31 weeks. The syndrome is more frequent in infants of diabetic mothers and in the second born of premature twins.

The transition from fetus to infant involves many complex adaptations at birth; the most important is the function of the lungs as a gas exchange organ. Preterm surfactant-deficient infants are less well equipped to deal with this transition.

**CASE REPORT:** Baby ‘X’- a live pre term male 18 days old baby was hospitalized in NICU with increased work breathing. Recurrent apnea spells and bradycardia associated with a drop in oxygen saturation. The baby was diagnosed to have respiratory syndrome.

**Diagnosis:** Pre term/SGA/HMD/Post surfactant

**Birth history:** Baby ‘X’ was born by normal vaginal delivery at 28 weeks of gestation and cried immediately after delivery. APGAR score was 6 at 1st mt and 8 at 5th mt and birth wt was 1.1kg. Cry, tone and activity was good at birth.

**ASSESSMENT**

**Ballord scoring**

**PHYSICAL:**

- **skin:** 0, lanugo: 0, plantar: 1, breast: 0, eye/ear: 1, genitalia: 0, posture - 1square window-2, arm recoil-0, scarf sign -1.

**NEURO MUSCULAR MATURITY**

- Posture-1, square window-2, arm recoil, scarf sign -1, heel - ear - 0. Ballard scoring showed 26-28 weeks of neuro muscular maturity.

**Vital signs:** HR- >140/mt, respiratory rate- >40 breaths/mt.

**Investigations:** Blood report showed Platelets -10000/cmm. Hb-11.2gm/dl,WBC -6000cells ,ESR-60mm/1hr, Serum sodium-144meq/l, Serum potassium-4.8meq/l, Serum chloride -100meq/l, Serum bilirubin-0.63mg/dl, Total bilirubin-10.44.

**Management:** In view of icterus double surface phototherapy was started. 1unit of platelets was transfused in view of low platelet count. The baby had recurrent apneic spells and drop in saturation and ventilated. Treatment was continued with antibiotics and Iv Infusion.

**DISCUSSION**

**Definition:** Acute lung disease of the newborn caused
Incidence and severity is inversely proportional to gestational age. HMD is the most common cause of respiratory failure during the first days after birth.

**Causes:**
- Immature development of the respiratory system or inadequate amount of surfactant in the lungs.
- In premature infants, respiratory distress syndrome develops because of impaired surfactant synthesis and secretion leading to atelectasis, ventilation-perfusion (V/Q) inequality, and hypoventilation with resultant hypoxemia and hypercarbia.
- The relative deficiency of surfactant decreases lung compliance and functional residual capacity, with increased dead space. The resulting large V/Q mismatch and right-to-left shunt may involve as much as 80% of the cardiac output.
- RDS is the leading cause of respiratory failure in preterm neonates. It is more common in males than females.

**Predisposing Factors:**
- Premature infant.
- Asphyxia at birth.
- Infant of diabetic mothers.
- Cesarean Section delivery.
- Previous history of hyaline membrane disease (HMD) in sibling.
- Multiple pregnancies.

**PATHOPHYSIOLOGY**

**Secondary surfactant deficiency may occur in infants with the following:**
- Pulmonary infections e.g. group B Strep
- Pulmonary hemorrhage
- Meconium aspiration pneumonia
- Oxygen toxicity; barotraumas to the Lungs
- Congenital diaphragmatic hernia and pulmonary hypoplasia

**ASSESSMENT CRITERIA OF RDS**

**Clinical Manifestations:**
- Tachypnea (80 to 120 breaths/min).
- Dyspnea.
- Substernal retraction.
- Fine inspiratory crackles.
- Audible expiratory grunt.
- Flaring of the nares.
- Cyanosis or pallor.

**As the disease progress:**
- Flaccidity, Unresponsiveness, Apnea, Diminished breath sounds

**Severe RDS is associated with**
- Shock like state.
- Diminished cardiac output and bradycardia.
- Low systemic blood pressure.

**Diagnostic Tests:**
Diagnosis of RDS is a Clinical diagnosis.
- Tachypnea
- Hypoxia
- Cyanosis
- Expiratory grunting (from partial closure of glottis)
- Subcostal and intercostal retractions
- Nasal flaring
- Extremely immature neonates may develop apnea and/or hypothermia
- Blood gases Analysis- Respiratory and metabolic acidosis
- Pulse Oximetry
- Complete blood count
- Serum Electrolytes, glucose, renal and liver function

**Echocardiogram:** diagnosing PDA, determine the direction and degree of shunting, making the diagnosis of pulmonary hypertension and excluding structural heart disease
- **Blood Culture** to rule out sepsis
Chest x-ray: shows congested lung field with a ground-glass appearance that represents alveolar atelectasis, and dark streaks.

Prediction of fetal lung maturity is derived by estimating the lecithin-to-sphingomyelin ratio and/or by testing for the presence of phosphatidylglycerol in the amniotic fluid obtained with amniocentesis.

Antenatal diagnosis of SP-B deficiency, a rare genetic disease, can also be antenatally diagnosed by analyzing the amniotic fluid; this diagnostic testing should be undertaken in previously affected siblings.

MANAGEMENT:
- **Mild distress** - observation & pulse oximetry
- **Severe distress** - immediate resuscitation, CXR, and laboratory tests

Therapeutic Management

**Delivery and resuscitation**
- A neonatologist experienced in the resuscitation and care of premature infants should attend the deliveries of fetuses born at less than 28 weeks’ gestation. These neonates are at a high risk for maladaptation, which further inhibits surfactant production.

- In the delivery room, nasal continuous positive airway pressure (CPAP) is often used in spontaneously breathing premature infants immediately after birth as a potential alternative to immediate intubation and surfactant replacement to minimize the severity of bronchopulmonary dysplasia (BPD).

- Corticosteroid treatment at recognition of a risk of preterm delivery is indicated. If the mother does not deliver within 1 week, retreatment may be considered; most perinatologists administer a single, 12-mg dose of betamethasone, rather than 2 doses.

**Surfactant Replacement Therapy**
- The advent of surfactant therapy has reduced the mortality rate from respiratory distress syndrome by approximately 50%.

- Early surfactant therapy in tiny neonates followed by rapid extubation to nasal continuous positive airway pressure (CPAP) decrease the need for and duration of mechanical ventilation and decrease the rate of pulmonary air leakage and 28-day mortality compared with selective surfactant therapy in respiratory distress syndrome followed by ventilation.

**Dosage**
- Premature neonates with surfactant deficiency and respiratory distress syndrome have an alveolar pool of about 5mg/kg.

- Recommended dosages of clinically available surfactant preparations are 50-200mg/kg, approximately the surfactant pool of term newborn lungs.

- Rapid bolus administration of surfactant after adequate lung recruitment with 3-4cm of positive end-expiratory pressure (PEEP) and adequate positive pressure may improve its homogeneous distribution

- Most neonates require 2 doses; however, as many as 4 doses, given at 6-hour to 12-hour intervals, were used in several clinical trials.
SURFACTANT

Beractant (Survanta): Beractant is a natural/modified bovine lung extract that lowers surface tension on alveolar surfaces during respiration and stabilizes alveoli against collapse at resting transpulmonary pressures. For endotracheal (et) use only. Survanta contains 10% sp-b.

Poractant (Curosurf): Poractant lowers surface tension on alveolar surfaces during respiration and stabilizes alveoli against collapse at resting transpulmonary pressures. It is indicated to treat respiratory distress syndrome in premature infants. Poractant is for ET use only. Curosurf has an SP-B content of 30%.

Calfactant (Infasurf): Calfactant is a natural calf lung extract containing phospholipids, fatty acids, and surfactant-associated proteins B (260mcg/mL) and C (390mcg/mL). It is for ET use only.

Lucinactant (Surfaxin): Synthetic KL4 protein (sinapultide) similar to SP-B. Contains DPPC and palmitoyloleoyl phosphatidylcholine (POPG) phospholipids.

Vapotherm: Vapotherm with heated and humidified, high-flow nasal canula (>2 L/min) has been used for respiratory support of neonates and to facilitate early extubation, as a means of providing respiratory support. This device allows the delivery of high flows of gas at body temperature with close to 100% relative humidity.

Nitric Oxide: Inhaled NO has selective pulmonary vasodilation and, in premature infants, it may have a role in decreasing inflammation, reducing oxidative stress, and enhancing alveolarization and lung growth.

The effects of NO in premature newborn infants may be dependent on the timing, dose, and duration of NO therapy and on the extent of the infant’s lung disease.

Vascular access procedures

Vascular access procedures used in infants with respiratory distress syndrome include:
- Intravenous (IV) line placement
- Umbilical arterial catheterization
- Umbilical artery cut down
- Peripheral artery cannulation
- Umbilical venous catheterization

SUPPORTIVE MANAGEMENT

Temperature regulation - neutral thermal environment

- Hypothermia increases oxygen consumption, further compromising neonates with respiratory distress syndrome who are born prematurely.
- Care for these babies in a neutral thermal environment with the use of a double-walled incubator or radiant warmer to prevent hypothermia during delivery, resuscitation, and transport.

Fluid, metabolic, and nutritional support

- Initially administer 5% or 10% dextrose intravenously at a rate of 60-80 mL/kg/d.
- Closely monitor blood glucose (with Dextrostix testing), electrolytes, calcium, and phosphorous levels, as well as renal function and hydration (as determined by body weight and urine output), to prevent any imbalance.
- Gradually increase fluid intake to 120-140 mL/kg/d. Extremely premature infants occasionally require fluid intake of 200-300mL/kg or more because of insensible water loss occurring from their large body surfaces.
- After the neonate is stable, IV nutrition with amino acids and lipid are commenced within 24-48 hours of...
birth.

✓ As soon as the patient can tolerate oral feedings, trophic feeding with small volumes (preferably breast milk) is commenced by using the orogastric tube to stimulate gut development.

✓ Gastric feedings are increased as tolerated, and IV nutritional support is decreased proportionately to maintain adequate fluid and calorie intake.

✓ Data suggest that an adequate supply of macronutrients, micronutrients, vitamins, and antioxidants should be provided to maintain optimal lung, brain, eye, and somatic growth.

❖ Circulation and anemia

✓ Assess the baby’s circulatory status by monitoring his or her heart rate, peripheral perfusion, and blood pressure.

✓ Administer blood or volume expanders, and use appropriate vasopressors to support circulation.

✓ Closely monitor blood withdrawn for laboratory tests in tiny babies and replace the blood with packed-cell transfusion when it reaches 10% of the baby's estimated blood volume or if the hematocrit level is less than 40-45%.

✓ Anemia and blood loss can be minimized by using placental transfusion at delivery, by limiting blood loss with in vivo blood gas and electrolyte estimations, and by using erythropoietin with iron in extremely premature neonates.

❖ Antibiotic administration

✓ Start antibiotics in all infants with respiratory distress at birth as prescribed after blood cultures, a complete blood count (CBC) with differential, and C-reactive protein levels are obtained.

✓ Discontinue antibiotics after 2-5 days if blood cultures are negative and if no maternal risk factors are found.

❖ Parent and Family Support

✓ Parents often undergo much emotional and/or financial stress with the birth of a critically ill, premature baby with respiratory distress syndrome and its associated complications. Hence, adequate support must be provided to parents and other family members to prevent or minimize these problems.

COMPLICATIONS

Acute complications of respiratory distress syndrome include the following:

- Alveolar rupture
- Infection
- Intracranial hemorrhage and periventricular leukomalacia
- Patent ductus arteriosus (PDA) with increasing left-to-right shunt
- Pulmonary hemorrhage
- Necrotizing enterocolitis (NEC) and/or gastrointestinal (GI) perforation
- Apnea of prematurity

Chronic complications of respiratory distress syndrome include the following:

- Bronchopulmonary dysplasia (BPD)
- Retinopathy of prematurity (ROP)
- Neurologic impairment

Advances include the following:

- The use of antenatal steroids to enhance pulmonary maturity
- Appropriate resuscitation facilitated by placental transfusion and immediate use of continuous positive airway pressure (CPAP) for alveolar recruitment
- Early administration of surfactant
- The use of gentler modes of ventilation, including early use of “bubble” nasal CPAP to minimize damage to the immature lungs.
- Supportive therapies, such as the diagnosis and management of patent ductus arteriosus (PDA), fluid and electrolyte management, trophic feeding and nutrition,
and the use of prophylactic fluconazole.

**Nursing Management**

**Nursing Diagnoses:**

1. Ineffective breathing pattern related to surfactant deficiency, alveolar instability, and pulmonary immaturity.
2. Impaired gas exchange related to immature alveolar structure and inability to maintain lung expansion.
3. Ineffective airway clearance related to obstruction or inappropriate positioning of endotracheal tube.
4. Risk for injury related to acid-base imbalance, oxygen levels, carbon dioxide levels from mechanical ventilation.

**Implementation**

- Hyperoxygenation and a closed suction system can be used to minimize complication during suction.
- Skin inspection and care.
- Changing position.
- Mouth care.

**Evaluation**

The effectiveness of nursing intervention is determined by continuous reassessment and evaluation of care based on:

- Frequent measurement of neonate’s vital signs.
- Observation of signs and symptoms of respiratory distress syndrome.

**Prevention of HMD**

- Prevention of premature delivery.
- Administration of corticosteroids to the mother (24 hours to 7 days before delivery).
- Prophylactic administration of artificial surfactant into trachea of premature neonate.

**CONCLUSION:**

RDS is a self-limiting disease if mild, and following a period of deterioration (approximately 48 hrs) and in the absence of complications, affected neonates begin to improve by 72 hours.

Neonates who survive the first 96 hours have a reasonable chance of recovery. Surfactant therapy decreased the use of long term ventilation and decreased period of stay in hospital. It also improves the outcome.

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4. von der Hardt, K; Schoof, E; Kandler, MA; Dötsch, J; Rascher, W (February 2002). “Aerosolized perfluorocarbon suppresses early pulmonary inflammatory response in a surfactant-depleted piglet model”. *Pediatric research* 51 (2): 177–82
WORKPLACE VIOLENCE

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Introduction:

Workplace violence refers to violence that originates from employees or employers and threatens employers and/or other employees. Violence in all its forms is a concern for staff and management alike. For employers, violence can lead to poor morale and a poor image for the organization, making it difficult to recruit and keep staff. It can also mean extra costs, such as those associated with absenteeism, higher insurance premiums and legal fees, fines and compensation payments where negligence is proven.

For employees violence can cause pain, distress and even disability or death. Physical attacks are obviously dangerous but serious or persistent verbal abuse or threats also can damage employees’ health through anxiety or stress. Peter Vajda identifies workplace gossip as a form of workplace violence, noting that it is “essentially a form of attack.

This can involve violence resulting from industrial disputes committed by or against unions, although this is not a major factor in most incidents.

Definition: The definition of work related violence that has received pan-European acceptance is as follows: “incidents where people are abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, well-being or health”. This definition establishes violence as a behaviour with the potential to cause harm. Broadly speaking there are three forms:

- Non-physical violence (intimidation, abuse, threats etc.)
- Physical violence (punching, kicking, pushing etc.)
- Aggravated physical violence (use of weapons, e.g. guns, knives, syringes, pieces of furniture, bottles, glasses, etc.)

Why do people actually resort to violence?

Violence is an example of what is termed ‘functional’ behavior. That which can be used by an individual to get what they want, or to provide them with some tangible benefit. They may want faster or better service, they may desire attention or alternatively to be left alone or scare people off. They may wish to acquire cash, drugs or other goods that don’t belong to them. They may crave the excitement or notoriety, or it may be the only way they can express themselves or influence others.

Types of workplace violence

By understanding the cause of the violence we will be better able to eliminate, reduce or manage the risk of it occurring. There are four main types of work related violence:

- Criminal violence: Violence perpetrated by individuals who have no relationship with the organization or victim. Normally their aim is to access cash, stock, drugs, or perform some other criminal or unlawful act.
- Service user violence: Violence perpetrated by individuals who are recipients of a service provided in the workplace or by the victim. This often arises through frustration with service delivery or some other by-product of the organisations core business activities.
- Worker-on-worker violence: Violence perpetrated by individuals working within the organization; colleagues, supervisors, managers etc. This is often linked to protests against enforced redundancies, grudges against specific members of staff, or in response to disciplinary action that the individual perceives as being unjust.
- Domestic violence: Violence perpetrated by individuals, outside of the organization, but who have a relationship with an employee e.g. partner, spouses or acquaintances. This is often perpetrated within the work setting, simply because the offender knows where a given individual is during the course of a working day.

Workplace violence and aggression

Buss identified eight types of aggression:
Verbal-passive-indirect (failure to deny false rumors about target, failure to provide information needed by target)
Verbal-passive-direct (“silent treatment”, failure to return communication, i.e. phone calls, e-mails)
Verbal-active-indirect (spreading false rumors, belittling ideas or work)
Verbal-active-direct (insulting, acting condescendingly, yelling)
Physical-passive-indirect (causing others to create a delay for the target)
Physical-passive-direct (reducing target’s ability to contribute, i.e. scheduling them to present at the end of the day where fewer people will be attending)
Physical-active-indirect (theft, destruction of property, unnecessary consumption of resources needed by the target)
Physical-active-direct (physical attack, nonverbal, vulgar gestures directed at the target)

In a study performed by Baron and Neuman, researchers found pay cuts and pay freezes, use of part-time employees, change in management, increased diversity, computer monitoring of employee performance, reengineering, and budget cuts were all significantly linked to increased workplace aggression. The study also showed a substantial amount of evidence linking unpleasant physical conditions (high temperature, poor lighting) and high negative effect, which facilitates workplace aggression.

In the United Kingdom there is a legal obligation to complete risk assessments. Regulation 3 of the Management of Health and Safety at Work Regulations states that, “every employer shall make a suitable and sufficient assessment of:

- The risks to the health and safety of his (or her) employees to which they are exposed whilst they are at work; and
- The risks to the health and safety of persons not in his employment arising out of or in connection with the conduct of him or his undertaking”.

Regulation for them obliges the employer to apply a hierarchy of risk controls.

In other countries, occupational health laws are also in place and commonly compel employers to take a similar approach to providing a safe and healthy place of work. In addition to completing assessments in order to satisfy legal requirements, consider practical value:

- They can be instrumental in reducing the number of ‘safety critical’ incidents that occur
- They underpin a process that creates a safe, secure and welcoming environment, which is likely to enhance corporate image as well as customer confidence and loyalty
- They ensure time and resources, including expenditure, are targeted efficiently and effectively

**What exactly is a risk assessment?**

Risk assessment can be described as the ‘systematic examination of work activities to determine if there are any ‘hazards’ that are likely to expose workers to the threat of harm or injury’.

A ‘hazard’ can be described as anything with the potential to cause harm; including people, objects and situations.

Any risk assessment must identify:

- The nature of the hazard and potential for harm
- The factors that increase the likelihood of staff exposure to the hazard
- The measures necessary to eliminate, reduce or manage the risk of exposure to the named hazard

**High-risk workplaces**

The following elements are commonly found in workplaces with the highest recorded incidence of workplace violence:

- Sexual harassment
- Verbal abuse
- Minimum-wage payrolls
- Discrimination
- Workplace bullying
- Poor or dangerous working conditions
- Lack of job security.
- Physical attacks (i.e. hitting, shoving)
- Threatening behavior (shaking fists, destroying property or throwing things)

**Occupational groups at higher risk from workplace violence**

The Canadian Centre for Occupational Health and Safety lists the following higher risk occupations.

- health care employees
- correctional officers
- social services employees
- teachers
- municipal housing inspectors
Dealing with disgruntled employees

When an employee is angry with an organization, organizational policies, or coworkers, it is important for the issue to be taken seriously before the issue escalates into aggression or violence. Workplace aggressors and those who are likely to commit an act of violence are more than likely to verbalize their frustrations, so personnel should be trained to recognize these cues and apt to deal with them. The following are tactics to use when dealing with an angry employee:

• Maintain eye contact
• Give the employee full attention. Stop what you were doing and show that you are taking the conversation seriously.
• Speak and move calmly and slowly.
• Sit, and encourage the employee to sit also. Arrange seating so you are situated closest to the door.
• Try to create a relaxed environment.
• Be aware of cultural differences. Don’t make assumptions based on your own background. Be aware of personal space and appropriate eye contact.
• Encourage the employee to tell you why they are upset.
• Do not interrupt. If you do not understand, ask them to clarify.
• Acknowledge the employee’s feelings.
• Ask for specific examples.
• If their complaint is valid, accept responsibility and criticism.
• Try to define the true problem.
• Ask open-ended questions.
• Be open and honest.
• Encourage the employee that you will investigate the problem and search for a solution. Assure them that you will be following up with them as soon as possible. Thank them for bringing the problem to your attention.

Preventative maintenance

The Employee Assistance Program (EAP) program originally designated to assist persons with addiction problems, and later offered family, marital, and financial counseling, now offers assistance in reducing workplace violence. The EAP, through counseling and consultation, aids in increasing employee productivity, efficiency, and morale in the workplace, which in turn decreases employee turnover and absenteeism. The EAP has designed a general program for diffusing workplace anger and violence. The elements of the program are:

• Diagnosis. An employee of an organization asks for assistance and the EAP staff attempts to diagnose the problem.
• Treatment. Counseling or therapy is provided. If the EAP is unable to assist the employee, the employee may be referred to the appropriate professional outside of the organization.
• Screening. Periodic screening and examinations of employees, especially of those in highly stressful positions, to detect warning signs of violence or aggression.
• Prevention. Employers use education and persuasion to communicate to employees with high risk levels that there must be alternative solutions to dealing and coping with stress.

Conclusion: For employees violence can cause pain, distress and even disability or death. Physical attacks are obviously dangerous but serious or persistent verbal abuse or threats also can damage employees’ health through anxiety or stress. workplace gossip as a form of workplace violence, noting that it is “essentially a form of attacks so the community health nurse need to focus on the causes and improve the safety of work environment in their working areas. It helps to maintain the good environment and preventing of many health issues.

References:
A study to assess the effectiveness of mentha spicata paste on dysmenorrhea among adolescent girls in Narayana College Of Nursing, Nellore.

INTRODUCTION: Dysmenorrhea is the most common gynecological problem in women in all ages. Most adolescence experience dysmenorrhea in the first 3 years after menarche. Young adult women ages 17 to 24 years are most likely to report painful menses between 50% and 80% of women report some level of discomfort associated with menses and 10 to 18% report severe dysmenorrhea. It has been estimated that up to 10% of women have severe pain which interfere with their functioning for 1-3 days a month.

Herbal supplement is found to be very beneficial for the treatment of menstrual problems. Prolonged result with zero adverse action on user is one among the main advantages of using herbal cures. Some of the herbs like mint leaves, sesame seeds, and bark extract of ashoka tree, etc are best recommended cures for the treatment of menstrual problems.

OBJECTIVES:
1. To identify adolescent girls with dysmenorrhea.
2. To assess the effectiveness of mentha spicata paste on dysmenorrhea among adolescent girls.
3. To find the association between the post test level of pain and selected demographic variables among adolescent girls

HYPOTHESES: H₀: There is no significant difference on dysmenorrhea before and after application of the mentha spicata paste among adolescent girls.

H₁: There is a significant difference on dysmenorrhea before and after the application of the mentha spicata paste among adolescent girls.

H₂: There is a significant association between the effectiveness of mentha spicata paste on dysmenorrhea and socio demographic variables among adolescent girls.

METHODOLOGY: A pre experimental one group pretest post test research design and non probability purposive sampling technique was adopted among 60 samples of adolescent girls at Narayana College of Nursing in Nellore based on the inclusion and exclusion criteria.

DESCRIPTION OF TOOL:
Part - 1: Demographic variables. Consist of age, menstrual pattern, religion, family income, days of cycle, mothers education, mothers occupation and source of health information.

Part - 2: It consists of numerical pain scale (0 - 10)

<table>
<thead>
<tr>
<th>Pain Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1.9</td>
<td>No Pain</td>
</tr>
<tr>
<td>2 - 4.9</td>
<td>Mild Pain</td>
</tr>
<tr>
<td>5 - 7.9</td>
<td>Moderate Pain</td>
</tr>
<tr>
<td>8 - 9.9</td>
<td>Severe Pain</td>
</tr>
<tr>
<td>10</td>
<td>Excruciating Pain</td>
</tr>
</tbody>
</table>
DATA COLLECTION PROCEDURE:
The data collection procedure was carried out for 6 weeks. The permission was obtained from principal, Narayana College of Nursing. 60 adolescent girls were selected by purposive sampling technique. Confidentiality of shared information was assured. The purpose of the study was explained and consent was obtained from girls. Pre Test was conducted for 60 girls by using the study tool. Intervention was given per each sample for 4 days before menstruation later post test was conducted by using the same study tool. Data was analyzed and interpreted by using descriptive and inferential statistical method (i.e. frequency and percentage mean, standard deviation, Z-test and chi-square).

RESULTS:
Frequency and percentage distribution of pre test and post test score of dysmenorrhea. (N=60)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Pain</th>
<th>Pre Test</th>
<th>Post Test</th>
<th>Z Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>f</td>
<td>%</td>
<td>f</td>
</tr>
<tr>
<td>1</td>
<td>No Pain</td>
<td>-</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>2</td>
<td>Mild Pain</td>
<td>18</td>
<td>30.0</td>
<td>23</td>
</tr>
<tr>
<td>3</td>
<td>Moderate Pain</td>
<td>15</td>
<td>25.0</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>Severe Pain</td>
<td>13</td>
<td>21.7</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Excruciating Pain</td>
<td>14</td>
<td>23.3</td>
<td>-</td>
</tr>
</tbody>
</table>

Effectiveness of mentha spicata paste on reducing dysmenorrhea among the adolescent girls in Narayana College of Nursing, Nellore.

The data revealed that there was reduction in the dysmenorrhea pain. The results indicated that the pretest mean of pain was 0.1198 and standard deviation was 7.1749 whereas the post test mean was 0.0644 and standard deviation 0.3769. The calculated value of Z test was 8.09 which exceed the tabulated value 1.645. Hence the null hypothesis was rejected. There was a significant impact of mentha spicata paste on dysmenorrhea.

There was significant association between dysmenorrhea among adolescents and their selected socio demographic variables family income was significant at 0.05 level and other variables like age, menstrual pattern, days of cycle, religion, mothers education, mother occupation, source of health information did not have any significant association.

RECOMMENDATIONS: On the basis of findings of the study the following recommendations have been made:

- A similar study can be conducted to find the dysmenorrhea among adolescent girls.
- An experimental study can be undertaken with one group pre test and post test for effective comparison.
- A similar study can be conducted with other interventions for reducing dysmenorrhea among adolescents.

CONCLUSION:
The findings of study revealed that the adolescent girls had dysmenorrhea mild to moderate. Menthe spicata paste has great benefit to these adolescent girls as it reduced the severity of pain. Nurse administrator also can develop specific guidelines on effectively reducing the dysmenorrhea.

References:
3. JOYCE N. BLACK. "Medical surgical Nursing" 6th editions saunders publication. volume I. Pp 980-981. en.m.wikipedia.org.
A study to assess effectiveness of structured teaching programme on knowledge regarding prevention of leg cramps among antenatal mothers at Maternal Child Health Center, Tirupathi.

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INTRODUCTION

Background of the study

"It is only in the act of nursing that a woman realizes her motherhood in visible and tangible fashion; it is a joy of every moment".

MITRA, (2005) Leg cramps is a common problem in pregnancy particularly at night. The causes are usually due to a sluggish circulation in the legs because of the pregnancy and it is made with the increased pressure as baby grows. The muscles in the leg go into spasm and it is painful but it usually resolves quickly once get out of the bed and stretching the muscles. If the pain doesn’t resolve particularly it is associated with any reddening of the area or swelling in one leg only it may be due to thrombosis.

Leg cramps are a very common occurrence for many women during their pregnancy. Most leg cramps are caused from the fatigue of carrying extra weight that is put on pregnant women. As the pregnant women gain more weight, leg cramps may increase. Cramps can also be aggravated by the expanding uterus putting pressure on the blood vessels that return blood from legs to heart and the nerves leading to legs. Leg cramps can occur at any time: but most likely notice them at night or bed time.

There is some speculation that too little calcium; potassium; or too muscle phosphorus can cause leg cramps. However, it is a good idea to increase calcium intake during pregnancy to avoid phosphorus has the some effect as not getting enough calcium could cause. Phosphorus has some effect as not getting enough calcium because it can prevent body from absorbing the calcium.

Leg cramps are uncomfortable yet the common pregnancy symptoms that may state to plague for in the second and third trimester of pregnancy. Leg cramps in pregnancy can also occur in the daytime. Pregnant women describe leg cramps as a sudden tightening of their muscles, which causes pain. Leg cramps in pregnancy are typically the most painful in the last months of pregnancy (the third trimester), but they can start in the late second trimester. If pregnancy mothers suffer from pregnancy leg cramps, they may get progressively worse as pregnancy week by week continues.

NEED FOR THE STUDY

Repeated muscular cramps has high incidence during the pregnancy and they almost begin in 25th week of pregnancy and are continued until the end of that. In a study, it is mentioned that 45% of women suffer from leg cramps during their pregnancies, 45% of which begins on 25th week of pregnancy and 76% of them have cramps twice or less in a week and 81% of the them experiences these cramps only during the night.

Jennifer, Hesseley, (2009) conducted a study to assess the prevalence of leg cramps during pregnancy and factors affecting the leg cramps. Sleep disturbance during pregnancy can result in excessive day time sleepiness; diminished day time performance; inability to concentrate, irritability and the potential for an increased length birth. Sleep disturbance may be the result of a sleep disorder; such as a leg cramps; a common yet benign disorder or restless leg syndrome, a sensory motor disorder. Both disrupt sleep; and distressing to the pregnant women; and mimic are another and other serious disorders. During pregnancy up to 30% of women
can be affected by the leg cramps, and up to 26% can be affected by restless legs syndrome.

**OBJECTIVES:**
- To assess the knowledge regarding prevention of leg cramps among antenatal mothers by pre test.
- To assess the effectiveness of structured teaching programme on prevention of leg cramps by comparing pre test and post test.
- To determine the association between post test knowledge and the selected demographic variables regarding prevention of leg cramps among antenatal mothers.

**REVIEW OF LITERATURE**
Sohrabvand Fetel., (2009), conducted a cross sectional descriptive analytic study among antenatal mothers to evaluate the frequency and distribution of leg cramps during pregnancy, in Tehran. 400 women in the third trimester of pregnancy were asked to record the symptoms of leg cramps. Their education level and job recorded and their total serum level of Ca and Mg was measured in the first visit. The result shows that prevalence of leg cramps was 54.75%. There was a statistically significant relationship between leg cramps and serum magnesium (p=0.04). There was no relation between calcium level and leg cramps (p=0.294). The women’s age, their nutritional habits and individuals characteristics were not significantly related to occurrence of leg cramps. The study concludes that leg cramps is a common symptom in pregnancy and in patients with low serum levels of magnesium, a magnesium supplements can be helpful.

Pktkin RM (2004), conducted a study to assess the calcium metabolism in pregnancy is a complex process involving calcium, phosphorus, vitamin D, parathyroid hormone (PTH) and calcium (CT) Calcium absorption is enhanced in pregnancy, and increased storage in the maternal skeleton probably occurs as well. Adequate amounts are provided by the current recommended dietary allowances of 1,200 mg daily which can be met readily by natural foods, specifically milk. If supplemental calcium is given, a non phosphate salt is probably advisable, since some evidences suggests that excessive phosphate intake may be related to leg cramps in pregnancy.

**NULL HYPOTHESES:**
- **H0_1:** There is no significant difference between pretest and post test knowledge among antenatal mothers regarding prevention of leg cramps.
- **H0_2:** There is no significant association the post test between their selected demographic variables regarding prevention of leg cramps among antenatal mothers.

**METHODS:** Pre experimental one group pre test and post test design was adopted to conduct study among antenatal mothers at Maternal Child Health centre, Tirupati

Non probability convenience sampling technique was utilized to select the samples of the study. The tool was validated by experts and modifications were made according to experts suggestions.

Pilot study was conducted and found highly reliable with ‘r’ value 0.92. Data was collected from 50 antenatal mothers to conduct the main study. Data was analyzed and interpreted by using descriptive and inferential statistics in terms of frequencies, percentages, mean standard deviation ‘t’ test and chi square value.

**MAJOR FINDINGS OF THE STUDY WERE:**
In the pretest, assessment among 50 antenatal mothers 47(94%) had inadequate knowledge, 2(4%) had moderate knowledge and 1(2%) had adequate knowledge regarding prevention of leg cramps.

In the post test assessment, among 50 antenatal mothers 48 (96%) had adequate knowledge, 2 (4%) had moderate knowledge and none of them had inadequate knowledge regarding prevention of leg cramps.

**Interrelationship between the pre test and post test knowledge.**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Activity</th>
<th>Inadequate knowledge &lt;50%</th>
<th>Moderate knowledge 50-75%</th>
<th>Adequate knowledge &gt;75%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Pretest</td>
<td>47</td>
<td>94%</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>2.</td>
<td>Post test</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>4%</td>
</tr>
</tbody>
</table>
Percentage Distribution of Interrelationship between the pre test and post test knowledge regarding prevention of Leg Cramps

Overall pretest mean was 9.800 and standard deviation was 3.805 and post test mean was 29.860 and standard deviation was 1.600. The obtained ‘t’ value 35.763 which was significant at 0.01 level. There was significant association between post test assessment levels of knowledge with selected demographic variable of education level of antenatal mothers.

Association between demographic characteristics with post test knowledge regarding prevention of leg cramps is determined by using chi-square test. (N=50)

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Demographic variables</th>
<th>Inadequate knowledge below 50%</th>
<th>Moderate knowledge 50-75%</th>
<th>Adequate knowledge &gt;75%</th>
<th>Chi-square X2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Education of the mothers</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Illiterate</td>
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<td></td>
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<td>Degree</td>
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</tbody>
</table>

**Interpretation:**

Table 1: Shows that there was significant association between knowledge of antenatal mothers with education at 0.01 level with df = 8 (chi square = 23.404) in post test

Mean and standard deviation of pretest and posttest among Antenatal mothers about prevention of leg cramps.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>t-value</th>
</tr>
</thead>
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<tr>
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<td>Mean</td>
<td>SD</td>
<td>Mean</td>
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<tr>
<td>Definition</td>
<td>0.540</td>
<td>0.780</td>
<td>1.960</td>
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<tr>
<td>Incidence</td>
<td>0.620</td>
<td>0.660</td>
<td>1.780</td>
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<tr>
<td>Causes</td>
<td>1.600</td>
<td>1.131</td>
<td>5.160</td>
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<tr>
<td>Signs and symptoms</td>
<td>1.380</td>
<td>0.892</td>
<td>3.660</td>
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<tr>
<td>Prevention measures</td>
<td>5.700</td>
<td>2.385</td>
<td>17.300</td>
</tr>
<tr>
<td>Total</td>
<td>9.800</td>
<td>3.805</td>
<td>29.586</td>
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</table>

** = Significant at 0.01 level
* = Significant at 0.05 level
NS= Not Significant

CONCLUSION:
The findings of this study revealed that structured teaching programme was effective in enhancing the knowledge regarding prevention of leg cramps among antenatal mothers.

BIBLIOGRAPHY
**MATERNAL - FETAL - MEDICINE (MFM)**

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**Introduction:**
A highly significant part of the prenatal assessment is screening for high risk factors. Risk factors are any findings that have been shown to have a negative effect on pregnancy outcome, either for the woman or her unborn child. Maternal - Fetal Medicine (MFM) is one of the most rapidly evolving fields in medicine especially in what concerns the fetus.

**Definition:**
Maternal - Fetal medicine (MFM) is the branch of obstetrics that focuses on the medical and surgical management of high - risk pregnancies.

High risk pregnancy is defined as pregnancy complicated by factors that may cause risk to the mother of fetus.

A woman is considered to have a high risk pregnancy when health concerns exist that may threaten the natural course of the development or birth of the baby, or that pose a risk to the mother.

**Services of MFM:**
MFM provides a comprehensive range of specialized services for both mother and baby. It includes a comprehensive range of screening, diagnostic and therapeutic services for both mother and the baby.

MFM specialists have training in obstetric ultrasound, invasive prenatal diagnosis using amniocentesis and chorionic villus sampling, and the management of high - risk pregnancies.

Some of them are further trained in the field of fetal diagnosis and prenatal therapy where they become competent in advanced procedures such as targeted fetal assessment using ultrasound and Doppler, fetal assessment using ultrasound and Doppler, fetal blood sampling and transfusion, fetoscopy, and fetal surgery or Treatment.

**MATERNAL SCREENING PROCEDURES**
Numerous routine screening procedures are available even when there is no family history of any disorder. Apart from them few screening test are needed.

**Screening Tests:**

**Ultrasound:** Routine anomaly scanning at between 18 and 20 weeks of gestation is often carried out as screening for fetal structural abnormalities and to detect the Nuchal translucency (NT) is a useful screening method for Down syndrome in fetus.

**Alpha - Fetoprotein:** Alpha - fetoprotein screening is a blood test that measures the level of alpha - fetoprotein in the mothers' blood during pregnancy. The AFP blood test is also called MSAFP (maternal serum AFP). It is done at 16 - 18 weeks of pregnancy.

Abnormal levels of AFP may signal the following:
- Open neural tube defects (ONTD) such as spina bifida
- Down syndrome, other chromosomal abnormalities.
- Defects in the abdominal wall of the fetus.
- Twins - more than one fetus is making the protein.

**Amniocentesis:** Amniocentesis is the removal, collection, and analysis of a sample of amniotic fluid from the amniotic sac. The amniotic fluid contains cells shed by the fetus, which contain genetic information. Findings from the amniotic fluid helps to rule out the chromosomal disorder, metabolic disorder, isoimmune hemolytic disease of the fetus, intrauterine infection etc.

**Chorionic Villous Sampling:**
Chorionic Villisampling is a procedure to obtain fetal cells in the first trimester of the pregnancy. For this test, a small sample of cells is taken from the placenta and tested. It is useful in
- Early diagnosis of a chromosomal abnormality - aneuploidy, trisomy etc.
- Early diagnosis of certain genetic defects.

**IN UTERO FETAL PROCEDURE:**
In Utero Fetal Procedure: Based on the results of certain prenatal tests, MFM specialists may recommend a fetal therapeutic procedure to treat the condition affecting the baby. Some of the foetal therapeutic procedures include.
Amnioinfusion: This procedure is performed when the amniotic fluid surrounding the fetus is severely decreased (severe oligohydramnios) or when there is absent amniotic fluid (anhydramnios). Adding fluid makes it easier to see the potential problems with the baby.

Intrauterine fetal transfusion: This procedure is done using ultrasound guidance to place a small needle through the mother’s abdomen into a small fetal blood vessel. Blood, platelets, or medications can be administered to the fetus through this technique.

An intrauterine transfusion provides blood to an Rh-positive fetus when fetal red blood cells are being destroyed by Rh antibodies. A blood transfusion is given to replace fetal red blood cells that are being destroyed by the Rh-sensitized mother’s immune system. This treatment is meant to keep the fetus healthy until he or she is mature enough to be delivered.

Transfusions can be given through the fetal abdomen or, more commonly, by delivering the blood into the umbilical vein.

Selective reduction (or multifetal pregnancy reduction or MFPR)

Selective reduction is the practice of aborting one or more fetuses in a multifetal pregnancy, say quadruplets to a twin or singleton pregnancy.

Selective reduction is done for both medical and non-medical reasons. Medical issues generally related to multiple births, including premature births, low birth weights, and associated medical problems. Selective reduction can also be used to reduce a twin pregnancy to a singleton one.

The reduction procedure is generally carried out during the first trimester of pregnancy. The most common method is to inject potassium chloride into the fetus’s heart; the heart stops and the fetus dies as a result. Generally, the fetal material is reabsorbed into the woman’s body.

Fetal Surgery: This type of surgery, which employs minimally invasive techniques, is used more often than open surgery. Surgeons can use fiberoptic telescopes and specially designed instruments to enter the uterus through small surgical openings to correct congenital malformations without major incisions or removing the fetus from the womb.

Minimally - invasive fetoscopic surgery (or Fetendo) has proven to be very useful for some, but not all, fetal conditions. Some examples include:

- Twin - twin transfusion syndrome
- Laser Ablation of Vessels
- Fetal bladder obstructions
- Aortic or Pulmonary Valvuloplasty - opening the Aortic of Pulmonary fetal heart valves to allow blood flow
- Atrial Septostomy - opening the interatrial septum of the fetal heart to allow unrestricted blood flow between the atria
- Congenital diaphragmatic hernia Balloon tracheal occlusion
- Spina bifida Fetoscopic closure of the malformation

Conclusion: Maternal Fetal Medicine provides specialist services among high risk mother for early detection of factors that may affect the maternal or fetal conditions and take prompt steps to prevent maternal and perinatal morbidity and mortality. Through this advanced service we can bring a healthy mother and health child in this world.

References:

- www.google.co.in-prenatal screening, screening of high risk pregnancy.
The promotion of health falls firmly into the remit of nursing. That is not to say that health promotion is an exclusively nurse-led activity; rather, that lies at the very heart of nursing. The Nurse encompasses the principles of health promotion; indeed, every consultation can be seen as a promoting opportunity. There is much debate about definition of health promotion and health education.

Health promotion is a behavioral social science that draws from the biological, environmental, psychological, physical and medical sciences to promote health and prevent disease, disability and premature death through education-driven voluntary behavior change activities. Health promotion is the development of individual, group, institutional, community and systemic strategies to improve health knowledge, attitudes, skills and behavior.

**WHY IS HEALTH PROMOTION IMPORTANT?**
The purpose of health promotion is to positively influence the health behavior of individuals and communities as well as the living and working conditions that influence their health.
- Health promotion improves the health status of individuals, families, communities, states, and the nation.
- Health promotion enhances the quality of life for all people.
- Health promotion reduces premature deaths.
- By focusing on prevention, health promotion reduces the costs (both financial and human) that individuals, employers, families, insurance companies, medical facilities, communities, the state and the nation would spend on medical treatment.

**Definitions:** Health: The world health organization (WHO) in 1948 defined health as a state of complete physical mental and social well being. World Health Organization’s (2005) Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. Health education is communication activity aimed at enhancing positive health and preventing or diminishing ill health in individuals and groups through influencing the beliefs, attitudes and behavior of those with power and of community at large.

**Values in Health Promotion:** Health promotion is implicitly based on several values:
- Equity and social justice
- A holistic definition of health
- Covers the full range of health determinants
- Recognizes the influence of environment on health
- Empowers people and builds individual and collective capacity
- Seeks to enhance people’s social participation
- Involves intersectorial collaboration.

**Factors affecting health:**
There are many factors which affect a person’s health status. Naidoo and wills (1994) listed the main influences upon health as genetic, biological, life style, environmental and social factors. It is important to remain aware of the multiplicity of factors affecting an individual’s health and therefore to consider the range of influence up on the person including family, employment, learned behavior, health beliefs, politics, housing and available health services.

**Implementing Health promotion in practice:**
Traditionally the focus of health promotion has been seen as an activity, which occurs in primary care. The Nurse can also be located in hospital settings where time and resources are frequently sited as reasoning for not putting health promotion into practice.

**Approaches to health education:** In order to work with individuals who have a wide variety of definitions of health and have numerous influences upon their health status, it is necessary to consider the variety of approaches to health promotion. Katz and Peherdy (1997) outline five approaches to health promotion: Medical, behavioural, educational, client centred and social change.
Medical approach: The medical approach to health promotion uses scientific methods to address the health problems of disease and ill health. Preventive measures include immunizations and screening to allow for prevention and the early detection of medically defined illness.

Behavioural approach: The behavioural approach seeks to encourage individuals to adopt healthy behaviours: The individual should then be at a decreased risk of developing diseases, which are associated with high-risk behaviours such as smoking, consumption of alcohol, excessive consumption of fatty foods. Health education is focused on behaviour change and relies heavily upon the individual willingness to adopt healthier lifestyle.

Education approach: The education approach aims to provide individuals with the knowledge and understanding necessary to make an informed choice about their health. This approach does not set out to persuade an individual to change in certain directions; rather, the aim is to provide the individual with the information necessary to make an appropriate decision.

Client centred approach: The client centred approach helps the client to identify concerns and priorities. The role of the health educator is to provide the client with the necessary tools and skills to get the agenda and to act upon the identified concerns.

Social change: Social change is directed at the environment with which a person lives. Political action is focused upon changing the social, physical or economic environment and thereby making it possible, or more likely, for individuals to make healthy lifestyle choices.

Models of health promotion: A model of health promotion helps to provide a framework to analyse and guide practice. There are many models of health promotion suits the style of activity with certain clients or client groups more than another. Tones(1996) has developed a model of empowerment and health promotion which brings together health education, self-and community empowerment, health public policy, environment and social circumstances and equity. Each of these concepts underpins the individual’s ability to achieve health. Beattie (1991) suggests that there are four strategies for health promotion: Individual persuasion, legislative action, personal counseling and community development. The strategy employed can therefore be authoritative or based on negotiation and may be an individual activity or the focus of collective activity.

The health belief model (Becker 1984) focuses on the role of health beliefs in determining an individual’s action. The health belief model is based on the assumption that each person will consider the cost and benefits of a particular behaviour and engage in health actions. Accordingly in order to engage in behaviour, which will prevent illness and/or promote health and wellbeing.

Ajzen and Fishbein (1980) Theory of reasoned action is another model which can help the nurse to understand the behaviour of patients and the reasons why some chose to adopt health lifestyle actions and other don’t. The health promotion model proposed by Nola JPender (1982 revised 1996) was designed to be a complementary counter part to models of health promotion. The model focuses on three areas to promote health, individual characteristics and experiences, behaviour specific cognitions and affects, behavioural out comes.

Helping people change: It is clearly of great concern to any health care professional involved in health promotion that if changes are made towards a healthier lifestyle, those changes should be permanent. Prochaska and diclemente (1984) developed a stage model of behaviour acquisition, which outlines the stages involved in changing behaviour.

This model has been widely used in primary health care is particularly relevant in the management and support of the people who are of overweight and attempting to change the dietary habits. This can help the nurse to support and understand the patient through the change process. Social support is essential to reinforce the need for behavioural change and to maintain the change.

Conclusion: Health promotion is defined as “efforts to enhance positive health and reduce the risk of ill health through the overlapping spheres of health education, prevention and health production.” The nurse have an important role to play at a variety of levels of health promotion, however during individual consultations, the activity of nursing intervention will tend to be focused upon health education at an individual level.

References:
2. www. nursingtheories. weebly.com/nola-pender.htm
Mrs. BM. Madhavi  
MS. c (N), Lecturer  
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SVIMS, Tirupathi.

Introduction: “First the man takes the drink, then the drink takes the drink, then the drink takes the man”.

The term Alcoholism was first used in 1849 by Magnus Huss, a physician to describe the systematic adverse effects of alcoholism. Alcohol is a group of substances the technical name of alcohol beverage is Ethanol or Ethyl alcohol; popularly, it is known as Alcohol.

Alcohol produces a sedative effect by depressing the central nervous system. Depending on the amount of alcohol ingested, the effect can range from feelings of mild sedation and relaxation to serious impairment of motor functions, speech, confusion and severe intoxication that can result in coma, respiratory failure and death.

Alcohol consumption is the leading risk factor in developing countries in Europe alone alcohol consumption was responsible for over 55,000 deaths among labourers aged 18 to 30 years in 1999.

It is common for a person suffering from alcoholism to drink well after physical health effects start to manifest. The physical health effects associated with alcohol consumption may include Cirrhosis of liver, Pancreatitis, Epilepsy, Poly neuropathy, alcoholic dementia, Heart disease, Increased chance of Cancer, Nutritional deficiencies, Sexual dysfunction, and Death from many sources.

Psychiatric disorders are common in alcoholics; especially Anxiety and Depression disorders, with as many as 25% of alcoholics presenting with severe psychiatric disturbances. Panic disorder can develop as a direct result of long term alcohol misuse. Panic disorder can also worsen or occur as part of the alcohol withdrawal syndrome.

Need for the study: “I have taken more out of alcohol than alcohol has taken out of me”.

Alcohol consumption has been steadily increasing in developing countries like India and decreasing in developed countries since the 1980s. The pattern of drinking to intoxication is more prevalent in developing countries indicating higher levels of risk due to drinking. 62.5 million alcohol users estimated in India per capita consumption of alcohol increased by 106.7% over the 15-year period from 1970 to 1996. Due to its large population, India has been identified as the potentially third largest market for alcoholic beverages in the world, which has attracted the attention of multinational liquor companies.

In 1992 in Canada the economic cost of alcohol use was estimated at more than 7.5 billion, representing 40.8% of the total costs of substance abuse and 1.1% of the Gross Domestic Product of the 6701 deaths resulting from alcohol consumption that year, 14.3% were from alcoholic cirrhosis. Also in 1992, 16.6% of hospital admissions due to alcohol related illness resulted from alcohol dependence syndrome. Clearly, problem of drinking and alcohol dependence are important health issues in Canada.

The World Health Organization (WHO) estimates that there are 60 to 70 million alcoholics in India, 50% are-hazardous drinkers and requires treatment.

Objectives:
1. To assess the knowledge of labourers regarding the ill effects of alcoholism.
2. To develop and conduct a structured teaching
programme on knowledge regarding ill effects of alcoholism.
3. To evaluate the effectiveness of structured teaching programme among labourers on ill effects of alcoholism among labourers.
4. To find out the association between knowledge scores of labourers and selected socio demographic variables.

Hypothesis of the study:

$H_1$: There is a statistically significant difference between the pre test and post test Knowledge scores among labourers.

$H_2$: There is statistically significant association between knowledge on selected socio demographic variables of labourers regarding ill effects of alcoholism.

Methodology: The data was collected by using a structured Interview Schedule. 100 Labourers were selected by non-probability convenience sampling. The data collection instrument was a Structured questionnaire to assess knowledge in Pre and Post test, STP on ill effects of alcoholism among labourers. The questionnaire included the following determinants:

- Demographic data.
- Questionnaire regarding the ill effects of alcoholism.

Knowledge assessment interview schedule: There was 30 questions. Each question has three options in which only one was the correct response and all other two were distracters. Each correct response is awarded - one mark and for incorrect response - zero mark. Maximum score for questionnaire was 30 and minimum - zero.

- Inadequate (<50%)
- Moderate (50-75%)
- Adequate (>75%)

Plan for Data Analyses: The data obtained were analyzed and tabulated according to the objectives of the study by using descriptive and inferential statistics.

Results:

The collected information was organized and presented under the following three sections.

- Percentage distribution of demographic variables
- Deals with the findings related to knowledge score of the labourers regarding ill effects of alcoholism.

Part A: A spect - wise distribution of scores during pre and post test.
Part B: Association between pre and post test knowledge scores.
Part C: Association between pre test and post test scores with selected demographic variables.

Aspect wise Mean pre test knowledge scores of respondents on ill effects of alcoholism

<table>
<thead>
<tr>
<th>No.</th>
<th>Knowledge</th>
<th>Max Score</th>
<th>Range Score</th>
<th>Knowledge Score</th>
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</thead>
<tbody>
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<td>1 - 8</td>
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<td>1 - 6</td>
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<td>Preventive aspects</td>
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<td>1 - 7</td>
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<td>Combined</td>
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<td>1 - 24</td>
<td>9.400</td>
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</table>

The above table shows aspect wise mean pre - test knowledge scores of respondents on ill effects of alcoholism.

Aspect wise mean pre-test knowledge scores of labourers on ill effects of alcoholism. 27.217% of the score obtained in Alcoholism, 25.138% of the score obtained in Ill effects, 24.522% of the score obtained in Signs and Symptoms, 22.959% of the score obtained in Preventive Aspects.

Aspect wise Mean Post test knowledge scores of respondents on ill effects of alcoholism

<table>
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<tr>
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<th>Range Score</th>
<th>Knowledge Score</th>
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<td>Score</td>
<td>Score</td>
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<td>Signs &amp; symptoms</td>
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<td>Combined</td>
<td>30</td>
<td>1 - 29</td>
<td>28.520</td>
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</table>

The above table shows aspect wise mean post test knowledge score of labourers on ill effects of alcoholism.

Aspect wise mean post test knowledge scores of labourers on ill effects of alcoholism. 77.041% of the
scores obtained in Preventive Aspects, 75.478% of the scores in Signs and Symptoms, and 74.862% of the scores obtained in Ill Effects, 72.783% of the scores obtained in Alcoholism.

**Major Findings of the Study:**

The major findings of the study were as follows:

**A. Findings related to demographic data of the subjects**
- Majority (57%) of the respondents were 29-39 years of age.
- Most of the respondents (100%) were males.
- Most of the respondents (77%) were married.
- 60% of the respondents have attained primary education.
- Majority (87%) of the respondents belonged to the income group 3000-5000.
- Majority (56%) of the respondents were taking alcohol for 4-7 years.
- 81% of the respondents were taking 1-2 pegs per day.
- Majority of the respondents (52%) were consuming to relieve from stress.
- 67% of the respondents started to consume alcohol at the age of 21-40 years.
- Most of the respondents (59%) for beginning to drink was to relieve body aches and discomfort.

**B. Findings related to the pre and post - test knowledge of respondents**
- Highest (27.217%) knowledge score in aspect wise pre - test mean knowledge score on ill effects of alcoholism was found in the aspect of Alcoholism.
- Highest (77.041%) knowledge score in aspect wise post-test mean knowledge score on ill effects of alcoholism was also found in the aspect of prevention.
- The post-test mean knowledge score was found higher (75.211%) when compared with pre-test mean knowledge score (24.789%).
- Aspect wise enhancement of knowledge score on ill effects of alcoholism was found higher (54.082%) in the aspect of Prevention.
- The statistical paired test indicates that enhancement in the mean knowledge scores found to be significant at 5 percent level for all the aspects under study.

**C. Findings related to association between demographic variables and pre-test and post-test knowledge scores**

The Association between knowledge score and demographic variables was computed by using $X^2$-test.
- There was non-significant association between marital status and knowledge score in pre test and post test.
- There was a significant association between educational status and knowledge score in pre and post-test.
- There was a significant association between influence to start taking alcohol and knowledge score in pre and post test.

**CONCLUSION:** The study concluded that structured teaching programme was effective in improving the knowledge of labour regarding ill effects of alcohol.

**REFERENCES:**
- Selvaraj P. Awareness of problems related to alcoholism. India. 2007; volume. 48, No.9, pp.442-82.
INTRODUCTION

Technology in the acute and critical care setting is typically equated with devices such as bedside monitors, bar coding devices, mechanical ventilators, dialysis machine etc which play a key role in patient safety and care.

The general public believes that technology will improve health care efficiency, quality, safety and cost. Patient care technology has become increasingly complex; transforming the way nursing care is conceptualized and delivered. Technology has been described as both part of the problem and part of the solution for safer health care.

Definitions:

- Technology- is defined as science of practical or industrial arts or applied science.
- Patient care Technology refers to the practical and applied methods that facilitate the delivery of care of patients, families and families.
- Patient safety technology is defined as the prevention of harm caused by errors of commission and omission.
- Errors of Omission- the errors that occur when a necessary therapy is not carried out.
  Eg: Non administration of medication.
- Errors of commission- Wrong dose of medicating given or is administered at wrong time.

GOALS OF PATIENT CARE TECHNOLOGY AND SAFETY

- Safe
- Patient centered
- Timely
- Efficient
- Effective
- Equitable

Categories Of Patient Care Technology

- Those that support direct hands on care of the patient.
- Those that support documentation.
- Those that support meeting the needs of patient and families.
- Those that support the staff caring for the patient.

TECHNOLOGIES COMMONLY USED BY NURSES

Direct Nursing Care Delivery Technology

- Barcode medication administration
- Intravenous tubing
- IV pumps
- Feeding pumps
- Nasogastric tubes
- Endotrachial tube
- Tracheostomy tubes
- Syringes
- Needles
- Urinary catheters and drainage bags
- Ostomy appliances
- Wound drainage tubes
- Chest tubes
- Suction equipment
- Oxygen and air regulators, tubing, and face masks
Oxygen tanks and regulators
Nebulizers
Dressings (from guaze to specialized materials)
Traction systems
Code carts

Indirect Nursing Care Delivery Technology
- Robotics
- Radio frequency identification
- Electronic inventory systems
- Computerized staffing systems

Communication With People Distanced By Place and Time
- Electronic medical records
- Electronic ordering systems
- Communication devices
  (cell phones, PDAs, "Voicera," Paging systems)
- Call systems, including emergency call bell.

PATIENT PROTECTIVE DEVICES
- Floor mats
- Beds
- Elopement/wandering alarms
- Fall alarms
- Hipprotectors
- Specialized mattresses (e.g., low air loss)
- Specialized lighting
- Hand rails in patient rooms, hall ways, and bathrooms
- Specialized seating cushions
- Limb compression devices

PATIENT ASSESSMENT, MONITORING AND SURVEILLANCE.
- Telemetry
- Bedside monitoring
- Ventilators
- Video surveillance
- Stethoscope
- Sphygmomanometer

- Thermometer
- Otoscope
- Ophthalmoscope
- Pulse oxymetry

PATIENT ASSISTIVE DEVICES
- Canes
- Walkers
- Robotics
- Stand assist lifts
- Trapeze bars
- Patient transfer devices ECD
- Bed pans
- Wheel chair
- Prosthetic limbs
- Orthotics (braces, shoes)

NURSE PROTECTIVE DEVICES
- Facemasks
- Gloves
- Gowns
- Hand sanitizer dispensers
- Mechanical lifts
- Patient transfers devices

REMOTE PATIENT MONITORING
- Telemedicine and telehealth

CONTINUOUS LEARNING
- Distance learning
- Video conferencing
- Online training

PATTERN IDENTIFICATION
- Electronic medical records
- Workload and staffing data systems.

Tips For Nurses To Influence Technology At The Bedside
- Organize equipment fairs to gain input from key users and stakeholders before purchases.
- Examine performance of technology on challenging
scenarios in a simulated setting with a small number (three to five) of untrained, representative users.

- Mentor and oversee temporary (agency) nurses and other personnel (e.g., resident physicians) during first-time use of sophisticated technology.
- Develop cogent arguments to administration to justify purchase of new equipment and technologies, balancing the cost of equipment (costs of purchase, training, and maintenance) against costs saved if equipment was not purchased.
- Report adverse events associated with medical devices to the concerned authorities.
- Serve as a resource person on your unit for new technologies by getting training early, communicating with vendors, training others on your unit, and offering to field questions as new technology is implemented.

RESEARCH IMPLICATIONS

SPECIFIC RESEARCH PRIORITIES INCLUDE THE FOLLOWING

- There is a paucity of research evaluating the outcomes of specific patient care technologies. Further research is needed to evaluate the immediate and long-term outcomes associated with specific technologies used in nursing practice. Research should include nursing, patient, and organization outcomes.

- Nursing practices and are delivery systems vary across sites. Further research is needed to evaluate the effects of various nurse processes and environment conditions on the use and effectiveness and efficiency of specific technologies used in nursing practice.

- There are a number of moderating and mediating factors effecting technology use in health care (e.g., organizational factors, social factors, physical environment and characteristics of technology). Further research is needed to examine this mediating and moderating factors and how they affect both the use of technology and outcomes.

- Variations in how technologies are implemented exist across organizational and practice settings. Research is needed to improve the process for introducing technology into the work place to optimize outcomes.

CONCLUSION:

Many patient safety technologies are already widely available. The first step for improving health care is having care that is safe and patient and patient centered at the most basic level. Information and communication technology can be applied to the health care environment to enhance patient safety and nurse efficiency.

REFERENCES:

Beneficial effects of virgin coconut oil on Serum cholesterol

Guided by: Prof. Dr. A. Jyothi,
Dept of Home Science,
SPMVV.

INTRODUCTION: Obesity is a serious international health problem that increases the risk of severe common disease. Obesity has been described as an epidemic because of the rapid increase in the number of overweight and obese individuals over the past 20 years. Obesity can occur at any age as long as the person is under positive energy balance. More females than males were found to be overweight due to effect of female sex and maternal BMI on adulthood obesity.

NEED FOR THE STUDY: Independent risk factor for increased adiposity in adulthood obesity and is a serious chronic disease caused by an imbalance between the energy expanded. Enlarged fat cells produce the clinical problems associated with obesity either because of increases the secretion of free fatty acids and numerous peptides from enlarged fat cells.

Obesity is a constellation of central adiposity, impaired fasting glucose, elevated blood pressure, and high serum cholesterol and the risk of cardiovascular diseases and diabetes is increased 1.5 to 2 folds.

Virgin coconut oil (VCO) extracted by wet process directly from coconut milk under a controlled temperature may have more beneficial effects than copra oil (CO) since it retains most of the unsaponifiable components like lauric acid, tocopherols, tocotrienols, and polyphenols. The primary purpose of the present study was to determine that the consumption of VCO on total cholesterol in obesity.

DESIGN AND METHODS:
Preparation of virgin coconut oil: The solid endosperm of mature coconut was crushed, made into a viscous slurry and squeezed through cheese cloth to obtain coconut milk which was refrigerated for 48 h. After 48 h, the milk was subjected to mild heating (50°C) in a thermostat oven. The obtained virgin oil was filtered through cheese cloth.

Intervention: This is an experimental study in which 15 randomly selected young obese women of 20-23 years of age in Tirupati are orally supplemented daily with 20 ml of virgin coconut oil for 60 days. All patients underwent nutritional status and biochemical investigation throughout the study to see the effect of VCO on Body Mass Index and serum cholesterol.

RESULTS AND DISCUSSION:
The general information shows that 53 percent of subjects were in the age of 20-21 years; whereas considering occupation 73 percent of subjects are...
students and 13 percent of subjects were in working groups, while considering income 80 percent of subjects had high income and only 20 percent of subjects belong to middle income; these independent factors like young age, socioeconomic status and sedentary occupation, modifies the eating habit by eating fast foods and junks and changes the life styles by modernization, slow down the metabolism causes premorbidity and early deaths.

After supplementation of Virgin coconut oil (VCO) in selected subjects there was decrease in Body mass index (BMI) levels from 30.5170 kg/m² to 28.6537 kg/m² with the difference of 1.8633 kg/m² and t-value is 9.6286 and p-value is 0.01. This reveals that results is statistically significant at 1% level.

Same trend was seen in serum cholesterol from 248.20 mg/dl to 227.67 mg/dl with the difference of 20.53 mg/dl, t-value is 6.8814 and p-value 0.01. This reveals that reduction is statistically significant at 1% level. Because Virgin coconut oil consists high amount of lauric acid, tocopherol, tocotrienols, and polyphenols, which increase the action of fraction of fat oxidative enzyme with this the raises the metabolic rate, fat oxidation, energy expenditure and decreases the fat storage, body fat mass in various parts of the body and maintain the normal cholesterol levels.

CONCLUSION:

Obesity is becoming more common with an alarming rate. The incidents of obesity are double with 2015. Obesity prevalence in young women, due to the several factors mainly socioeconomic, eating habits and sedentary activities, which predisposing to several chronic diseases mainly heart diseases by elevated cholesterol status.

Uniqueness and beneficial effect of Virgin coconut oil, consists of high level of Lauric acid, tocopherol, tocotrienols, and polyphenols are better the nutritional status by reducing BMI and cholesterol status by increased fat oxidation.

REFERENCES:

1. Fife (2003) “Eat fat; Look thin a safe and natural way to loss weight permanently”; Piccadilly Books; Springs Ltd.
Ageing is a biological process and experienced by the humankind in all times. It refers to a sequence of changes across a life span of an individual. Chronological age of 65 years and above as a ‘elderly’ or older person in India, “senior citizen” means any person being a citizen of India, who has attained the age of sixty years or above. *(NPOP, MOSJE and GOI)*

**CLASSIFICATION OF OLD AGE**

Age group 60-69 years - Young old or ‘not so old’, Age group 70-79 years -Old old ,Age group 80 years and over - ‘older old’ or ‘very old’.

**Demography: Geriatric population**

- Advances in medicine have increased the life expectancy resulting in an increase in the geriatric population. Globally, elderly constitute 11% of total population. *(United Nations Population Division report, 2010)*
- In India: adults over 60 years constitute 8 percent of total. *(Census 2011)*

**10 FACTS ON AGEING**

1. World population is rapidly ageing
2. Number of people aged 80 and older will quadruple in the period 2000 to 2050
3. By 2050, 80% of older people will live in low and middle-income countries.
4. Main health burdens for older people are from non-communicable diseases
5. Older people in low- and middle-income countries carry a greater disease burden than those in the rich world.
6. Need for long-term care is rising.
7. Effective, community-level primary health care for older people is crucial.
9. Healthy ageing starts with healthy behaviors in earlier stages of life.

We need to reinvent our assumptions of old age. Over the past decades, India’s health programmes and policies have been focusing on issues like population stabilization, maternal and child health, and disease control.

Current statistics for the elderly in India gives a new set of medical, social, and economic problems that could arise if a timely initiative in this direction is not taken by the program managers and policy makers.

There is a need to highlight the medical and socio-economic problems that are being faced by the elderly people in India, and strategies for improvement in their quality of life also need to be explored.

**HEALTH PROBLEMS IN BOTH GENDERS**

- Ocular Diseases: Cataract, Glaucoma, Presbyopia.
- Reduced Muscular Strength and Coordination : Accidents and Injuries
- Cardiovascular Diseases: IHD, Stroke and Hypertension.
- Chronic respiratory illness: COPD, Asthma, bronchitis.
- Mental problems: dementia, depression and mood disorders.
- Complication of Diabetes.
- Cancers: Oral, gastric, lung and colorectal cancers.
- Nutritional Deficiencies.
- Dental Problems.
• Hearing Defects.
• Increased Susceptibility to Infections: RTI, UTI.
• Deg. Neurological Diseases: Alzheimer’s and Parkinsonism.

Factors Effects Health Need Of Elderly People

MAJOR CONCERNS OF ELDERLY WOMEN:

Destitution/ Alienation / Isolation
• Marginalization/isolation or alienation in old age is among the most common issues that are affecting older women constantly.
• Older women, who are still living with their sons/daughters and grand-children are also suffering from emotional alienation.
• Due to fast changing socio-economic scenario of the country, fast paced modern life style and Rapid urbanization across the country.
• Younger generations hardly interact with their elderly family members.

Social Insecurity
➢ Older women, who live in cities, are prone to social alienation/marginalization in comparison to older women of villages.
➢ Joint family system (to a certain extent) is still alive in rural areas.
➢ Older women, who live in semi urban situations/industrial townships also find it difficult to cope with old age, particularly after their children have grown up and husbands retire.
➢ Due to lack of social protection, older women are forced to lead a life full of distress.

Financial insecurity
➢ Increased life span of older women in old age, their financial needs are emerging as a major concern.
➢ Many older women have property/money but they cannot possibly use the money or take financial decisions on their own.
➢ Social traditions don’t allow them to use their ancestral property/money for their own welfare.
➢ They may be rich or poor; they always have to act according to others’ directives.
➢ Habitual of sacrificing their own interests for the good of other family members throughout their life.

Medical problems
➢ Due to negligence, lack of awareness, financial support and religious mindset of women, older women often face acute health problems.
➢ Most of the older women are living within the four walls and barely come out in open public places, most of their health problems remain unnoticed.
➢ Older women living alone could not share their pain, since there is no one to lend her patient hearing.

Emotional Insecurity
➢ Older women face family problems like uncomfortable relations with son and daughter-in-law, limited interaction with children, grand-children.
➢ Daughters-in-law don’t like their interference in family matters, children are busy with their jobs.
➢ Husbands invariably have mood swings after retirement and mostly restrict their free movements.
➢ Old age, women turn towards religious rituals and activities, pilgrimage, etc. after losing their life-partner or any other family members.

SOLUTIONS:

PREVENTIVE INTERVENTIONS
➢ Vaccinations: Influenza immunization annually, Pneumococcal immunization once at the age of 65 years.
➢ Myocardial infarction: Daily aspirin in patients with prior history or with cardiovascular risks factors.
➢ Osteoporosis: Calcium 1,200 mg daily and vitamin D at least 800 IU daily.

Exercise: Increased physical activity improves physical function, muscle strength, mood, sleep and metabolic profile.
➢ Regular, moderate intensity exercise can reduce the rate of age associated decline in physical function.
➢ 150 minutes/week of moderate intensity aerobic activity Eg: Brisk walking and muscle strengthening exercise involving all major muscles.

Nutrition: Basic principles of healthy diet are also valid for older people, namely: Consumption of fruits, vegetables, whole grains 2. Good hydration, at least 1,000 mL of fluids/day 3. Fat-free and low-fat free dairy products, legumes, poultry 4. Fish at least once a week 5. Supervised medications and ensuring the drug compliance in elderly

Screening and early management
➢ Osteoporosis: Bone mineral density (BMD) at least once after the age of 65 years, once in every 2–3 years.
➢ Hypertension: Blood pressure at least once a year, more often in patients with hypertension.
➢ Diabetes: Serum glucose and hemoglobin A1C every 3 years, more often in patients who are obese or
hypertensive.

- Lipid disorders: Lipid profile every 5 years, more often in patients who are diabetics or any cardiovascular disease.
- Colorectal cancer: Stool occult blood test, sigmoidoscopy or colonoscopy, regularly up to age of 75 years.
- Breast cancer: Mammography every 2 years between ages 50 and 74 years.
- Cervical cancer: Pap smear every 3 years up to age of 65 years.

**SOLUTIONS FOR PSYCHOLOGICAL PROBLEMS**

- Spend time in taking care of grand children.
- Play with them and try to educate them in studies and Indian culture How to behave as Grandparents.
- Spend time in offering prayers and reading ancient scriptures.
- Do some physical exercises & Perform yoga and meditation.
- Be active in the house and try to be helpful to them.
- Take the children to the nearby park for play.
- Generally keep some time of 15 minutes to observe silence.
- Write personal diary, what did during the day and what are plans for the future.
- Remain in contact with all family members and close friends Phone them regularly.
- Find the local library and go there for reading books.
- Tackle Stress Changes in our life style in our day-to-day environments and a normal part of life.

**MAJOR GOVT. INITIATIVES**

- **Ministry of Social Justice & Empowerment:**
  - Ministry of Social Justice & Empowerment National Policy on Older Persons (NPOP), 1999
  - Support to ensure Financial and food security, health care, shelter and other needs of older persons.
  - Equitable share in development, protection against abuse and exploitation, and availability of services to improve the quality of their lives.
- **Maintenance and Welfare of Parents and Senior Citizens Act, 2007**
- A senior citizen including parent who is unable to maintain himself from his own earning or property owned by him,
- It is an obligation of the children or relative, to maintain his needs so that he / she may lead a normal life.
- If children or relatives, neglect or refuse- Tribunal may order them to make a monthly allowance which shall not exceed 10,000/month.
- Establishment of old age homes- one must accommodate minimum of 150 senior citizens.
- Separate beds for elderly in all Govt. hospitals.
- Separate queue for the elderly in hospitals.
- Treatment facilities for chronic degenerative diseases & research

**MINISTRY OF HEALTH AND FAMILY WELFARE**

- National Programme for the Health Care of Elderly (NPHCE)-2010
- **Strategies for NPHCE 2010:**
  - CORE STARTERGIES
    - PHC/CHC level equipment, training, additional human resources (CHC), IEC,
    - Community level - domiciliary visits by trained health care workers
    - District Hospital 10 bedded wards, additional human resources
    - Training IEC using mass media, folk media and other communication

**SCHEMES UNDER OTHER MINISTRIES**

- **Ministry of Railways:**
  - Separate ticket counters for senior citizens of age 60 years and above at various (Passenger Reservation System) PRS centres.
  - Provision of lower berth to male passengers of 60 years and above and female passengers of 45 years and above.
  - 40% and 50% concession in rail fare for male passengers aged 60 years and above and female passengers aged 58 years and above respectively.
  - Wheel chairs at stations for old age passengers.

- **Ministry of Civil Aviation:**
  - Air India provides concession up to 50% for male senior citizens of 65 years and above, and female senior citizens of 63 years and above in air fares.

- **Ministry of Finance:**
  - Facilities for senior citizens of 65 years
    - Income tax exemption up to Rs. 2.40 lakh/yr
    - Deduction of Rs 20,000 (Section 80D) is allowed to an individual who pays medical insurance premium for his/her parent or parents, who is a senior citizen.
An individual is eligible for a deduction of the amount spent or Rs 60,000, whichever is less for medical treatment of a dependent senior citizen.

Extra 0.5% interest for the elderly on fixed deposit

Ministry of Rural Development:
- Annapurna Scheme
  - Benefits: 10 kgs of food grains per month is provided free of cost to the person
  - Implementing Indira Gandhi National Old-age Pension Scheme
  - Pension amount: Rs 400 (Rs 200 from central and 200 from state govt.)
  - Beneficiaries: over 60 years and belonging to BPL family
  - Launched in 2007

Department of Pensions and Pensioner Grievances
- A Pension Portal has been set up to enable senior citizens to get information regarding the status of their application, the amount of pension, documents required, if any, etc.
- The Portal also provides for lodging of grievances.
- As per recommendation of the Sixth Pay Commission, additional pension to be provided to older persons
- Age Group % pension to be added: 80+20 85+30 90+40 95+50 100+100

Strategies & Recommendations
- Primary health services:
  - Geriatric health care - as a part of primary health services
  - Care at rural areas should be strengthened.
  - Training of Medical Officers, Peripheral health workers and volunteers
  - Screening camps & mobile clinics for reaching out to the elderly population.
  - Involves NGO’s particularly in difficult to reach areas.
  - “Community Geriatric Health Workers” may be trained to provide home care to the disabled elderly population.
  - Employment of a trained female medical officer to address the increasing health problems of elderly women.
  - Strengthening the elderly in the process self-help by means of physical, psychosocial, and vocational rehabilitation.
  - Capacity building of the community leaders.

- Secondary level health facilities:
  - Set up geriatric wards
  - Distinct OPD services providing screening services as well as curative and rehabilitative services at the tertiary care level.
  - Set up a comprehensive multidisciplinary team-providing specialist services.
  - Geriatric health problems must be addressed at all three levels of prevention.
  - Health promotion measures
  - Screening for non-communicable diseases
  - Rehabilitation: visual aids/mobility aids, physiotherapy
  - Focus on vulnerable groups - BPL or other marginalized sections of the society.
  - Economic security: At the national level, mixture of pension schemes and social security schemes can help to the elderly.

Role of Media:
- Make the people aware about the problems and services available.
- Create a positive perception of the senior citizens in the society.
- Research in Geriatrics and Gerontology: common chronic and neuro-degenerative disorders, process of ageing, pharmacokinetics and pharmacodynamics of drugs, and research in alternative medicine.

CONCLUSION
Increased life expectancy, rapid urbanization and lifestyle changes have led to an emergence of varied problems for the elderly in India. This paper has mainly focused on the health issues of the elderly, it must be remembered that complete health care to the elderly is possible only by strategies for improvement in their quality of life also comprehensive and multidisciplinary approach.

REFERENCE
2. Indian Journal of Gerontology Vol. 27 No. 4, 2013
4. United Nations, World Demographic Estimate and Projections
6. National programme for health care of elderly
7. Dr. Abhay Dhanorkar 2012.
Imagine a plant that can nourish our body by providing most of the protein you need to live, help prevent the annoying sniffling and sneezing of allergies, reinforce your immune system, help control high blood pressure and cholesterol, and help protect us from cancer. Does such a “super food” exist? Yes. It’s called Spirulina.

According to World Health Organization (WHO) Spirulina is an interesting food rich in iron and protein which can be administered to children without risk. WHO also declared it as the best food for future. Spirulina is blue - green algae it is a simple, one-celled form of algae that thrives in warm, alkaline fresh-water bodies. The name “Spirulina” is derived from the Latin word for “helix” or “spiral” Produced from two species of cyanobacteria Arthospira platensis & Arthospira maxicana.

History of Spirulina: A German Algae scientist, Dr. Darwin discovered the existence of the spiral shaped algae and named it Spirulina Dr. Clement of France in 1962 found that the Ganimou Kanemlu people living around Lake Chades in Africa had stronger bodies than other civilized people at that time, despite poor living conditions and limited resources. Ganimou people eat a blue green algae found floating on the lakes surface. This algae was Spirulina.

Why Spirulina is known as food of the future: Spirulina is being developed as the “food of the future” because of its amazing ability to synthesize high-quality concentrated food more efficiently than any other algae. Spirulina contains 65 to 71 percent complete protein, with all essential amino acids in perfect balance. Spirulina won “the best natural food “ award in west Germany's International Food Expo. The United Nations has conducted a 5-year toxicology study on Spirulina and found it to be completely non-toxic! National Aeronautics Space Administration (NASA) Scientists from USA tested and found that 1 kg of Spirulina is nutritionally equal to 1,000 kg of assorted Vegetables and Fruits.

Active ingredients of Spirulina are:

Spirulina (dried) Nutritional value per 100 g :

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Carbohydrates</td>
<td>23.9g</td>
</tr>
<tr>
<td>Sugars</td>
<td>3.1g</td>
</tr>
<tr>
<td>Dietary fiber</td>
<td>3.6g</td>
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<tr>
<td>Fat</td>
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<tr>
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<tr>
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<tr>
<td>Thiamine(B1)</td>
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</tr>
<tr>
<td>Riboflavin (B2)</td>
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<tr>
<td>Niacin (B3)</td>
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</tr>
<tr>
<td>Folate (B9)</td>
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<tr>
<td>Pantothenic-acid (B5)</td>
<td>3.48 mg</td>
</tr>
<tr>
<td>Vitamin B6</td>
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</tr>
</tbody>
</table>

Narayana Nursing Journal 40  Love For Care
Spirulina Benefits

1. **Cleansing**: Spirulina promotes the body natural cleansing processes. You feel fitter, more cheerful, and you have more energy.

2. **Restoring**: Spirulina compensates for deficiencies in the diet and stimulates the metabolism. Your physical condition improves noticeably and you recover faster after exertion.

3. **Fortifying**: Spirulina boosts resistance and activates the body natural defense mechanisms. You feel stronger and are better able to cope with the pressures of everyday life.

**Health Properties**: Though it does taste like pond scum, Spirulina has some great health-boosting qualities:

- Spirulina is 65% protein and amino acids including the essential fatty acid gamma linolenic acid (GLA) which has gotten a lot of attention for its anti-inflammatory properties.
- Spirulina contains Omega 3-, 6 and 9s and is especially high in Omega-3s.

**Spirulina - A powerful Antioxidant**: Spirulina is exceptionally rich in antioxidants that neutralize free-radicals. Spirulina contains beta-carotene, tocopherols and phenolic acids, which are proven to exhibit antioxidant properties. Phycocyanin is able to scavenge the very dangerous hydroxy radical and inhibit the oxidation of lipids in the liver and kidneys. A study demonstrated 71% antioxidant capacity for the group taking the Spirulina extract and 54% for the group that did not, indicating strong antioxidant protection (Miranda., 1998., Brazilian Journal of Medical and Biological Research).

**Spirulina Prevents Cancer**: Spirulina has been found useful in cancer prevention. The anti-mutagenic effect of Spirulina is beneficial in cancer protection and treatment. Experimental studies have demonstrated its profound effect on oral cancer. Spirulina was found to reverse oral leukoplakia in tobacco chewers in Kerala. Complete regression was observed in 45% of the treated people with a dose of 1g/day for 12 months. Calcium spirulan isolated from Spirulina platensis, reduced the lung metastasis of B16-BL6 melanoma cells by inhibiting the tumor invasion of basement membrane (Mishima et al., 1998., Clinical & Experimental Metastasis).

**Spirulina is Cardio protective**: Spirulina is cholesterol free. Reduces the level of serum LDL (bad cholesterol) and raises HDL (good cholesterol). Spirulina cause a significant change in vascular tone by increasing the synthesis and release of nitric oxide and by decreasing the synthesis and release of a vasoconstricting substance from the endothelial cells.

**Spirulina was found to lower cholesterol**: Clinical studies have shown that thirty healthy men with high cholesterol, mild hypertension and hyperlipidemia after eating Spirulina for eight weeks were found to have lower cholesterol, triglycerides and low density lipoprotein (LDL). The findings concluded that antioxidants such as beta carotene, vitamin C and E, selenium etc present in Spirulina offer significant protection against cardiovascular diseases.

**Dietetic therapy with Spirulina for liver diseases**: A diet high in protein and vitamins is generally indicated in these patients in order to improve liver function. Spirulina which is abundant in vitamins and minerals is one of the optimum nutritional supplements to improve liver function and protect the liver.

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**Nutrient Data**

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Cystine</td>
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<td>Phenylalanine</td>
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<tr>
<td>Glycine</td>
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<tr>
<td>Proline</td>
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<td>Serine</td>
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<tr>
<td>Water</td>
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<tr>
<td>µg = micrograms</td>
<td></td>
</tr>
<tr>
<td>mg = milligrams</td>
<td></td>
</tr>
<tr>
<td>IU = International units</td>
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</tbody>
</table>

Source: USDA Nutrient Database
Dietetic therapy with Spirulina for diabetes mellitus: These patients are required to reduce their food intake and to supplement balanced amounts of necessary nutrients and dietary fiber. These conflicting demands are fulfilled only by Spirulina which contains protein and trace elements abundantly. (Clinical test performed by Chiba Hygienic College; Literature No.44, 273-277, 1991)

Anti-Viral Aqueous extracts of Spirulina inhibits the replication of the HIV-1 virus in human T-cells of the immune system, mononuclear blood cells and Langerhans cells of the pancreas. Japanese scientists discovered an anti-viral compound in Spirulina called Calcium Spirulan it was found to be active against numerous viruses, including influenza, herpes, and HIV.

Spirulina for Anemia One table spoon of Spirulina a day can eliminate iron deficiency, the most common reason for anemia.

Spirulina for malnutrition Baby saved from malnutrition by Spirulina, in Togo, West Africa. Spirulina is recommended for nursing mothers. For newborns, malnutrition is often caused by a lack of mother’s milk, the mother herself often being ill. Spirulina given to the mother helps a return to lactation and the babies rapidly gain weight.

Spirulina for Athletes: Athletes need extra nutrition. Spirulina contains GLA which is known to stimulate prostaglandins, master hormones which regulate every cell of the body, including heart, skin, circulation and musculature. Correct prostaglandin levels are necessary for good health and performance. World Class and Olympic athletes in China and Cuba use Spirulina to improve performance.

Spirulina reducing Pre-menstrual syndrome (PMS) Studies show women with more severe PMS have unusually low levels of certain nutrients, so many health experts urge a nutritional approach. Three key factors increase the severity of PMS – poor nutrition, lack of exercise and stress. Many clinics recommend foods or supplements rich in B-complex, magnesium, zinc, beta carotene, GLA and other vitamins, minerals and herbs. By containing many of these nutrients, Spirulina is useful in a PMS reducing plan, and several PMS supplements contain Spirulina.

Spirulina is used as slimming agent in USA. The phenylalanine present in Spirulina is said to signal the brain to stop hunger pangs leading to reduction in food uptake. Spirulina is used in balms and anti-wrinkle creams. It helps in skin metabolism, cell regeneration and skin secretion. Spirulina is used in Japan as a safe bio-lipstick and eyeliner.

CONCLUSION: WHO in 1992 declared “Spirulina is a high quality food product, rich in iron and protein, safe to consume and an excellent nutrient supplement for children”. Over 200 scientific studies have demonstrated potential health benefits of Spirulina. To maintain good health and longevity, use Spirulina, nature’s gift of super food to mankind.

REFERENCES:

External links
- “Spirulina”. Beth Israel Deaconess Medical Center. August 2011.
TRANSCULTURAL NURSING THEORY

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INTRODUCTION:
Transcultural nursing is an essential aspect of healthcare today. The ever increasing multicultural population in different countries poses a significant challenge to nurses providing individualize and holistic care to the patients. This requires the nurses to recognize and appreciate cultural differences in healthcare values, beliefs and customs. Nurses must acquire the necessary knowledge and skills in cultural competency. Culturally competent nursing care helps ensure patient satisfaction and positive outcomes. Transcultural nursing shows how professional nursing interacts with the concept of culture.

DEFINITION: According to Madeleine Leininger, transcultural nursing is a substantive area of study and practice that focuses on the comparative cultural values of caring, the belief and practices of individuals or groups of similar or different cultures.

GOAL OF TRANSCULTURAL NURSING:
• To give cultural congruent nursing care.
• To provide culture specific and universal nursing care.
• To aid in facing adverse human conditions, illness or death in culturally meaningful ways.

DEFINITIONS:
Transcultural Nursing:
➢ Transcultural nursing is a comparative study of cultures to understand similarities (culture universal) and differences (culture - specific) across human groups (Leininger, 1991).

Culture:
➢ Set values, beliefs and traditions, that are held by a specific group of people and handed down from generation to generation.
➢ Culture is also beliefs, habits, likes, dislikes, customs and rituals learn from one’s family.
➢ Culture is the learned, shared and transmitted values, beliefs, norms and life way practices of a particular group that guide thinking, decisions, and actions in patterned ways.
➢ Culture is learned by each generation through both formal and informal life experiences.
➢ Language is primary through means of transmitting culture.
➢ The practices of particular culture often arise because of the group’s social and physical environment.
➢ Culture practice and beliefs are adapted over time but they mainly remain constant as long as they satisfy needs.

Religion:
➢ Is a set of belief in a divine or super human power (or powers) to be obeyed and worshipped as the creator and ruler of the universe?

Ethnic:
➢ Refers to a group of people who share a common and distinctive culture and who are members of a specific group.

Ethnicity:
➢ A consciousness of belonging to a group.

Cultural Identify:
➢ The sense of being part of an ethnic group or culture.

Culture - universals:
➢ Commonalities of values, norms of behavior, and life patterns that are similar among different cultures.

Culture - specifies:
➢ Values, beliefs, and patterns of behavior that tend to be unique to a designate culture.

Material culture:
➢ Refers to objects (dress, art, religious artifacts)
**Non-material culture:**
- Refers to beliefs, customs, languages, social institutions.

**Subculture:**
- Composed of people who have a distinct identity but are related to a larger cultural group.

**Bicultural:**
- A person who crosses two cultures, lifestyles, and sets of values.

**Diversity:**
- Refers to the fact or state of being different. Diversity can occur between cultures and within a cultural group.

**Acculturation:**
- People of a minority group tend to assume the attitudes, values, beliefs, and practices of the dominant society resulting in a blended cultural pattern.

**Cultural shock:**
- The state of being disoriented or unable to respond to a different cultural environment because of its sudden strangeness, unfamiliarity, and incompatibility to the stranger’s perceptions and expectations at it is differentiated from others by symbolic markers (cultures, biology, territory, religion).

**Ethnic group:**
- Share a common social and cultural heritage that is passed on to successive generations.

**Ethnic identity:**
- Refers to a subjective perspective of the person’s heritage and to a sense of belonging to a group that is distinguishable from other group.

**Race:**
- The classification of people according to shared biologic characteristics, genetic markers, or features. Not all people of the same race have the same culture.

**Cultural awareness:**
- It is an in-depth self-examination of one’s own background, recognizing biases and prejudices and assumptions about other people.

**Culturally congruent care:**
- Care that fits the people’s valued life patterns and set of meanings - which is generated from the people themselves, rather than based on predetermined criteria.

**Culturally competent care:**
- Is the ability of the practitioner to bridge cultural gaps in caring, work with cultural differences and enable clients and families to achieve meaningful and supportive caring.

**NURSING DECISIONS:** Leininger (1991) identified three nursing decisions and action modes to achieve culturally congruent care.
1. Cultural preservation or maintenance.
2. Cultural care accommodation or negotiation.
3. Cultural care repatterning or restructuring.

**MAJOR CONCEPTS [ Leininger (1991) ]**
- Illness and wellness are shaped by a variety of factors including perception and coping skills, as well as the social level of the patient.
- Cultural competence is an important component of nursing.
- Culture influences all spheres of human life. It defines health, illness, and the search for relief from disease or distress.
- Religious and cultural knowledge is an important ingredient in health care.
- The health concepts held by many cultural groups may result in people choosing not to seek modern medical treatment procedures.
- Health care providers need to be flexible in the design of programs, policies, and services to meet the needs and concerns of the culturally diverse population, groups that are likely to be encountered.
- Most cases of lay illness have multiple causalities and may require several different approaches to diagnosis, treatment, and cure including folk and Western medical interventions.
- The use of traditional or alternate models of health care delivery is widely varied and may come into conflict with western models of health care practice.
- Culture guides behavior into acceptable ways for the people in a specific group as such culture originates and develops within the social structure through interpersonal interactions.
- For a nurse to successfully provide care for a client of a different cultural or ethnic background, effective intercultural communication must take place.
Health Practices in Different Cultures:

- **Use of Protective Objects**: Protective objects can be worn or carried or hung in the home - charms worn on a string or chain around the neck, wrist, or waist to protect the wearer from the evil eye or evil spirits.

- **Use of Substances**: It is believed that certain food substances can be ingested to prevent illness. E.g. eating raw garlic or onion to prevent illness or wear them on the body or hang them in the home.

- **Religious Practices**: Burning of candles, rituals of redemption etc..

- **Traditional Remedies**: The use of folk or traditional medicine is seen among people from all walk of life and cultural ethnic background.

- **Healers**: Within a given community, specific people are known to have the power to heal.

- **Immigration**: Immigrant groups have their own cultural attitudes ranging beliefs and practices regarding these areas.

- **Gender Roles**: In many cultures, the male is dominant figure and often they take decisions related to health practices and treatment. In some other cultures females are dominant. In some cultures, women are discriminated in providing proper treatment for illness.

- **Beliefs about mental health**: Mental illnesses are caused by a lack of harmony of emotions or by evil spirits. Problems in this are most likely related to transgressions committed in a past life.

- **Economic Factors**: Factors such as unemployment, underemployment, homelessness, lack of health insurance poverty prevent people from entering the health care system.

- **Time orientation**: It varies for different cultures groups.

- **Personal Space**: Respect the client’s personal space when performing nursing procedures. The nurse should also welcome visiting members of the family and extended family.

NURSING METAPARADIGM:

She criticizes the nursing metaparadigm concepts of person, environment, health and nursing.

- She considers ‘nursing’ as a discipline and a profession and the term ‘nursing’ can’t explain the phenomenon of nursing.

- The term ‘person’ is too limited and culture-bound to explain nursing, as the term person does not exist in every culture.

- The concept of ‘health’ is not distinct to nursing as many disciplines use the term.

- Instead of ‘environment’, Leininger uses the concept ‘environmental context’, which includes ‘events with meaning’ and ‘interpretations’ given to them particularly physical, ecological, socio-political and/ or cultural settings.

NURSING PROCESS AND ROLE OF NURSE

- Determine the client’s cultural heritage and language skills.

Determine if any of his health beliefs relate to the cause of the illness or to the problem.
Collect information about any home remedies the person is taking to treat the symptoms.
Nurses should evaluate their attitudes toward ethnic nursing care.
Self-evaluation helps the nurse to become more comfortable when providing care to clients from diverse backgrounds.
Understand the influence of culture, race and ethnicity on the development of social emotional relationship, child rearing practices and attitude toward health.
Collect information about the socioeconomic status of the family and its influence on their health promotion and wellness.
Identify the religious practices of the family and their influence on health promotion belief in families.
Understanding of the general characteristics of the major ethnic groups, but always individualizes care.
The nursing diagnosis for clients should include potential problems in their interaction with the health care system and problems involving the effects of culture.
The planning and implementation of nursing interventions should be adapted as much as possible to the client’s cultural background.
Evaluation should include the nurse’s self-evaluations of attitudes and emotions toward providing nursing care to clients from diverse sociocultural backgrounds.
Self-evaluation by the nurse is crucial as he or she increases skills for interaction.

APPLICATION TO NURSING:
➢ To develop understanding, respect and appreciation for the individuality and diversity of patients beliefs, values, spirituality and culture regarding illness, its meaning, cause, treatment, and outcome.
➢ To encourage in developing and maintaining a program of physical, emotional and spiritual self-care introduce therapies such as Ayurveda and Panchakarma.

The relative significance of culturally appropriate health care cannot be understood if the nurse does not understand the value of culturally relevant nursing diagnoses.

The application of the North American Nursing Diagnosis Association (NANDA) taxonomy:

Few nursing diagnoses used in accordance to transcultural nursing theory are,
1. impaired verbal communication
2. social isolation and
3. noncompliance in culturally diverse situations.

Nursing diagnoses must tend to,
1. focus on the client rather than the provider and therefore do not acknowledge the existence of other culturally relevant viewpoints (such as those expressed by the provider);
2. be generalized and, as a result, increase the likelihood, when applied in diverse cultural settings, for stereotyping and victimization; and
3. involve mislabeling phenomena, which in actuality arise as expressions of cultural dissonance rather than expressions of political, social, psychological, or economic factors.

CONCLUSION:
Nurses need to be aware of and sensitive to the cultural needs of clients. The practice of nursing today demands that the nurse identify and meet the cultural needs of diverse groups, understand the social and cultural reality of the client, family, and community, develop expertise to implement culturally acceptable strategies to provide nursing care, and identify and use resources acceptable to the client (Andrews and Boyle, 2002).

REFERENCES:
01. The basic emotional task for the toddler is:  
**Ans:** d. Independence  
02. An example of displacement is:  
**Ans:** d. Pent-up emotions directed to other than the primary source  
03. A 5-year-old is frequently found slapping his little sister. This behaviour is probably caused by:  
**Ans:** a. Sibling rivalry  
04. The nurse recognize that dementia of the Alzheimer's type is characterized by:  
**Ans:** d. Areas of brain destruction called senile plaques  
05. Following the last dose of methadone hydrochloride, withdrawal symptoms are expected to reach a peak in:  
**Ans:** c. 48 to 72 hours  
06. A client expresses the belief that the CBI is out to kill him. This is an example of:  
**Ans:** c. A delusion of persecution  
07. Feelings of self-effacement are best demonstrated by a client's:  
**Ans:** c. "No one listens to me" attitude  
08. When approaching a client during a period of great overactivity, it is essential to:  
**Ans:** a. Use a firm, warm, consistent approach  
09. The activity that would be the least therapeutic for severely depressed clients would be:  
**Ans:** d. Allowing the clients to plan their own activities  
10. The nurse understands that one of the most difficult tasks for the depressed client is the expression of:  
**Ans:** c. Anger toward others  
11. A phobic reaction will rarely occur unless the person:  
**Ans:** d. Comes into contact with the feared object  
12. A 28-year-old client is admitted to the psychiatric unit of the hospital with a diagnosis of conversion disorder. The client is unable to move either leg. The nurse would expect a person with this diagnosis to:  
**Ans:** c. Appear calm and composed  
13. An adolescent is diagnosed as having anorexia nervosa. The nurse understands that the etiology of this disorder is:  
**Ans:** d. An unconscious fear of growing up  
14. A person who deliberately pretends an illness is usually thought to be:  
**Ans:** b. Malingering  
15. Therapeutic treatment of a female client with ritualistic behavior should be directed towards helping her to:  
**Ans:** d. Understand her behavior is caused by unconscious impulses that she fears  
16. A common manageable side of neuroleptics is:  
**Ans:** d. Unintentional tremors  
17. Photosensitization is a side effect associated with the use of:  
**Ans:** d. Chlorpromazine hydrochloride (Thorazine)  
18. To foster sound interpersonal relationships during an initial meeting with a family, the nurse should assume the role of:  
**Ans:** b. Stranger  
19. Self-help groups such as Alcoholics Anonymous help members to learn that:  
**Ans:** b. Their problems are not unique  
20. The most advantageous therapy for a preschool-age child with a history of physical and sexual abuse would be:  
**Ans:** a. Play therapy
Questions for qualifying examinations

Child Health Nursing

01. A characteristic of infants and young children who have experienced maternal deprivation is:
   a. Extreme activity
   b. Proneness to illness
   c. Responsiveness to stimuli
   d. Tendency toward overeating

02. The primary task to be accomplished between 12 and 15 months of age is to learn to:
   a. Walk erect
   b. Climb stairs
   c. Use a spoon
   d. Say simple words

03. When evaluating a 3 - year - old's developmental progress, the nurse should recognize that development is delayed when the child is unable to:
   a. Copy a square
   b. Hop on one foot
   c. Catch a ball reliably
   d. Use a spoon effectively

04. The average 5 - year - old is incapable of:
   a. Tying shoelaces
   b. Abstract thought
   c. Making decisions
   d. Hand - eye coordination

05. The nurse should encourage two 6 - year - old boys in the playroom to play with:
   a. Clay
   b. Checkers
   c. A board game
   d. An erector set

06. A 7 - year - old is admitted for surgery. Preoperatively it is essential that the nurse:
   a. Observe the child's ASO titer
   b. Provide the child's ASO titer
   c. Check for loose teeth and report the findings to the physician
   d. Encourage a parent to stay until the child goes to the operating room

07. The earliest clinical sign in idiopathic respiratory distress syndrome in a young infant is usually:
   a. Grunting
   b. Cyanosis
   c. Rapid respiration
   d. Sternal and subcostal retractions

08. Selection of drugs of choice for the treatment of pneumonia depends primarily on:
   a. Tolerance of the organism
   b. Selectivity of the organism
   c. Sensitivity of the organism
   d. Preference of the physician

09. The most important nursing intervention for a 3 - year - old child with a diagnosis of nephrosis is:
   a. Encouraging fluids
   b. Regulating the diet
   c. Preventing infection
   d. Maintaining bed rest

10. If a child develops cyanosis early during a tonicclonic seizure, it is most appropriate for the nurse to:
    a. Inset an oral airway
    b. Administer oxygen by mask
    c. Use a padded tongue blade
    d. Observe without intervening

11. When performing a physical assessment of a newborn with Down syndrome, the nurse should carefully evaluate the infant's:
    a. Heart sounds
    b. Anterior fontanel
    c. Pupillary reaction
    d. Lower extremities

12. When caring for an infant with a meningocele prior to surgical correction, a primary nursing goal would be to:
    a. Prevent infection
    b. Prevent skin breakdown
    c. Observe for increasing paralysis
    d. Observe for bowel and bladder dysfunction

13. The most serious complication of meningitis in young children is:
    a. Epilepsy
    b. Blindness
    c. Peripheral circulatory collapse
    d. Communicating hydrocephalus

14. An evening snack is planned for a child receiving NPH (Humulin N) insulin. The nurse understands that this will provide:
    a. Added calories to help the child gain weight
    b. Encouragement for the child to stay on a diet
    c. High - carbohydrate nourishment for immediate utilization
    d. Nourishment with a latent effect to counteract late insulin activity

15. Under certain circumstances the virus that causes chickenpox can also cause:
    a. Athlete's foot
    b. Herpes zoster
    c. German measles
    d. Infectious hepatitis

16. The major influence on eating habits of the early school - aged child is the:
    a. Availability of food selections
    b. Smell and appearance of food
    c. Example of parents at mealtime
    d. Food preferences of the peer group

17. In a baby born with a unilateral cleft lip and palate, feeding will probably be:
    a. Limited to IV fluids
    b. With a soft, large - holed nipple
    c. Too difficult because of breathing problems
    d. With a rubber - tipped syringe or medicine dropper

18. In cystic fibrosis, frequent stools and tenacious mucus often produce:
    a. Anal fissures
    b. Intussusception
    c. Meconium ileus
    d. Rectal prolapse

19. Dietary treatment of children with PKU includes:
    a. Protein - free diet
    b. Low - phenylalanine diet
    c. Phenylalanine - free diet
    d. Dietary supplement for phenylalanine

20. When vomiting is uncontrolled in an infant, the nurse should observe for signs of:
    a. Tetany
    b. Acidosis
    c. Alkalosis
    d. Hyperactivity
PROBABILITY - DEFINITIONS AND NOTATION

Before discussing the rules of probability, we state the following definitions: Two events are mutually exclusive or disjoint if they cannot occur at the same time.

- The probability that Event A occurs, given that Event B has occurred, is called a conditional probability. The conditional probability of Event A, given Event B, is denoted by the symbol P(A|B).
- The complement of an event is the event not occurring. The probability that Event A will not occur is denoted by P(A').
- The probability that Events A and B both occur is the probability of the intersection of A and B. The probability of the intersection of Events A and B is denoted by P(A ∩ B). If Events A and B are mutually exclusive, P(A ∩ B) = 0.
- The probability that Events A or B occur is the probability of the union of A and B. The probability of the union of Events A and B is denoted by P(A ∪ B).
- If the occurrence of Event A changes the probability of Event B, then Events A and B are dependent. On the other hand, if the occurrence of Event A does not change the probability of Event B, then Events A and B are independent.
- Probability Calculator: Use the Probability Calculator to compute the probability of an event from the known probabilities of other events. The Probability Calculator is free and easy to use. It can be found under the Stat Tools tab, which appears in the header of every Stat Trek web page. Probability Calculator Rule of Subtraction

In a previous lesson, we learned two important properties of probability:

- The probability of an event ranges from 0 to 1.
- The sum of probabilities of all possible events equals 1.

The rule of subtraction follows directly from these properties.

Rule of Subtraction: The probability that event A will occur is equal to 1 minus the probability that event A will not occur. P(A) = 1 - P(A').

Suppose, for example, the probability that Bill will graduate from college is 0.80. What is the probability that Bill will not graduate from college? Based on the rule of subtraction, the probability that Bill will not graduate is 1.00 - 0.80 or 0.20.

Rule of Multiplication

The rule of multiplication applies to the situation when we want to know the probability of the intersection of two events; that is, we want to know the probability that two events (Event A and Event B) both occur.

Rule of Multiplication: The probability that Events A and B both occur is equal to the probability that Event A occurs times the probability that Event B occurs, given that A has occurred. P(A ∩ B) = P(A)P(B|A)

**Example:** An urn contains 6 red marbles and 4 black marbles. Two marbles are drawn with replacement from the urn. What is the probability that both of the marbles are black?

In the beginning, there are 10 marbles in the urn, 4 of which are black. Therefore, P(B|A) = 4/10.

After the first selection, there are 9 marbles in the urn, 3 of which are black. Therefore, P(B|A) = 3/9.

Therefore, based on the rule of multiplication:

P(A ∩ B) = P(A)P(B|A)


Rule of Addition

The rule of addition applies to the following situation. We have two events, and we want to know the probability that either event occurs.

**Rule of Addition**: The probability that Event A or Event B occurs is equal to the probability that Event A occurs plus the probability that Event B occurs minus the probability that both Events A and B occur.

P(A ∪ B) = P(A) + P(B) - P(A ∩ B)

Note: Invoking the fact that P(A ∩ B) = P(A)P(B|A), the Addition Rule can also be expressed as

P(A ∪ B) = P(A) + P(B) - P(A)P(B|A)

**Example:** A student goes to the library. The probability that she checks out (a) a work of fiction is 0.40, (b) a work of non-fiction is 0.30, and (c) both fiction and non-fiction is 0.20. What is the probability that the student checks out a work of fiction, non-fiction, or both?

Solution: Let F = the event that the student checks out fiction; and let N = the event that the student checks out non-fiction. Then, based on the rule of addition:

P(F ∪ N) = P(F) + P(N) - P(F ∩ N)

P(F ∪ N) = 0.40 + 0.30 - 0.20 = 0.50

Test Your Understanding

Problem 1

An urn contains 6 red marbles and 4 black marbles. Two marbles are drawn with replacement from the urn. What is the probability that both of the marbles are black?

(A) 0.16 (B) 0.32 (C) 0.36 (D) 0.40 (E) 0.60

**Solution:** The correct answer is (A). Let A = the event that the first marble is black; and let B = the event that the second marble is black. We know the following:

- In the beginning, there are 10 marbles in the urn, 4 of which are black. Therefore, P(A) = 4/10.
- After the first selection, we replace the selected marble; so there are still 10 marbles in the urn, 4 of which are black. Therefore, P(B|A) = 4/10.

- Therefore, based on the rule of multiplication:

P(A ∩ B) = P(A)P(B|A)

P(A ∩ B) = (4/10)(4/10) = 16/100 = 0.16

**Problem 2:** A card is drawn randomly from a deck of ordinary playing cards. You win $10 if the card is a spade or an ace. What is the probability that you will win the game?

(A) 1/13 (B) 13/52 (C) 4/13 (D) 17/52 (E) None of the above.

**Solution:** The correct answer is (C). Let S = the event that the card is a spade; and let A = the event that the card is an ace. We know the following:

- There are 52 % cards in the deck.
- There are 13 spades, so P(S) = 13/52.
- There are 4 aces, so P(A) = 4/52.
- There is 1 ace that is also a spade, so P(S ∩ A) = 1/52.

Therefore, based on the rule of addition:

P(S ∪ A) = P(S) + P(A) - P(S ∩ A)

P(S ∪ A) = 13/52 + 4/52 - 1/52 = 16/52 = 4/13
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