Narayana College Of Nursing

Courses Offered
M.Sc (N) - 2 Years Degree Course
1. Medical Surgical Nursing
2. Obstetrics & Gynecology Nursing
3. Psychiatric Nursing
4. Community Health Nursing
5. Paediatric Nursing

Eligibility
A. Pass in B.Sc. (N) with First Class marks and 1 Years Experience after registration Post

Basic Diploma Courses
❖ Post Basic Diploma in Critical care Nursing
❖ Post Basic Diploma in Emergency and Disaster Nursing
❖ Post Basic Diploma in Psychiatric / Mental Health Nursing
❖ Post Basic Diploma in Orthopedic Nursing
❖ Post Basic Diploma in Neonatal Nursing
❖ Post Basic Diploma in Cardiothoracic Nursing

GNM / B.Sc.(N) :- 1 Year Experience after registration

P.B.B.Sc.(N) :- 2 Year Course Eligibility :- GNM Pass

B.Sc. (N) :- 4 Years Course
A. Pass in Intermediate Examination with Biology, English, Physics and Chemistry
   (or) Intermediate

Vocational (Nursing) Examination conducted by the board of Intermediate Examination, A.P.
(or) Any Examination recognised as equivalent thereto..

B. Should have scored more than 45% of marks in PCBE.

GNM :-
A. Pass in Intermediate Examination any group
B. Should have secured more than 40% of marks in the optional subjects.
The value of care giving seems to be at an all-time low, whether it is clinical (bedside) or for children and elderly). Thus, it is not surprising that modern society often fails to respect the nursing professionals to the extent of underplaying their strengths, skills, and even clinical abilities. While qualities such as kindness, team spirit, and willingness to get their hands dirty are the core of this profession, nursing professionals have a complex variety of set duties, involving drug dosage, trouble-shooting, ongoing patient monitoring, and providing holistic comfort and support to the sick and needy. Beyond classical role, the nursing professional has currently ventured into other roles as well, as a nurse practitioner, administrator, researcher, or even an educator. Thus, considering the wide spectrum of duties performed by nursing professionals, they do deserve more status and power rather than be treated like the status now. In contrary, it has been identified that the most trustful profession is nursing only. We will get all these by propaganda through mass media, print media etc, this world is behind the advertisements. So we the nurses do publicity about our commitments and services what we are rendering to the human from the time of conception to crimination. We have to publish our research projects, thesis and concepts regarding Non communicable diseases. But what is happening in India, the TNAI has went to court for the salary of nurses. Most of the state governments are not bothered about the nurses working in private institutions. The nurses have to fight for their rights. I feel it is high time for the nurses to fight for their respect, remuneration, power and private practices.
Evaluate the Impact of baby-friendly hospital initiative policies on lactation success among mothers

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Evaluate the Impact of baby-friendly hospital initiative policies on lactation success among mothers.

Mrs. Bharathi. M,
Principal,
Karnataka College of Nursing,
Bangalore - 64.

The ‘Baby-friendly hospital initiative’ (BFHI), is intended to give every baby. Best start in life by ensuring that, in environment such as hospital birthing units, breastfeeding is promoted as the norm and not supplemented by infant formula. The baby-friendly hospital initiative policies is a global United Nations Integrated Child Education Fund (UNICEF)/World Health Organization (WHO) sponsored effort to promote breastfeeding.

The Baby Friendly Hospital Initiative, based upon the ‘Ten Steps to Successful Breastfeeding’, is an effective evidence-based model of prenatal care that protects, promotes, and supports breastfeeding. It seems that now-a-days, women are more concern in bringing more income to the family and they do not have the time for their babies to even breastfeed. Hence, researcher felt need of finding out the effectiveness of baby-friendly hospital initiative polices in this commercial era.

Statement of the problem: “A descriptive study to evaluate the impact of baby-friendly hospital initiative policies on lactation success among mothers in selected hospitals at Bangalore.”

The objectives of the study were:
1. To assess the existing knowledge of mothers on baby-friendly hospital initiative policies.
2. To find out association between knowledge of mothers with demographic variables.

RESEARCH HYPOTHESIS
H₁: There will be an association between knowledge of mothers with demographic variables.
H₂: There will be an inadequate knowledge among mothers about BFHI policies.

Method:
Research design: used was Non Experimental descriptive design.
Setting of the study: The present study was conducted in postpartum ward, pediatric ward, and outpatient pediatric department of K.C. G Hospital, Bangalore.
Samples: In the present study the samples were mothers having baby up to one year of age, who were present in the hospital during the time of data collection.
Sampling Technique: Purposive sampling technique,
Sample Size: Comprised of 60 mothers having baby up to one year of age.
Criteria for sample selection
Inclusion criteria
1. Mothers had baby up to one year of age.
2. Mothers who were present at the time of data collection.
3. Mothers who were willing to participate in the study.
Exclusion criteria
1. Mothers who did not know how to read English and Kannada.
2. Mothers who were not breast feeding.
Analysis of the collected data:
Section - 1: Demographic Characteristics of Respondents (n=60)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Category</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 - 30</td>
<td>50</td>
<td>83.3</td>
</tr>
<tr>
<td>30 - 40</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>Educational status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>14</td>
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</tr>
<tr>
<td>Higher sec</td>
<td>22</td>
<td>36.7</td>
</tr>
<tr>
<td>Diploma</td>
<td>17</td>
<td>28.3</td>
</tr>
<tr>
<td>Graduate</td>
<td>07</td>
<td>11.7</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>29</td>
<td>48.3</td>
</tr>
<tr>
<td>Unskilled worker</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>Office worker</td>
<td>07</td>
<td>11.7</td>
</tr>
<tr>
<td>Skilled worker</td>
<td>12</td>
<td>20.0</td>
</tr>
<tr>
<td>Type of Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal vaginal</td>
<td>31</td>
<td>51.7</td>
</tr>
<tr>
<td>Caesarean</td>
<td>29</td>
<td>48.3</td>
</tr>
<tr>
<td>Place of Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government</td>
<td>29</td>
<td>48.3</td>
</tr>
<tr>
<td>Private</td>
<td>24</td>
<td>40.0</td>
</tr>
<tr>
<td>Home delivery</td>
<td>07</td>
<td>11.7</td>
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<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>53</td>
<td>88.3</td>
</tr>
<tr>
<td>Muslim</td>
<td>07</td>
<td>11.7</td>
</tr>
<tr>
<td>Type of Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint</td>
<td>32</td>
<td>53.3</td>
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<tr>
<td>Nuclear</td>
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<tr>
<td>Single parent</td>
<td>13</td>
<td>21.7</td>
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<td>Family Income / month</td>
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<td>Below Rs.5,000</td>
<td>34</td>
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<td>Rs.5,001-10,000</td>
<td>11</td>
<td>18.3</td>
</tr>
<tr>
<td>Rs.10,001-15,000</td>
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<td>25.0</td>
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<tr>
<td>Number of Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>32</td>
<td>53.3</td>
</tr>
<tr>
<td>Two</td>
<td>21</td>
<td>35.0</td>
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<tr>
<td>Three</td>
<td>07</td>
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<td>Received information on baby friendly hospital</td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>44</td>
<td>73.3</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>26.7</td>
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Initiative policies

<table>
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<tr>
<th>Source of information</th>
<th>Nurses</th>
<th>26</th>
<th>43.3</th>
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<tbody>
<tr>
<td>Doctors</td>
<td>18</td>
<td>30.0</td>
<td></td>
</tr>
</tbody>
</table>

Availability of Health care facility nearby

<table>
<thead>
<tr>
<th>Source of Facility</th>
<th>Government</th>
<th>40</th>
<th>66.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non government</td>
<td>04</td>
<td>6.7</td>
<td></td>
</tr>
</tbody>
</table>

Section - 2: Overall and Aspect wise Knowledge scores of Respondents on Baby-friendly hospital initiative policies

Overall Knowledge scores of Respondents on Baby-friendly hospital initiative policies. Out of 60 respondents, 34(56.7%) were having inadequate knowledge, 26(43.3%) moderate knowledge and no one had adequate knowledge.

Classification of Respondents Knowledge level on BFHI policies

Aspect wise Mean Knowledge scores of Respondents on BFHI policies

<table>
<thead>
<tr>
<th>Knowledge Aspects</th>
<th>statements</th>
<th>max score</th>
<th>range score</th>
<th>knowledge n=60 score mean sd</th>
<th>mean sd</th>
<th>mean sd</th>
<th>sd</th>
</tr>
</thead>
<tbody>
<tr>
<td>General information on breast milk and breast feeding</td>
<td>16</td>
<td>16</td>
<td>2-15</td>
<td>8.50 3.0</td>
<td>53.1 18.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of breast feeding</td>
<td>11</td>
<td>11</td>
<td>1-10</td>
<td>4.85 2.0</td>
<td>47.5 31.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusive breast feeding</td>
<td>02</td>
<td>02</td>
<td>0-2</td>
<td>0.93 0.6</td>
<td>46.7 31.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section.-3: Association between Demographic variables and Knowledge level on Baby friendly hospital initiative policies on Lactation success

The study found demographic variables (Age group, educational status, type of delivery, place of delivery and number of children, availability of health care facility nearby and source of facility ) were associated with knowledge level of respondents which is highly significant at p<0.005 level. Hypothesis stated was accepted. The study also revealed that there was no significant association between respondent’s level of knowledge on BFHI policies and the demographic variables like occupation, religion, type of family, family income, received information on BFHI policies and source of information. Hence stated hypothesis was rejected.

Major findings of the study:

The present study shows that majority of the respondents, 34(56.7%) were having Inadequate knowledge, about baby-friendly hospital initiative policies. The overall mean knowledge scores of respondents was 17.13 (S.D=5.6). Aspect wise mean knowledge scores of respondents showed that only 8.3% mothers were having adequate knowledge in aspects I & II,13.3% were having adequate knowledge, in aspect IV and none of the mother had adequate knowledge about aspect III. 40% mothers had moderate knowledge in aspect I, 20% mothers had moderate knowledge on aspect II. 16.7% mothers had moderate knowledge in aspect III.15% mothers had moderate knowledge in aspect IV.71.7% mothers had inadequate knowledge with respect to aspect III and IV.51.7% of mothers had inadequate knowledge in respect to aspect I.83.3% mothers had inadequate knowledge in aspect III. Hence majority of mothers had inadequate knowledge in every aspect.

Recommendations

1. A similar study can be undertaken to assess the knowledge of health workers.
2. A comparative study may be conducted among health workers of BFHI certified and NON BFHI certified hospitals.
3. An intervention study can be done to improve the knowledge of health personals regarding baby-friendly hospital initiative policies.

Conclusion: Expert in child nutrition, health and development have agreed that breastfeeding is the most effective way to provide a baby with a caring environment and complete food, which gives protection against infection and disease in the children. Thus, indicate that the improvement in the knowledge of mothers has a great effect on implementation of BFHI policies and as well as the well being of the infants.

References:

Knowledge Regarding Services Rendered Under ICDS Among Anganwadi Workers At Venkatachalam, Nellore District A P.

Dr. Indira. S, Principal, Narayana College of Nursing, Chinthareddypalem, Nellore.

Mrs. Vanaja kumari. B, Professor & HOD, Community Health Nursing, Narayana College of Nursing, Chinthareddypalem, Nellore.

Abstract: The ICDS program was initiated for the welfare of children and development of human resources. The beneficiaries of the program are up to 6 years, adolescent girls [11-18 years], pregnant women, nursing mother and women of 15-45 years. **Aim:** 1. To assess the level of knowledge regarding services rendered under ICDS among Anganwadi workers in primary health center. 2. To find out the association between level of knowledge regarding services rendered under ICDS and selected socio-demographic variables. **Material and method:** Study conducted by using the descriptive research design, the samples was selected by using non probability Convenience sampling technique. The collected data was organized, tabulated, analyzed and interpreted by using descriptive and inferential statistics based on the objectives of the study. **Results:** The study results Shows that with regard to level of knowledge regarding services rendered under ICDS among Anganwadi workers (2) 6.66% members are having good knowledge, (17) 56.66% members are having adequate knowledge and (11) 36.66% members are having poor knowledge. **Conclusion:** The study was concluded that, most of the anganwadi workers had adequate knowledge about ICDS services, as a community health nurse need to improve and update information about ICDS services among anganwadi workers. **Key words:** knowledge, ICDS, Anganwadi workers.

INTRODUCTION:

The most important scheme in the field of child welfare is the Integrated Child Development Scheme (ICDS). The national policy for children, government of India, started ICDS program in 1975, under ministry of social and women welfare. The ICDS services mainly concentrated on children nutritional and health status of children in the age group of 0-6 years. ICDS lay the foundation for proper psychological, physical and social development of the child. ICDS services helps to reduce mortality, morbidity, and malnutrition and school dropout. ICDS function is to achieve effective co-ordination of policy and implementation among the various department promote child development.

The strategy adopted in ICDS is one of simultaneous delivery of early childhood services. While the health component forms a major component, ICDS much more than a mere health programe for delivery of social service input for development. The blue print for the scheme was prepared by the department of social welfare in 1975. The ICDS services including supplementary nutrition, immunization, health check-up, medical referral services, nutrition and health education for women and non-formal education of children up to the age of 6 years.

The ICDS scheme is working at village level is rural area and also urban and tribal area. In 1975 number
of ICDS project was only 33, which was started on experimental basis. In India child mortality rate in 2004 was 85 in 1000 live birth. It was about 34% of all death. It was 242/1000 live birth in 1960. In India, infant mortality rate is 55. Under 5 mortality rate in 2009 is 78.6. There should be a decline in the child death rate and the pregnant mother mortality and morbidity rate is essential for the survival of the country. The major cause of child mortality and morbidity among children under 5 years in developed countries.

OBJECTIVES
❖ To assess the level of knowledge regarding services rendered under ICDS among Anganwadi workers in primary health center.
❖ To find out the association between levels of knowledge regarding services rendered under ICDS and selected socio-demographic variables among anganwadi workers.

DETAILED RESEARCH PLAN:
Research Approach: A quantitative research approach was adapted to the study.
Research design: Descriptive research design was used for the present study.
Settings: The study was conducted in selected anganwadi at Nellore.
Sample Size: The sample size for this study was 30 anganwadi workers.
Sampling Technique: The samples were selected by using non probability Convenience sampling technique.
Variables: The variable of the study includes demographic variables and research variables.
Demographic Variables: Age, religion, marital status, language known and years of experience.
Research variables: The level of knowledge regarding services rendered under ICDS among anganwadi workers.

RESULTS AND DISCUSSION:
Table- 1: Frequency and percentage distribution of level of knowledge regarding services rendered under ICDS among Anganwadi workers. (n=30)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Level of knowledge</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.</td>
<td>Good knowledge</td>
<td>2</td>
<td>6.6</td>
</tr>
<tr>
<td>02.</td>
<td>Adequate knowledge</td>
<td>17</td>
<td>56.7</td>
</tr>
<tr>
<td>03.</td>
<td>Poor knowledge</td>
<td>11</td>
<td>36.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table no -1: Shows that with regard to level of knowledge regarding services rendered under ICDS among Anganwadi workers (2) 6.6 are having good knowledge, (17) 56.7 are having adequate knowledge and (11) 36.7 are having poor knowledge.

Table-2: Mean and standard deviation of level of knowledge regarding services rendered under ICDS among Anganwadi workers. (n=30)

<table>
<thead>
<tr>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.8</td>
<td>3.84</td>
</tr>
</tbody>
</table>

Table-2: Shows that mean and standard deviation of knowledge regarding services rendered under ICDS among Anganwadi workers mean is 14.8 with standard deviation of 3.84.

Association Between Levels Of Knowledge Regarding Services Rendered Under ICDS And Selected Socio-Demographic Variables.
There is a significant association between the level of knowledge Regarding Services Rendered Under ICDS among anganwadi worker with their selected socio demographic variables like age, religion,
language and years of experience. There is no significant relationship between levels of knowledge Regarding Services Rendered under ICDS among anganwadi worker with demographics variables such as marital status.

**Recommendations:** On the basis of findings of the study, it is recommended that,

- The study can be replicated in large sample so that finding can be generalized.
- Comparative study can be conducted to find out the knowledge and practice of anganwadi worker on ICDS services among different areas.
- Special training programs and periodical continued educational program regarding ICDS services for anganwadi workers for updating their knowledge.

**Nursing implications:** The investigator had drawn the following implications from the study which is vital concern for nursing practice, nursing education, nursing administration and nursing research.

**Nursing practice:** Being the nurses, the orientation of anganwadi workers towards the pregnant mothers and children up to 6 years will help them to improve the practice of caring the mother and children.

**Nursing education:** In the present nursing curriculum, emphasis is placed on theory and care of mother and child. The emphasis should focus on pregnancy complication, supplementary nutrition and education of children up to 6 years.

**Nursing administration:** The nurses as an administration should provide the needed equipment and communicate with the policy making authorities in making appropriate protocol to follow. Proper health education using adequate A - V adis should be frequently given by the health professionals.

**Nursing research:** The essence of research is built up a body of knowledge in nursing as an evolving profession. The result of the study can be provided a shared knowledge base, formulate the protocol and better managed care among anganwadi workers for pregnant mother and children.

**CONCLUSION:** The study was concluded that, most of the anganwadi workers had adequate knowledge about ICDS services, as a community health nurse need to improve and update information about ICDS services among anganwadi workers.

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- B. Vanaja Kumara, A descriptive study to assess the knowledge of mothers regarding anemia during pregnancy in selected urban area in Bangalore with a view to develop an information booklet. Narayana Nursing Journal - Volume – 1, June 2013.
Effectiveness of computer assisted teaching programme on knowledge regarding problems of open field defecation among adults in selected rural community at Nellore


Mrs. Vanaja kumari. B, Professor & HOD

Abstract: Objectives: 1. To assess the pre and post test level of knowledge among adults on problems of open field defecation. 2. To determine the effectiveness of computer assisted teaching programme on problems of open field defecation among adults 3. To associate Pre test level of knowledge on open field defecation among adults with their selected socio demographic variables Methodology: An evaluative study was done by using one group pre and post test design with sample size of 150 adults, sample were selected by using simple random Sampling technique, structured questionnaire were used to assess the pre test level of knowledge among adults and computer assisted teaching programme on problems of open field defecation was provided and post test level of knowledge was assessed. Results: Paired "t" test calculated value was 9.438 at and the table value was 2.76 at p<0.05. Conclusion: The study revealed that adults were improved their level of knowledge on problems of open field defecation with planned teaching programme. Key words: Effectiveness, Knowledge, computer assisted teaching programme, open field defecation.

INTRODUCTION

“HEALTH SHOULD MEAN A LOT MORE THAN ESCAPE FROM DEATH OR ESCAPE FROM DISEASE”

Health is an important for the individual as well as community. Good health is a reflection of hygienic practices of an individual. Elimination of waste is one of the basic needs of human beings. The term defecation is defined as a bowel movement in which feaces are evacuated through the rectum and anus. open field defecation is passage of stools in an open environment. It is commonly practiced custom in rural areas where sanitation facilities are ignored. Human excreta in open environment causes health hazards like hook worm infestation, diarrhea, cholera, dysentery and other health problems.

Open defecation is one of such unhealthy practices which is widely prevalent in rural India. Human excreta are source of infection which contain pathogenic bacteria, viruses, protozoa, parasites and their eggs. An excreta of a sick person is the main source of infection which contain disease agent about an estimate of 2.6 billion people (or) about one third of the global population do not access to proper toilet according to WHO and about 700 million people in India doesn’t have access to proper toilet.

Defecation in the open field can contaminate
water supply which lead to the spread of diseases such as diarrhea, worm infestation and killing thousands of people every year. These diseases are not only a burden on the community in terms of sickness, mortality and a low expectation of life, but prevent country’s social and economic progress.

**NEED FOR THE STUDY:** According to “UNICEF” about one billion people or 15% of the global population practice open defecation, India has the highest number of people practicing open defecation around 490 million people nearly a third of the population, most of it occurs in rural areas, where the prevalence is estimated at 52% of population, as opposed to urban areas, where prevalence is estimated at 7.5%.

Over the past 22 years the number of people practicing open defecation fell by 21% from 1.3 billion in 1990 to 1 billion in 2012. 82% of one billion people practicing open defecation in the world live in just 10 countries.

A study conducted by “Jack sim” takes a very keen interest in such matters as the founder and president of the world toilet organization (WTO) India has “A lot of work to do” to improve sanitation, not just because of its impact on health and the spread of disease such as diarrhea which UNICEF says kills 1000 Indian children aged under five every day.

**OBJECTIVES:**
1. To assess the pre and post test level of knowledge among adults on problems of open field defecation.
2. To determine the effectiveness of computer assisted teaching programme on problems of open field defecation among adults.
3. To associate Pre test level of knowledge on open field defecation among adults with their selected socio demographic variables.

**ASSUMPTIONS**
- Adults may have basic knowledge regarding problems of open field defecation.
- Adults may be able to understand the problems of open field defecation.
- Adults may show interest to share their knowledge on problems of open field defecation by answering the questions.
- Computer assisted teaching programme may be a motivating factor for adults in selected rural community to prevent open field defecation.

**HYPOTHESIS**

\[ H_1: \] there will be significant difference in pre and post test level of knowledge on problems of open field defecation among adults.

\[ H_2: \] there will be significant association between pre test level of knowledge and selected demographic variables of adults.

**NULL HYPOTHESIS**

\[ H_{01}: \] there will not be significant difference in pre and post test level of knowledge on problems of open field defecation among adults.

\[ H_{02}: \] there will not be significant association between pre test level of knowledge and selected demographic variables of adults.

**OPERATIONAL DEFINITIONS:**

- **Assess:** To evaluate the knowledge acquired through experience and education on open field defecation.
- **Problems:** Something that is difficult to deal with open field defecation.
- **Open field defecation:** The practices of defecation in the open area
- **Computer assisted teaching programme:** detailed computer teaching aid designed for a group of adults to provide information regarding problems of open field defecation.
DELIMITATIONS:
The study was delimited to Varigonda village, Nellore. District only. The study was delimited to 150 adults only.

MATERIALS AND METHODS
Research approach: Quantitative research approach was adopted to conduct the study.
Research design: Pre-experimental one group pre-test post-test design was used.

One group pre-test post-test design

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Pre-test</th>
<th>Intervenion</th>
<th>Post-test after 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>$O_1$</td>
<td>X</td>
<td>$O_2$</td>
</tr>
</tbody>
</table>

Key

$O_1$: Assessing the pre-test knowledge on problems of open field defecation by using structured knowledge questionnaire.

X: Administration of computer assisted teaching programme to the Adults.

$O_2$: Assessing the post-test knowledge on problems of open field defecation on adults by using the same tool.

Variables

Independent variable: Computer assisted teaching programme.

Dependent variable: Knowledge on problems of open field defecation.

Settings

The study was conducted at Varigonda in Nellore district.

Population: Adults of rural community at Nellore.

Sampling procedure: Simple random sampling technique by using lottery method was used for selection of sample.

Sample size: In this study sample size was 150 adults who were fulfilling inclusion criteria.

Criteria for sample selection

Inclusion criteria

- Adults in the age group between 20 years to 45 years.
- Adults who are willing to participate in the study.
- Adults who can able to read and communicate Telugu.

Exclusion criteria

- Adults who were not available at the time of data collection.

Instruments used for data collection

Part-1 Structured knowledge questionnaire was used to determine the level of knowledge among adults regarding problems of open field defecation.

Part-2 Computer assisted teaching programme on Problems of open field defecation.

Score Interpretation: Structured questionnaire consist of 35 questions. To assess the knowledge on problems of open field defecation. Each correct answer was scored with “1” Mark, and wrong answer was scored with “0”.

<table>
<thead>
<tr>
<th>Level of knowledge</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade - A+ (90% above)</td>
<td>Outstanding</td>
</tr>
<tr>
<td>Grade - A (80 - 89%)</td>
<td>Excellent</td>
</tr>
<tr>
<td>Grade - B+ (70 - 79%)</td>
<td>Very Good</td>
</tr>
<tr>
<td>Grade - B (60 - 69%)</td>
<td>Good</td>
</tr>
<tr>
<td>Grade - C+ (50 - 59%)</td>
<td>Above average</td>
</tr>
<tr>
<td>Grade - C (40 - 49%)</td>
<td>Average</td>
</tr>
<tr>
<td>Grade - D+ (30 - 39%)</td>
<td>Poor</td>
</tr>
<tr>
<td>Grade - D (30% Below)</td>
<td>Very Poor</td>
</tr>
</tbody>
</table>

Data collection method

Formal permission was obtained from
concerned authority. Informed consent was obtained from the participants. Simple random sampling technique was used to select adults by using lottery method and who meets the inclusion criteria were selected. The structured knowledge questionnaire was used to assess the knowledge of adults regarding problems of open field defecation followed by computer assisted teaching programme was provided with the help of A - V aids and post test was conducted on 7th day after computer assisted teaching programme.

**Data Analysis** was done based on the objectives of the study by using Descriptive and Inferential Statistics.

**RESULTS AND DISCUSSION**

**Table 1: Frequency and percentage distribution based on Age among Adults** (n=150)

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 - 25</td>
<td>69</td>
<td>46</td>
</tr>
<tr>
<td>25 - 30</td>
<td>52</td>
<td>34.7</td>
</tr>
<tr>
<td>30 - 35</td>
<td>16</td>
<td>10.7</td>
</tr>
<tr>
<td>35 - 40</td>
<td>13</td>
<td>8.6</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table shows with regard to age of housewives 69(46.0%) are between 20-25 years, 52 (34.7%) are between 25-30 years, 16 (10.6%) are between 30-35 years and 13 (8.6%) are between 35-40 years.

**Table-2: Frequency and percentage distribution based on Gender among adults** (n =150)

<table>
<thead>
<tr>
<th>Gender</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>48</td>
<td>32</td>
</tr>
<tr>
<td>Female</td>
<td>102</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table shows with regard to gender of adults 48 (32%) were male and 102 (68%) adults were females.

**Table-3: Frequency and percentage distribution of educational status among adults.** (n=150)

<table>
<thead>
<tr>
<th>Educational status</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Illiterate</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>b. Primary Education</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>c. High school</td>
<td>49</td>
<td>32.7</td>
</tr>
<tr>
<td>d. Intermediate</td>
<td>23</td>
<td>15.3</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>100</td>
</tr>
</tbody>
</table>
The above table shows that about educational status 18(12%) were illiterate, 60 (40%) were completed their primary education, 49(32.7%) were completed high school, 23(15.3%) adults were completed their intermediate education.

Table-5: Frequency and percentage distribution of Type of family among adults (n=150)

<table>
<thead>
<tr>
<th>Type of Family</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Nuclear Family</td>
<td>132</td>
<td>88</td>
</tr>
<tr>
<td>b. Joint Family</td>
<td>016</td>
<td>10.7</td>
</tr>
<tr>
<td>c. Extended Family</td>
<td>002</td>
<td>01.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>150</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5 shows with regard to type of family, 132(88%) were living in nuclear family, 16(10.7%) were living in Joint family and 2(1.3%) adults were living in extended family.

Table-6: Frequency and percentage distribution based source of information on problems of open field defecation among adults. (n=150)

<table>
<thead>
<tr>
<th>Educational status</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Family members</td>
<td>53</td>
<td>35.3</td>
</tr>
<tr>
<td>b. Relatives / Friends</td>
<td>40</td>
<td>26.7</td>
</tr>
<tr>
<td>c. Health personnel</td>
<td>32</td>
<td>21.3</td>
</tr>
<tr>
<td>d. Mass media</td>
<td>25</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>150</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table shows that about source of information on problems of open field defecation, 53(35.3%) were got information from family members, 40 (26.7%) were from relatives and friends, 32(21.3%) were got information from health personnel, 25(16.7%) adults were got information from mass media.

In pre test, 3 (2%) award A grade, 9 (6%) scored B+ grade, 10 (6.7%) got B grade, 13 (8.7%) scored C+ grade, 15 (10%) got C grade, 42 (28%) got D+ grade and 58 (38.6%) scored D grade. Where as in post test, 14 (9.3%) awarded A+ grade, 25 (16.7%) scored A grade, 28 (18.7%) got B+ grade, 38 (25.3%) got B grade and 45 (30%) got C grade of knowledge.

The above table shows with regard to level of knowledge among adults in pre test 3(2%) adults were in Grade-A (80-89%) where as in post test 25(16.6%) adults were in Grade-A (80-89%) and in pre test 58(38.6%) adults were in Grade-D (30%Below).

Table-8: Comparison of mean and standard deviation of pre test and post test scores of knowledge among adults.

<table>
<thead>
<tr>
<th>Level of knowledge</th>
<th>Pre test</th>
<th>Post test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td>%</td>
</tr>
<tr>
<td>Grade - A+ (90% above)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Grade - A (80 - 89%)</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Grade - B+ (70 - 79%)</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Grade - B (60 - 69%)</td>
<td>10</td>
<td>6.6</td>
</tr>
<tr>
<td>Grade - C+ (50 - 59%)</td>
<td>13</td>
<td>8.6</td>
</tr>
<tr>
<td>Grade - C (40 - 49%)</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Grade - D+ (30 - 39%)</td>
<td>42</td>
<td>28</td>
</tr>
<tr>
<td>Grade - D (30% Below)</td>
<td>58</td>
<td>38.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>150</td>
<td>100</td>
</tr>
</tbody>
</table>
The above table shows that the comparison of mean and standard deviation of pre test and post test scores of knowledge among adults on problems of open field defecation. The pre test mean was 15.67 with Standard deviation of 2.02. The post test mean was 26.83 with Standard deviation of 2.71. The calculated value of paired test was 5.489 and table value was 2.76. The calculated value was greater than the table value; hence the null hypothesis was rejected and research hypothesis was accepted. There was statistically significant improvement on knowledge among adults with computer assisted teaching programme on problems of open field defecation. Association between level of knowledge on open field defecation with selected socio demographic variables of adults.

The association between the level of knowledge and socio demographic variables among adults shown that age, gender, type of family a is not significant, where as education, occupation, family income and source of information was significant.

RECOMMENDATION: On the basis of finding of the study recommendation are being made.

A similar study can be replicated to a large sample to generalize findings special education programme can be provided to adults to prevent open field defecation.

A similar study can be done in different setting.

A comparative study can be conducted to assess knowledge on problems of open field defecation among adults in urban and rural areas.

A similar study can be conducted by using other educational methods like demonstration, role play etc.

A similar study can be conducted to assess attitude and practice of open field defecation.

Conclusion: The study revealed that adults were improved their level of knowledge on problems of open field defecation with planned teaching programme.

REFERENCE
2. BHIM BAHADUR: “Journal of transaction of the royal society of tropical medicine and hygiene,water handling, sanititation and defecation practices in rural southern India” (2007),volume 101, page no.1124-1130.
BMI and HYPERTENSION

Dr. Indira. S, Principal,
Narayana College of Nursing,
Chinthareddypalem, Nellore.

Abstract: Obesity is a growing global health concern, with a rapid increase being observed in morbid obesity. Obesity is strongly associated with hypertension and cardiovascular disease. The present study attempted to assess the correlation between BMI and hypertension. Aim: To assess the correlation between BMI and hypertension. Setting and Design: The study was conducted in rural areas of Nellore by using a descriptive design. Materials and Methods: A total of 134 samples were included in this study. All these samples belong to rural areas of Nellore. Samples were selected by using convenience sampling technique. Statistical Analysis Used: The collected data was organized, tabulated, analysed and interpreted by using descriptive statistics like actual numbers and percentages, mean, standard deviation and inferential statistics like Chi-square test, Karl Pearson correlation coefficient was used appropriately. ‘p’ value less than 0.05 were considered statistically significant. Results: Out of 134 samples, with regard to the category of the blood pressure 37(27.6%) had stage-I hypertension, 16(11.9%) had stage-II hypertension, 10(7.46%) had stage-III hypertension, 17(12.7%) had grade-I isolated systolic hypertension, and 3(2.3%) had grade-II isolated systolic hypertension, known hypertensive cases are 60(44.77%), newly diagnosed cases are 23(17.16%). with regard to BMI, among 134 samples 36(14.4%) were overweight and 13(5.2%) were obese. The correlation coefficient value is 0.19 which states that there is a positive correlation between BMI and hypertension. Conclusion: The results show a positive correlation between BMI and Hypertension. Keywords: BMI, Hypertension, Obesity , Adults, Correlation.

Background of the study: Obesity is a growing global health concern, with a rapid increase being observed in morbid obesity. Obesity is associated with an increased cardiovascular risk and earlier onset of cardiovascular morbidity.

The relevance of both hypertension and obesity, as important public health challenges, is increasing worldwide. Compared with the year 2000, the number of adults with hypertension is predicted to increase by 60% to a total of 1.56 billion by the year 2025 [1]. The growing prevalence of obesity is increasingly recognized as one of the most important risk factors for the development of hypertension. This epidemic of obesity and obesity-related hypertension is paralleled by an alarming increase in the incidence of diabetes mellitus and chronic kidney disease.

Obesity and in particular central obesity have been consistently associated with hypertension and increased cardiovascular risk. Based on population studies, risk estimates indicate that at least two-thirds of the prevalence of hypertension can be directly attributed to obesity [2]. Apart from hypertension,
abdominal adiposity has also been implicated in the pathogenesis of coronary artery disease, sleep apnoea, stroke and congestive heart failure [3].

The research of Dr. Indira. A et al. [4] and other studies [5-7] shows the high prevalence of hypertension and BMI among various categories of people of Nellore. Since studies on BMI and its relation to hypertension are scanty from this region of Nellore (Andhra Pradesh - India) so, an attempt is being made to find out the relation between BMI and hypertension.

**Research Design:** Descriptive design.

**Research Setting:** The study was conducted in rural areas of Nellore.

**Sampling Technique:** Convenience sampling technique.

**Sample Size:** A Total of 134 participants were evaluated.

**Data collection procedure:** This study was conducted by the advanced research team of Narayana College of Nursing which includes subject interview and clinical examination for one time to collect the following. Participants were included if they were free of diabetes, hypertension and any other diseases and declared healthy based on clinician’s judgment. Detailed interview was done and data collection forms were used to collect Demographic (area of living, age and gender), Height was measured using Stadio meter. Weight with calibrated weighing machine. Body mass index (BMI) was calculated using formula weight (kg)/height (m²). BMI was categorized according to the international standards (Haslett et al., 2000) into four groups, < 18.5 kg/m² (Underweight), 18.6 – 24.9 kg/m² (Normal), 25.0 – 29.9 (Overweight) and >30 kg/m² (obesity). Blood pressure was recorded by aneroid B.P apparatus. Blood pressure was categorized according Indian hypertension guidelines-III.

**Statistical Analysis Used:** The collected data was organized, tabulated, analysed and interpreted by using descriptive statistics like actual numbers and percentages, mean, standard deviation and inferential statistics like Chi-square test, Karl Pearson correlation coefficient was used appropriately. ‘p’ value less than 0.05 were considered statistically significant.

**Results and Discussion**

A Total of 134 participants were evaluated, all are rural adults. 62/134 were males and 72/134 were females.

**Table-1:** Frequency and Percentage distribution of Blood Pressure

<table>
<thead>
<tr>
<th>HTN Blood Pressure</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td>Normal</td>
<td>11</td>
<td>8.2</td>
</tr>
<tr>
<td>High Normal</td>
<td>24</td>
<td>17.9</td>
</tr>
<tr>
<td>Stage - I</td>
<td>37</td>
<td>27.6</td>
</tr>
<tr>
<td>Stage - II</td>
<td>16</td>
<td>11.9</td>
</tr>
<tr>
<td>Stage - III</td>
<td>10</td>
<td>7.5</td>
</tr>
<tr>
<td>Grade - I</td>
<td>17</td>
<td>12.7</td>
</tr>
<tr>
<td>Grade - II</td>
<td>03</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>134</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The table shows that, 16 (11.9%) were having optimal blood pressure, 11(8.2%) were having normal, 24 (17.9%) were having high normal, 37 (27.6%) were having Stage-I, 16 (11.9%) were having Stage- II, 10 (7.46%) were having Stage- III, 17 (12.7%) were having Grade-I, 3 (2.3%) were having Grade-II hypertension.

**Table - 2:** Frequency and Percentage distribution of BMI

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Freq</th>
<th>Per</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under weight (BMI = &lt; 18)</td>
<td>2</td>
<td>1.49</td>
</tr>
</tbody>
</table>
Among 134 samples, 2 (1.49%) were under weight, 75 (55.98%) were normal, 27(20.14%) were over weight and 30 (22.39%) were Obese.

**Table-3:** Correlation between BMI and hypertension (n=294)

<table>
<thead>
<tr>
<th>BMI criteria</th>
<th>Blood Pressure</th>
<th>Person correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Under weight (BMI = &lt; 18)</td>
<td>2</td>
<td>1.49</td>
</tr>
<tr>
<td>Normal (BMI = 18.0-22.9 kg/m²)</td>
<td>75</td>
<td>55.98</td>
</tr>
<tr>
<td>Over weight (BMI=23.0-24.9 kg/m²)</td>
<td>27</td>
<td>20.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese (BMI=25&amp; above kg/m²)</td>
<td>30</td>
<td>22.39</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table shows the correlation between BMI and HT. The correlation coefficient value is 0.19 which states that there is a positive correlation between BMI and hypertension.

As we are knowing the complications of obesity and hypertension dietary modifications like inclusion of spirulina [8], good physical activity, reducing the stress helps to reduce the complications. The present study results are supported with the findings of the previous studies conducted in Nellore region [9-11].

**CONCLUSION:** The results show a positive correlation between BMI and Hypertension. Therefore, the habit of regular diets with content of plenty of fiber, ω-3, good vegetable and animal proteins, antioxidant, less fat and sugar, vitamins and regular exercise, are healthy practices allowing the body’s nutritional signaling mechanisms to equilibrate to reference levels.

**References:**
Effectiveness of puppet show and slide show on knowledge of diabetes mellitus among diabetic and non diabetic clients in Endocrinology OPD, NMCH, Nellore.

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Abstract: Diabetes, often referred by doctors as diabetes mellitus, describes a group of metabolic diseases in which the person has high blood glucose (blood sugar), either because insulin production is inadequate, or because the body’s cells do not respond properly to insulin, or both. Objective: To assess the level of knowledge on diabetes among diabetic and non-diabetic clients in Endocrinology OPD, NMCH, and Nellore. Materials and Methods: one group pre test – post test design and purposive sampling technique was followed which included 42 samples were used. Data was collected using structured questionnaire. Data analysis was done with SPSS. Results: shows that with regard to level of knowledge among 18 diabetic clients in pre test score, 6 (33.3%) had B grade knowledge and in post test score, 7 (38.8%) had A grade knowledge. Among 24 non-diabetic clients in pre test score, 8 (33.4%) had C grade knowledge and in post test score, 11 (45.9%) had A grade knowledge. Conclusions: The study findings concluded that puppet show and slide show was very effective in improving knowledge on diabetes mellitus in both diabetic and non diabetic clients. Key words: diabetes, insulin, intrauterine development.

INTRODUCTION: Diabetes mellitus (DM) constitutes a growing global public health problem, from 30 million people affected 10 years ago to about 135 million today, and an estimated 300 million by 2025. This global epidemic involves not only the industrialized world but also less developed countries where urbanization and industrialization are proceeding rapidly.

Diabetes mellitus is a group of metabolic disorder arising either due to relative or absolute deficiency of a digestive hormone called insulin or inability or resistance of body cells to use the available insulin. Risk factors are family history, obesity, impaired glucose to tolerance, hypertension and history of gestational diabetes mellitus. Clinical manifestations include 3 P’s polyuria, polyphagia, polydipsia, fatigue, weakness, sudden vision changes, tingling or numbness of hands and foot, dry skin. Patients with Diabetes mellitus cannot be cured, but they can control it with proper care, regular exercise, diet, and drug. Proper care, regular administration of drug can provide desired outcome, control diabetes, and prevent its complications.

The main underlying causes of the disease are genetic and environmental factors, such as urbanization and industrialization, as well as increased longevity and changes in lifestyle from a traditional healthy and active life to a modern, sedentary, stressful life and over-consumption of energy-dense foods. The prevalence of diabetes mellitus varies among populations due to differences in genetic susceptibility and social risk factors such as change in diet, obesity,
physical inactivity and, possibly, factors relating to intrauterine development.

Diabetes mellitus needs to be treated by a holistic approach through dietary adjustment, exercise, medication (if needed) and education and self-care measures. Type 2 diabetes mellitus is a preventable disease. These need to focus on health promoting activities to raise awareness among healthy people of the risk factors for diabetes mellitus.

Diabetes is one of the most deadly, disabling, and costly diseases facing the nation at this time and the disease continues to be on the rise at epidemic proportions.

The global prevalence of diabetes is set to double over the next 25 years. Developing countries like India, already top of the diabetes league, are expected to face much of this burden. Epidemiological studies show that the prevalence of diabetes is particularly high in urban areas in India. Cities are also home to a large pool of people with a great risk of developing diabetes in the future.

NEED FOR THE STUDY:

Diabetes has emerged as a major healthcare problem in India. According to Diabetes Atlas published by the International Diabetes Federation (IDF), it is estimated that, 40 million persons with diabetes in India in 2007 and this number is predicted to rise to almost 70 million people by 2025. The countries with the largest number of diabetic people will be India, China and USA by 2030. It is estimated that every fifth person with diabetes will be an Indian. Due to these sheer numbers, the economic burden due to diabetes in India is amongst the highest in the world. The real burden of the disease is however due to its associated complications which lead to increased morbidity and mortality. WHO estimates that mortality from diabetes, heart disease and stroke costs about $210 billion in India in the year 2005. Much of the heart disease and stroke in these estimates was linked to diabetes. WHO estimates that diabetes, heart disease and stroke together will cost about $ 333.6 billion over the next 10 years in India alone.

According to a survey conducted by market research firm IMRB and commissioned by world leader in diabetes care - Novo Nordisk, more than 60 percent of the Indian urban public does not know to control diabetes and it affects primary organs like heart, kidney and eyes.

Rapid urbanization and industrialization have produced advancement on the social and economic front in developing countries such as India which have resulted in dramatic lifestyle changes leading to lifestyle related diseases. The transition from a traditional to modern lifestyle, consumption of diets rich in fat and calories combined with a high level of mental stress has compounded the problem further. There are several studies from various parts of India which reveal a rising trend in the prevalence of type II diabetes in the urban areas. A National Urban Survey in 2000 observed that the prevalence of diabetes in urban India in adults was 12.1 percent. Recent data has illustrated the impact of socioeconomic transition occurring in rural India. The transition has occurred in the last 15 years and the prevalence has risen from 2.4 percent to 6.4 percent.

Recent reports show strikingly high prevalence of diabetes among urban Asian Indians; however, there are very few studies comparing urban, peri-urban and rural prevalence rates of diabetes and their risk factors at the national level. Diabetes was diagnosed based on self-reported diabetes diagnosed by a physician. The lowest prevalence of self-reported diabetes was recorded in rural (3.1%) followed by peri-urban/slum (3.2%) and the highest in urban areas.
(7.3%). The number of deaths attributed annually to diabetes is around 3.2 million. Diabetes has become one of the major causes of premature illness and death in most countries, mainly through the increased risk of cardiovascular disease (CVD).

STATEMENT OF THE PROBLEM: A study to assess the effectiveness of puppet show and slide show on knowledge of diabetes mellitus among diabetic and non-diabetic clients in Endocrinology OPD, NMCH, Nellore.

OBJECTIVES OF THE STUDY:
♣ To assess the level of knowledge on diabetes mellitus among diabetic clients.
♣ To assess the level of knowledge on diabetes mellitus among non-diabetic clients.
♣ To evaluate the effectiveness of puppet show and slide show among diabetic and non-diabetic clients.
♣ To compare the pre test and post test score among diabetic and non-diabetic clients.

METHODOLOGY:
Research design: Pretest and post test research design was used.
Setting: The study conducted in Endocrinology OPD, Narayana Medical college and hospital, Nellore.
Sample: diabetic and non-diabetic clients.
Sample size: 18 Diabeties and 24 non diabetic client.
Sampling technique: non probability purposive sampling technique was adopted.
Criteria for sample selection: Inclusion criteria.
➢ Those who are willing to participate and be available during the period of study.
Exclusion criteria
➢ Those who are not willing to participate in the study.
➢ Those who are not available during data collection.

DESCRIPTION OF THE TOOL: PART I: Deals with demographic data which includes age, sex, education, occupation, monthly family income, religion, family history, co morbid diseases and habits.

PART II: Knowledge regarding diabetic mellitus.

SCORE INTERPRETATION:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Score</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+</td>
<td>29 - 35</td>
<td>&gt; 85</td>
</tr>
<tr>
<td>A</td>
<td>25 - 28</td>
<td>71 - 85</td>
</tr>
<tr>
<td>B</td>
<td>15 - 24</td>
<td>61 - 70</td>
</tr>
<tr>
<td>C</td>
<td>8 - 14</td>
<td>51 - 60</td>
</tr>
<tr>
<td>D</td>
<td>1 - 7</td>
<td>≤ 50</td>
</tr>
</tbody>
</table>

DATA COLLECTION PROCEDURE:
The main study was conducted in Endocrinology OPD, NMCH, Nellore, prior permission has been obtained from principal of Narayana Nursing Institutions. By using purposive sampling technique has been selected for the study. Comfortable position has been provided for samples. Puppet show and slide show was done for both diabetic and non-diabetic clients.

PLAN FOR DATA ANALYSIS: The scores obtained was tabulated using descriptive statistics such as frequency, percentage and level of knowledge among diabetic and non diabetic clients.

DATA ANALYSIS AND INTERPRETATION:
Table no-01: Frequency and Percentage distribution of level of knowledge among Diabetic clients

n=18

<table>
<thead>
<tr>
<th>Grade</th>
<th>Diabetic Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre Test</td>
</tr>
<tr>
<td></td>
<td>Fre (f)</td>
</tr>
<tr>
<td>A+</td>
<td>1</td>
</tr>
</tbody>
</table>
Among 18 diabetic clients, in pre-test 1 (5.5%) awarded A+ grade, 5 (27.7%) scored A grade, 6 (33.4%) got B grade, 3 (16.7%) scored C grade and D grade respectively. Whereas in post-test, 3 (16.7%) awarded A+ grade, 7 (38.8%) scored A grade, 5 (27.8%) got B grade and 3 (16.7%) got D grade.

**Table no-02: Frequency and Percentage distribution of level of knowledge among Non diabetic clients.**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Pre Test</th>
<th>Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fre (f)</td>
<td>Per (%)</td>
</tr>
<tr>
<td>A+</td>
<td>1</td>
<td>4.1</td>
</tr>
<tr>
<td>A</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>B</td>
<td>4</td>
<td>16.7</td>
</tr>
<tr>
<td>C</td>
<td>8</td>
<td>33.4</td>
</tr>
<tr>
<td>D</td>
<td>5</td>
<td>20.8</td>
</tr>
</tbody>
</table>

Among 24 non-diabetic clients, in pretest, 1 (4.1%) awarded A+ grade, 6 (25%) scored A grade, 4 (16.7%) got B grade, 8 (33.4%) scored C grade and 5 (20.8%) got D grade. Whereas in post test 6 (25%) awarded A+ grade, 11 (45.9%) scored A grade, 6 (25%) got B grade and 1 (4.1%) got C grade.

**CONCLUSION:** The study findings concluded that puppet show and slide show was very effective in improving knowledge on diabetes mellitus in both diabetic and non-diabetic clients.

**BIBLIOGRAPHY:**
ABSTRACT: Obesity is the medical condition in which excess fat has accumulated to the extent that may be having a negative effect on health. People are generally considered obese when their body mass index is over 30 kg/m². Objectives: 1. To assess the prevalence of obesity among school children. 2. To find out association between the prevalence of obesity among school children with their selected socio demographic variables. Materials and Methods: The researcher was used quantitative research approach with Descriptive research design. The 100 samples were selected by using Non-probability convenience sampling technique to assess the prevalence of obesity among school children in NTR Nagar at Nellore. Data was analyzed by using descriptive and inferential statistics. The results revealed that with regards to prevalence of obesity among school children 27(27%) are underweight, 40(40%) are normal, 29(29%) were overweight and 4 (4%) were obese. Key Words: Prevalence, Obesity, School Children.

Introduction: Obesity is most commonly caused a combination of excessive food intake, lack of physical activity and genetic susceptibility. A few causes are primarily by genes endocrine disorders, medications or mental illness. Evidence to support the view that obese people eat little yet gain weight due to a slow metabolism is not generally supported an average, obese people have greater energy expenditure than their thin counterpart, due to the energy required to maintain an increased body mass.

Obesity increases the likelihood of various disease particularly heart diseases, type-II diabetes, obstructive sleep apnea, certain types of cancer, osteoarthritis. Obesity is also one of the risk factor for stroke and coronary heart disease, asthma, pulmonary hypertension, diabetic mellitus, infertility, hypogonadism, gall stones, stress incontinence and colorectal cancer in both genders. The epidemic reflects changes in behavior pattern including decreased physical activity and over consumption of high fat energy dense food and individual become obese because of a biological pre disposition to gain weight readily when they are exposed to an unfavorable environment.

Objectives:
➢ To assess the prevalence of obesity among school children.
➢ To find out the association between the prevalence of obesity among school children with their selected socio demographic variables.

MATERIALS AND METHODS: Research Approach: Quantitative research approach was adopted to assess the prevalence of obesity among
school children in NTR Nagar, Nellore.

Research Design: The research design was used for the present study is descriptive research design.

Setting of the Study: The present study was conducted in NTR Nagar at Nellore.

Target Population: The target population of the study includes school children.

Accessible Population: The accessible population of the study comprise of school children in NTR Nagar, Nellore.

Sample: The sample for the present study includes 100 school children who fulfill the inclusion criteria.

Sample Size: The sample size for the present study include 100 school children in NTR Nagar, Nellore.

Sampling Technique: Non probability convenience sampling technique was adopted for this study.

Description of the Tool: The tool is developed with the help of extensive review from various text books, journals, internet sources and by the discussion and guidance from experts. The tool consist of 2 parts.

Part-A: It deals with Socio Demographic Variables age, gender, birth order of child, dietary pattern.

Part-B: It deals with structured questionnaire to assess prevalence of obesity among the school children in NTR Nagar, Nellore.

RESULT AND DISCUSSION:

Table No-1: Frequency and percentage distribution of prevalence of obesity among school children.

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency (F)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under weight</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Normal</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Over weight</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Obesity</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table no-1: shows that in relation to prevalence of obesity among school children 27(27%) are underweight, 40(40%) are normal, 29(29%) were overweight and 4 (4%) were obese.

Table no-2: Mean and standard deviation of Body Mass Index and mid upper arm circumference among children.

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>15.72</td>
<td>2.24</td>
</tr>
<tr>
<td>MUAC</td>
<td>18.62</td>
<td>1.07</td>
</tr>
<tr>
<td>HIGHT</td>
<td>122.23</td>
<td>1.65</td>
</tr>
<tr>
<td>WEIGHT</td>
<td>24.48</td>
<td>1.44</td>
</tr>
</tbody>
</table>

Table no-2: Shows that prevalence of obesity among school children the BMI mean is 15.72 with standard deviation of 2.24 and mid upper arm circumference mean is 18.62 with standard deviation of 1.07 and height mean is 122.23 with standard deviation of 1.65 and weight mean is 24.48 with standard deviation of 1.44.

Association between the prevalence of obesity with their selected socio demographic variables: There is a significant association between the prevalence of obesity with their selected socio demographic variables with Birth order of the child, Dietary pattern and there is no significance association between the prevalence of obesity with the socio demographic variables like age, Gender, Religion, Term maturity at birth.

Association between the prevalence of obesity with dietary habits: There is a significance association between prevalence of obesity with dietary habits are number of meals taken per day, intake of animal food, frequency of taking animal food, daily intake of fruits, intake of milk and milk products, frequency of taking milk products, frequency of eating fast foods, hours of watching TV.

There is no significant association between prevalence of obesity with dietary habits like history of skipping breakfast, eating pattern during stress, frequency of eating outside, quantity of intake of vegetables, daily intake of pulses and legumes, frequency of eating chocolates, quantity of fruits intake per day, intake of beverages, physical activity, type of physical activity, duration of physical activity, hours spent in playing video in computer games each day, history of any systemic disease, history of endocrine disease, history of taking drugs such as corticosteroids, history of obesity in the family, history of frequent illness.

Nursing Implications: The findings of the study have
several implications for nursing practice, nursing education, nursing research.

Nursing Practice: The nurses as member of the health team should be aware of the causes, risk factors and management of obesity.

Nursing Education: Obesity is the leading cause of death among the children and also the nurse educator should teach the staff and student nurses regarding the obesity. Identify the risk factors their educate how to manage the obesity or children and also about normal growth.

Nursing Administration: The nurse administrator should conduct awareness program regarding prevention of risk of the obesity for children and also to reduce the obesity among children who are already affected.

Nursing Research: The findings of the study can generalized to increase the body of knowledge in nursing field continuing research and health to understand the importance of prevalence of obesity to screen the children and to give information to reduce the obesity and also effect of obesity.

CONCLUSION: The study findings shows that the prevalence of overweight is high in NTR Nagar. As a health personal’s need to create awareness on life styles of peoples.

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HYDROCEPHALUS CASE STUDY

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Abstract: Hydrocephalus is a collection of excessive cerebrospinal fluid. The child presented with the complaints of feeding unable to recognize the parents, decreased activity, severe head ache. sunset eyes. The patient undergone ventriculoperitoneal shunt. Key Words: Hydrocephalus Phalus, case study Nursing care.

INTRODUCTION:
Hydrocephalus affects hundreds of thousands of Americans, in every stage of life, from infants to the elderly. The term hydrocephalus is derived from two words: “hydro,” meaning water, and “cephalus,” referring to the head. Hydrocephalus can be defined broadly as a disturbance of cerebrospinal fluid (CSF) formation, flow, or absorption, leading to an increase in volume occupied by this fluid in the central nervous system. This condition could also be termed a hydrodynamic CSF disorder.

DEFINITION:
Hydrocephalus is a condition characterized by an excess of cerebrospinal fluid (CSF) within the ventricular and subarachnoid spaces of the cranial cavity.

Need for the study
Hydrocephalus cases are affecting the entire world every day.

The incidence of congenital hydrocephalus is 3 per 1, 000 live births; the incidence of acquired hydrocephalus is not known exactly due to the variety of disorders that may cause it. Incidence of acquired hydrocephalus is unknown. Shunt dependence occurs in 75% of all cases of treated hydrocephalus and in 50% of children with communicating hydrocephalus. Incidence is equal in males and females. Incidence of human hydrocephalus presents a bimodal age curve; one peak occurs in infancy and is related to the various forms of congenital malformations. Adult hydrocephalus represents approximately 40% of total cases of hydrocephalus.

CASE REPORT:
Master. Naveed 10 years old boy was admitted in the paediatric ward in the hospital with complaints of poor feeding, unable to recognize the parents, decreased activity, sunset eye severe head ache and diagnosed as congenital hydrocephalus.

DIAGNOSIS:

CT scan brain plain: scans have shown that cerebrospinal fluid (CSF) is at a higher level than usual.

MRI brain: Which shows ventricles in the brain become blocked or narrowed angle of the frontal horns on coronal view, downward bowing of the floor of the third ventricle, elevation of the corpus callosum.

CSF analysis: protein concentration 6 g/l.

DISCUSSION:
Causes: Congenital abnormalities.

CLASSIFICATION:
There are two types of hydrocephalus:
1. Non-communicating: In the non-communicating type of congenital hydrocephalus, an obstruction occurs in the free circulation of CSF.
2. Communicating: In the communicating type of hydrocephalus, no obstruction of the free flow of the CSF exists between the ventricles and the spinal theca; rather, the condition is caused by defective absorption of CSF, thus causing increased pressure on the brain or spinal cord.
3. Congenital hydrocephalus: Congenital hydrocephalus is present in babies when they’re born and can be caused by birth defects, such as spine bifida, or as a result of an infection that the mother develops during pregnancy, such as mumps or rubella (German measles). It’s estimated that spine bifida affects one baby in every 1,000 born in Ireland. Most of them will have hydrocephalus. Congenital hydrocephalus carries the risk of long-term mental and physical disabilities as a result of permanent brain damage.

4. Acquired hydrocephalus: Acquired hydrocephalus can affect children or adults. It usually develops after an injury or illness. For example, it may occur after a serious head injury or as a complication of a medical condition, such as a brain tumour.

5. Normal pressure hydrocephalus: Normal pressure hydrocephalus (NPH) is a poorly understood condition that usually affects people over 50 years old. It can sometimes develop after an injury or a stroke, but in most cases the cause is unknown. The average age of people with NPH is 75.

CAUSES:

1. Cerebrospinal fluid and the brain
   Hydrocephalus can develop if:
   - There’s a blockage in one of the ventricles so that excess fluid can’t move out of the brain.
   - There’s a problem with the arachnoid villi so that fluid is unable to filter into the blood vessels.
   - The brain starts to produce too much cerebrospinal fluid.

2. Congenital hydrocephalus
   Congenital hydrocephalus, where a baby is born with the condition, may be the result of a brain defect that restricts the flow of cerebrospinal fluid. For example, the passages that connect the ventricles in the brain become blocked or narrowed.

   These defects in the development of the brain can be caused by health conditions known to cause birth defects. For example, most children born with the most serious type of spine bifida will develop hydrocephalus.

   Congenital hydrocephalus can also occur in babies born prematurely (before week 37 of the pregnancy). Some premature babies experience bleeding in their brain, which can block the flow of cerebrospinal fluid and cause hydrocephalus. Other possible causes of congenital hydrocephalus include:
   - X-linked hydrocephalus - where the condition occurs as a result of a mutation (change in the genetic material) of the X chromosome.
   - rare genetic disorders, such as Dandy Walker malformation.
   - arachnoid cysts - fluid filled sacs located between the brain or spinal cord and the arachnoid membrane, which is one of the three membranes surrounding the brain and spinal cord.

   In many cases of congenital hydrocephalus, the cause is unknown. This is medically referred to as idiopathic.

3. Acquired hydrocephalus that develops in adults or children (acquired hydrocephalus) is usually the result of an injury or illness that causes a blockage between the ventricles of the brain.

   Possible causes of acquired hydrocephalus include:
   - bleeding inside the brain - for example, if blood leaks out of blood vessels over the surface of the brain (subarachnoid haemorrhage).
   - blood clots inside the blood vessels in the brain (venous thrombosis).
   - meningitis - an infection of the protective membranes that surround the brain and spinal cord.
   - brain tumours
   - head injury

   It’s also possible for someone to be born with narrowed passage ways in their brain that restrict the flow of cerebrospinal fluid, but don’t cause any symptoms until years later.

4. Normal pressure hydrocephalus
   Hydrocephalus that develops in older people (normal pressure hydrocephalus or NPH) can occur after a brain injury, bleeding in the brain or infection. However, in most cases, there’s no clear reason why the condition occurs.

   There are several theories to explain what happens to the brain in cases of NPH. Some are outlined below.
5. Problems with the arachnoid villi, one idea is that NPH occurs when something goes wrong with the arachnoid villi, which is the layer of tissue that allows cerebrospinal fluid to filter into the blood vessels. This means that the blood vessels don’t reabsorb the fluid. This creates a gradual increase in pressure, which can cause progressive brain damage.

6. **Underlying health conditions:** NPH may be caused by underlying health conditions that affect the normal flow of blood. For example, diabetes, heart disease or having a high level of cholesterol in the blood.

The exact cause is unknown, but conditions that affect blood vessels within the brain or that supply blood to the brain (cerebrovascular disease) may be linked to NPH.

**PATHOPHYSIOLOGY:**

Normally, a delicate balance exists between the rate of formation and absorption of CSF.

↓

In hydrocephalus, this balance is disturbed.

↓

CSF is formed mainly in the lateral ventricles by the choroid plexus and is absorbed into the venous system through the arachnoid villi.

↓

CSF circulates within the ventricles and the subarachnoid space.

↓

An obstruction may occur in the free circulation of CSF; this blockage causes increased pressure on the brain or spinal cord.

↓

The site of obstruction may be at the foramen of Monro, the aqueduct of Sylvius, the foramen of Luschka, or the foramen of Magendie.

↓

If there is no obstruction, the condition may be caused by defective absorption of CSF, thus causing increased pressure on the brain or spinal cord.

**CLINICAL MANIFESTATIONS:**

Clinical features of hydrocephalus are influenced by the patient’s age, the cause of the hydrocephalus, the location of the obstruction, its duration, and its rapidity of onset.

❖ **Poor feeding:** The infant with hydrocephalus has trouble in feeding due to the difficulty of his condition.

❖ **Large head:** An excessively large head at birth is suggestive of hydrocephalus.

❖ **Bulging of the anterior fontanels:** The anterior fontanel becomes tense and bulging, the skull enlarges in all diameters, and the scalp becomes shiny and its veins dilate.

❖ **Setting sun sign:** If pressure continues to increase without intervention, the eyes appear to be pushed downward slightly with the sclera visible above the iris - the so-called setting sun sign.

❖ **High-pitched cry:** The intracranial pressure may increase and the infant’s cry could become high-pitched.

❖ **Irritability:** Irritability is also caused by an increase in the intracranial pressure.

❖ **Projectile vomiting:** An increase in the intracranial pressure can cause projectile vomiting.

**Urinary symptoms**

The change in the way that you walk is often followed by bouts of urinary incontinence, which may include symptoms such as:

❖ a frequent need to urinate

❖ an urgent need to urinate

❖ loss of bladder control

**Mental abilities**

The normal thinking process also starts to slow down. *This can take the form of:*

❖ being slow to respond to questions

❖ reacting slowly to situations

❖ being slow to process information.

**Other symptoms of acquired hydrocephalus include:**

❖ neck pain

❖ feeling sick

❖ being sick - which may be worse in the morning

❖ drowsiness, which can progress to a coma

❖ changes in your mental state, such as confusion

❖ blurred vision or double vision

❖ difficulty walking
not being able to control bladder and in some cases, bowel incontinence

**ASSESSMENT AND DIAGNOSTIC FINDINGS:**
Examination in infants may include the following:
CT scan of the brain with hydrocephalus. Black areas in the middle of the brain are abnormally large and filled with fluid.

1. **Computed tomography (CT) scanning.** CT scan should be undertaken to assess the overall size of the ventricles, and to determine if periventricular oedema or “lucency” is present. A CT scan is also useful to assess the size of the fourth ventricle - if large, this suggests a communicating hydrocephalus, whereas a relatively small fourth ventricle implies obstructive hydrocephalus that might be best treated by endoscopic third ventriculostomy rather than a ventriculo-peritoneal shunt. the size of ventricles and other structures.

2. **Magnetic resonance imaging (MRI).** MRI is used to assess for Chiari malformation or cerebella or periaqueductal tumors.

3. **Ultrasonography through anterior fontanel in infants.** This study assesses for subependymal and intra ventricular hemorrhage; to follow infants for possible progressive hydrocephalus.

4. **Skull radiography.** To detect erosion of sella turcica, or “beaten copper cranium” or “beaten silver cranium” - the latter can also be seen in craniostenosis; (after shunt insertion) to confirm correct positioning of installed hardware.

5. **MRI cine.** To measure CSF stroke volume (SV) in the cerebral aqueduct; however, such measurements don’t appear to be useful in predicting response to shunting.

6. **Diffusion tensor imaging (DTI).** To detect differences in fractional anisotropy and mean diffusivity of the brain parenchyma surrounding the ventricles; allows recognition of microstructural changes in periventricular white matter region that may be too subtle on conventional MRI.

7. **Radionuclide cisternography (in NPH).** To assess the prognosis with regard to possible shunting—however, due to its poor sensitivity in predicting shunt response when the ventricular to total intracranial activity (V/T) ratio is less than 32%, this test is no longer commonly used.

8. **ICP monitoring/CSF infusion studies** ICP monitoring and CSF infusion studies are now being used more frequently in young patients with mild symptoms and older patients with possible low grade hydrocephalus. ICP monitoring may reveal “B waves” either at night time alone or throughout the day and night. An ICP above 15 mm Hg at frequent intervals during the night or day while asleep or resting is abnormal, and patients with functioning shunts should normally have an ICP below or near to zero while 45° head up in bed and scans have shown that cerebrospinal fluid (CSF) is at a higher level than usual.

**MEDICAL MANAGEMENT:**
The goal of treatment in clients with hydrocephalus is to reduce or prevent brain damage by improving the flow of CSF which may include surgery to provide shunting for drainage of the excess fluid from the ventricles to an extracranial space such as the peritoneum or right atrium (in older children) or management with medications to reduce ICP if progression is slow or surgery is contraindicated.

**Pharmacologic Therapy**
The following medications are used to treat hydrocephalus.

- **Diuretics:** Acetazolamide (ACZ) and furosemide (FUR) treat post hemorrhagic hydrocephalus in neonates; both are diuretics that also appear to decrease secretion of CSF at the level of the choroid plexus.

- **Anticonvulsants:** Helps to interfere impulse transmission of cerebral cortex and prevent seizures.

- **Antibiotics:** Culture and sensitivity dependent for shunt infections such as septicemia, ventriculitis, meningitis, or given as a prophylactic treatment.

**Surgical Management**
Surgical intervention is the only effective means of relieving brain pressure and preventing additional damage to the brain tissue.

1. **Surgery:** Surgical treatment is the preferred therapeutic option in patients with hydrocephalus.
2. **Ventriculoperitoneal (VP) shunt**: A ventriculoperitoneal (VP) shunt is a medical device that relieves pressure on the brain caused by fluid accumulation.

3. **Ventriculoatrial (VA) shunt**: Ventriculoatrial shunt placement enables cerebrospinal fluid (CSF) to flow from the cerebral ventricular system to the atrium of the heart.

4. **Lumboperitoneal shunt**: Only used for communicating hydrocephalus, CSF fistula, or pseudotumor cerebri.

5. **Torkildsen shunt**: Effective only in acquired obstructive hydrocephalus.

6. **Ventriculopleural shunt (second-line therapy)**: 

**COMPLICATIONS OF SHUNTING**

**Shunt obstruction**: Shunt obstruction may occur proximally in the ventricular catheter as a result of choroid plexus, red cells, tumour cells, or a high protein concentration in the CSF. Blockage of the distal catheter can occur as a result of body growth (if the shunt was placed during childhood), adhesions within the abdominal cavity, especially when associated with a low grade infection, pregnancy, and occasionally constipation.

**Infection**: Shunt infections are usually caused by the patient’s own skin organisms, which gain access to shunt tubing during the shunt procedure. Typically this contamination will cause an internal shunt colonisation where the bacteria settle and grow on the internal wall of the shunt catheter and valve, establishing adherent colonies. However, some bacteria set up a ventriculitis without full colonisation of the shunt, and others cause an external shunt infection (deep wound infection).

The most important clinical features of a shunt infection are as follows:

- General malaise, Pyrexia, Headaches, vomiting, neck stiffness, Abdominal tenderness or distension, Recurrent lower end shunt obstruction, Recent shunt operation, 90% of VP shunt infections present within three months of a shunt operation, Raised C reactive protein, High peripheral and CSF white cell count, Culture of organism from CSF.

**Over-drainage**: The perfect shunt valve has yet to be designed and many current models allow over-drainage of CSF due to the siphoning effect. The hydrostatic pressure (25-75 cm CSF) caused by the weight of the column of CSF within the distal catheter leads to fluid being sucked out of the ventricles in the upright position.

**Subdural hematoma**: can occur during the first six months after a shunt insertion and has been shown to be related to the amount of CSF released at operation. Small collections occur up to 30% of patients after shunt insertion in the elderly, but symptomatic collections requiring surgery affect only 10–15%. The symptoms of a shunt related subdural collection include headaches, confusion, hemiparesis, and drowsiness.

**NURSING MANAGEMENT**: Managing a child with hydrocephalus warrants skill and compassion for nurses and all the members of the healthcare team.

**Nursing Assessment**: Accurate information is essential in the assessment of the child with hydrocephalus.

- **Head circumference**: Measurement of the newborn’s head is essential.
- **Neurologic and vital signs**: Obtaining accurate vital and neurologic signs is necessary before and after surgery.
- **Check the fontanelles**: If the fontanelles are not closed, carefully observe them for any signs of bulging.
- **Monitor increase in intracranial pressure**: Observe, report, and document all signs of ICP.
- **History taking**: If the child has returned for revision of an existing shunt, obtain a complete history before surgery from the family caregiver to provide a baseline of the child’s behavior.

**NURSING DIAGNOSES**: Based on the assessment data, the major nursing diagnoses are:

1. **Risk for Injury related to increased ICP**:

**Interventions**:

- Monitor the patient.
- Monitor the newborn’s level of consciousness.
- Check the pupils for equality and reaction.
- Monitor the neurologic status, and observe for a shrill
cry, lethargy, or irritability.

- Measure and record the head circumference daily.
- Keep suction and oxygen equipment convenient at the bedside.

2. Risk for Impaired Skin Integrity related to pressure from physical immobility.

**Interventions:**
- After a shunting procedure, keep the newborn’s head turned away from the operative site until the physician allows a change in position.
- Reposition the newborn at least every 2 hours, as permitted.
- Inspect the dressings over the shunt site immediately after the surgery, every hour for the first 3 to 4 hours, and then at least every 4 hours.

3. Risk for Infection related to the presence of a shunt.

- Closely observe for and promptly report any signs of infection
- Perform wound care thoroughly as ordered.
- Administer antibiotics as prescribed.

4. Risk for Delayed Growth and Development related to impaired ability to achieve developmental tasks.

**Interventions:**
- The newborn needs social interaction and needs to be talked to.
- Played with, and given the opportunity for activity.
- Provide toys appropriate for his mental and physical capacity.

5. Anxiety related to the family caregiver’s fear of the surgical outcome.

**Interventions:**
- Explain to the family the condition and the anatomy of the surgical procedure in terms they can understand.
- Encourage them to express their anxieties and ask questions.
- Give accurate, nontechnical answers that are easy to understand.

6. Deficient Knowledge related to the family’s understanding of the child’s condition and home care.

- Demonstrate care of the shunt to the family caregivers and have them perform a return demonstration.
- Provide them with a list of signs and symptoms that should be reported, and discuss appropriate growth and development expectations for the child, and stress realistic goals.

**REFERENCES:**

CASE STUDY ON POST CRICOID WEB

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ABSTRACT: Plummer Vinson syndrome is known as the association of post cricoids dysphasia, upper oesophageal web, and iron deficiency anemia. Although correction of iron deficiency may result in resolution of dysphagia and sometimes disappearance of the web, dilation therapy is usually necessary to remove webs and relieve dysphagia. Plummer Vinson syndrome with recurrent post cricoid web. Patient had undergone balloon dilatation for the web three years back and was symptom free for three years. The patient presented this time with significant dysphagia, sideropenia, angular stomatitis and generalized weakness.

Key Words: Post cricoid web Plummer vision syndroms.

INTRODUCTION: Plummer Vinson syndrome is characterized by dysphagia, iron deficiency anemia and post cricoidal esophageal web. Walden storm introduced the term ‘sideropenic dysphagia’ because of absence of stainable iron in the bone marrow. There is increased predisposition to upper aerodigestive tract malignancies in these patients. In 1937 Ahlbom found out that the risk of carcinoma was not confined to the post cricoids area but also to the buccal mucosa, tongue and all levels of esophagus. Paterson commented on the association with “malignant disease at the mouth of the gullet” in his 1919 report since at that time, the increased incidence of upper aero digestive tract carcinoma in patients with Plummer vinson syndrome has been well established. The reported rates range from 4% to 10% with almost all cases occurring at the post cricoids location. Reported here a case of 9 year old boy with dysphagia, upper esophageal web with subsequent endoscopy showed mid esophageal growth.

CASE REPORT: Master venkata Praveen 9 years boy admitted in pediatric ward on 19.04.18 with complaints of fever since 5 days, cough and dysphagia, upper post esophageal web, anemia.

DIAGNOSIS:
❖ History collection.
❖ Physical examination
❖ CBP with peripheral smear
❖ Total iron profile.
❖ CRP
❖ Endoscopy

MANAGEMENT: Through endoscopy this web was forcibly dilated using Gilliard dilators with 9mm dilator which were passed over the guide wire.
❖ Esophageal dilatation
❖ Endoscopic sphincterotomy.

Esophageal dilatation: Two types of mechanical bougies are used for esophageal dilatation. Both types of dilators are equally effective and safe. Perform an initial endoscopy prior to esophageal dilatation to confirm the diagnosis when using maloney dilators.

Endoscopic sphincterotomy: Endoscopic electro cautery incision using a papillotome catheter was
reported to be successful in alleviating symptoms associated with refractory lower esophageal rings.

- Iron supplementation
- Inj. Fevastin 150mg sos.
- Inj.ceftriaxone 750mg BD

DISCUSSION:

Causes:
- Etiology is unclear.
- Congenital may develop.
- Autoimmunity.
- Genetic predisposition.
- Proposed etiopathogenic mechanisms include and nutritional deficiencies.

Risk factors:
- Whites
- Esophageal webs are associated with bullous diseases
- Epidermolysis bullosa.
- Pemphigus
- Bullous pemphigoid.
- Women are at higher risk.
- Celiac disease.

PATHOPHYSIOLOGY:

- Congenital theory
  - During embryonic development the esophagus fails to recanalize completely.
  - Ciliated pulmonary epithelium and bronchial remnants evolves.
  - Esophageal cricoids web
  - Dysphagia

CLINICAL MANIFESTATIONS:
- Dysphagia, is typically intermittent and limited to solids.
- Odynophagia (painful swallowing also called algia phagia).
- Choking spells and aspiration may occur because of proximal location of the web.
- Weakness, fatigue and dyspnea are secondary to iron deficiency anemia.

- Weight loss is uncommon.
- Angular stomatitis.
- Glossitis.
- Koilonychias.
- Pallor.

Others include:
- Spleenomegaly.
- Enlarged nodular thyroid glands
- Gastritis.

DIAGNOSIS:
- CBC
- Iron studies: increased total iron binding capacities.
- Barium esophagography: conventional barium swallow may defect the web.
- Video fluroscopy.
- Upper GI endoscopy.

MANAGEMENT:
- Treat iron deficiency and its underlying cause
- Treat dysphagia and web:
  - Dysphagia usually require mechanical dilatation. The web can often be disrupted during simple passage of the endoscope in to the esophagus.
  - Diet modification include iron.
- ND: VAG laser therapy.
- Needle knife electro incision has been described as a therapeutic alternative to dilatation.

DIET:
- Advise patients to eat slowly and chew thoroughly. Solid foods should be prepared and cut in small pieces, especially meals.
- Long term monitoring: repeat esophageal dilatations may be require in patients with recurrent dysphagia.

COMPLICATIONS:
- Increased risk for hypo pharyngeal and esophageal cancers.
- Esophageal tears.
- Developing squamous cell carcinoma of the oral cavity, esophagus and hypopharynx.

PREVENTION:
- Good nutrition with adequate intake of iron may
prevent this disorder.
- Good nutrition should also include balanced diet and exercise.

**NUTRITION:**
- Iron supplements.
- Improvement of dysphagia after 2 weeks of oral iron therapy.
- Solid foods should be prepared and cut in small pieces.

**NURSING INTERVENTIONS:**
Impaired swallowing related to destruction of esophagus dysphagia as evidenced by decreased food intake.

**Interventions:**
- Before meal time, provide for adequate rest periods
- Eliminate any environmental stimuli.
- Feed the child at frequent intervals
- Monitor weight daily.

2. Imbalanced nutrition less than body requirement related to inability to swallow as evidenced by weight loss.

**Interventions**
- Document actual weight using weighing scale:
- Obtain nutritional history include family significant others or caregiver in assessment.
- Determine the etiological factors for reduced nutritional intake
- Monitor patient weight daily or weekly.
- Encourage patient intake participation in recording food intake using a daily log.
- Risk for aspiration related to proximal location of the web.
- Keep suction machine available when feeding high risk patients.
- If aspiration does occur, suction immediately.
- Inform health care provider instantly of noted decrease in cough/ gag reflexes or difficulty in swallowing.
- Keep head of bed elevated when feeding for at least a half hour afterward.
- Allow the patient to chew thoroughly and eat slowly during meals.
- Offer liquids for after food is eaten.

3. Delayed growth and development related to poor nutrition intake as evidenced by monitoring weight of the child.

**Interventions:**
- Assess the factors causing development disorders of children.
- Identification and use of educational resources to facilitate optimal child development.
- Monitor the child's pattern of growth (height, weight, head circumference and refer to a dietitian to obtain nutritional intervention.

4. Risk for aspiration related to presence of web.

**Intervention:**
- Assess the risk of aspiration.
- Provide Swd in small and frequent.
- Provide head in small pieces.
- Advise the child to swallow the swd thonrghly before swallowing.
- Elevate the head and while swallowing (upright position)
- Do not hurry while taking food.

**References:**
2. Christopher A. ET AL Webs and Rings in Modern Surgical Pathology (Second Edition), 2009
A study to assess the knowledge of postnatal mothers on newborn care in SRM General hospital at Kattangulathur

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Narayana College of Nursing,
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Abstract: “The end of pregnancy journey comes after 40 weeks and the birth of the baby is one of the life’s most wondrous moments”. Newborn babies have amazing abilities yet, they are tiny, powerless and completely dependent on others for every aspects like feeding, comfort and warmth. Aim of this study was to assess the knowledge of postnatal mothers on newborn care. Objectives of this study was to assess the knowledge of postnatal mothers on newborn care and to associate the knowledge of postnatal mothers in newborn care with selected demographic variables quantitative research approach was adopted and descriptive research design used to assess the knowledge of postnatal mothers on newborn care. 30 samples were selected by simple random sampling technique. Questionnaire was prepared to assess the knowledge of post natal mothers on newborn care. The results of the study shows that 36.6% of women had inadequate knowledge, 30% had moderate knowledge and 33.3% had adequate knowledge on newborn care. Conclusion: The study concluded that majority of mothers had inadequate knowledge on newborn care. Therefore, the investigator felt that more importance should be given to improve the knowledge of postnatal mothers on newborn care. So the investigator education regarding newborn care to the post natal mothers. Key word: postnatal mothers, newborn care, knowledge.

INTRODUCTION: Newborn care are the activities and precautions recommended for new parents or caregivers. It is also an educational goal of many hospital and birthing centers when it’s time to bring their infant home.

Taking a newborn care class during pregnancy can prepare caregivers for the real thing. But feeding and diapering a baby doll isn’t quite the same. During the stay in a hospital or birthing center, clinicians and nurses help with basic baby care. These health providers will demonstrate basic infant care. Newborn care basics like handling a newborn, including supporting the baby’s neck, bathing, dressing, swaddling, feeding and burping and, cleaning the umbilical cord.

BACKGROUND OF THE STUDY: Immediate newborn period is very crucial as the baby is biologically and physiologically immature and undergoes a lot of change by every minute of its life.

Rampji (2005) reported that the incidence of nosocomial sepsis in neonates increased from 1.5 to 37% in India.

STATEMENT OF THE PROBLEM.

A study to assess the knowledge of postnatal mothers on newborn care in SRM General Hospital at Kattangulathur.

THE OBJECTIVES OF THE STUDY:
1. To assess the knowledge of postnatal mothers on newborn care.
To associate the knowledge of postnatal mothers on newborn care with their selected demographic variables.

OPERATIONAL DEFINITIONS

Knowledge
Refers to awareness and understanding of information regarding newborn care.

Postnatal mothers
Postnatal mothers who are in the period of six hours after delivery to six weeks.

Newborn care
Newborn care is essential care which includes warmth, breast feeding, immunization, cord care, eye care, skin care prevents the infection and able to adjust with environment.

ASSUMPTIONS
A post natal mothers may have some knowledge on newborn care and it will affect the health of the child.

DELIMITATION
1. Mothers who are in the period of six hours to six weeks after delivery.
2. Its delimited to only assessment of knowledge on newborn care.
3. Data collection had done 6 hrs after delivery.

METHODOLOGY

RESEARCH DESIGN: Descriptive research design was adopted for this study.
1. SAMPLE: Mothers who are in the period of six hours to six weeks after delivery.
SAMPLE SIZE: Sample size was 30 postnatal mothers.

SAMPLING TECHNIQUE: Simple random sampling technique was adopted for selecting the sample.

CRITERIA FOR SAMPLE SELECTION:
Inclusion criteria:
1. Postnatal mothers who were in the period of 6 hours after delivery to six weeks.
2. Mothers who could read Tamil and English.
Exclusion criteria:
1. Postnatal mothers who are in late postpartum period.

DEVELOPMENT OF TOOL
Questionnaire was prepared to assess the knowledge of post natal mothers on newborn care.

DATA COLLECTION PROCEDURE
The study was conducted for a period of 6 weeks. During this period 30 postnatal mothers who met the inclusion criteria were selected by using simple random sampling technique. The samples were seated comfortably and a brief introduction about the investigator and study were given. Consent was taken from the sample. Confidentiality of the responses was assured. The data was collected by interview method. The question was posed to the mothers and options were red one by one. Tick mark was placed over the answer as soon as the mother responded. If the mother did not understand either the question or response, both were repeated to them. After completing the session At the end, the investigator thanked the women who participated in the study, nursing personnel and chief gynecologist for extending their maximum cooperation throughout the study.

PLAN FOR DATA ANALYSIS

Descriptive Statistics
Demographic variables of the samples were analyzed by using Frequency and Percentage distribution.
Inferential Statistics
Association of variables were analyzed by Chi-square test.

RESULTS
Demographic variables of postnatal mothers reveals that, 7(23.3%) were less than 20 yrs and 18(60%) were 20-30 yrs, 16 (53.3%) mothers were primipara and 14(46.6%) mothers were multipara, 2(6.6%) mothers were uneducated, 23 mothers were studied till higher secondary, 5(16.6%) mothers were graduated, 13(42%) mothers from low socioeconomic status and 17(56.6%) mothers from nuclear family.

Distribution of postnatal mother’s knowledge on newborn care

<table>
<thead>
<tr>
<th>Knowledge Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
<td>11</td>
<td>36.7</td>
</tr>
<tr>
<td>Moderately Adequate</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Adequate</td>
<td>10</td>
<td>33.3</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

The above table describes that 11 (36.6%) of women had inadequate knowledge, 9 (30%) had moderately adequate knowledge and 10 (33.3%) had adequate knowledge on newborn care.

There was significant association between knowledge on newborn care such as educational status, and no significant association between knowledge on newborn care such as age and pariety of mother.

NURSING IMPLICATIONS

NURSING PRACTICE
Nurses are working in hospital and community play vital role in newborn care and prevention of infections.

NURSING EDUCATION
Newborn care should be given special focus in nursing education including latest modalities in prevention of infection.

NURSING ADMINISTRATION
The nursing administrator has the responsibility to increase the knowledge of nurses in early identification and management of newborn care in all aspects.

NURSING RESEARCH
The essence of research is to build up a body of knowledge in nursing as an evolving profession.

CONCLUSION:
The study concluded that majority of mothers had inadequate knowledge on newborn care. Therefore, the investigator felt that more importance should be given to improve the knowledge of postnatal mothers on newborn care. So the investigator education regarding newborn care to the post natal mothers

REFERENCE’S:
1. Augural “Acute newborn care” the nurse practitioner sep 2000 volume 20, page No; 20-29
KNOWLEDGE ON MANAGEMENT OF RESPIRATORY TRACT INFECTION AMONG MOTHERS OF UNDER FIVE CHILDREN

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Abstract: Introduction: Respiratory tract infection is a major cause of morbidity and mortality in developing and also developed countries. Almost 150 million new episodes of respiratory tract infection identified per year worldwide more than 90% of which occur in developing countries. Nearly 30% of total annual deaths occur in children younger than 5 years old. Objectives: To assess the knowledge regarding management of respiratory tract infections among mothers of under five children. And to find out association between the knowledge regarding management of respiratory infection among mothers of under five children and the selected Socio demographic variables. Methodology: Non experimental, cross sectional descriptive research design was adopted, sixty mothers of under five children were selected through non-probability convenience sampling technique. Structured questionnaire methods was adopted to collect the data. Collected data was analyzed based on descriptive and inferential statistics. Result: among 60 samples 12 (20%) mothers have inadequate knowledge, 44 (73.33%) mothers have moderately adequate knowledge and 4 (6.67%) mothers have inadequate knowledge regarding management of respiratory tract infection. The mean is 25.7 with standard deviation of 4.57. Conclusion: The findings of the study reveal that Majority of mothers have Moderately Adequate Knowledge. Educational programme to be organized or prevention of respiratory tract infection to improve the knowledge of mothers of under five children to reduce the prevalence of respiratory tract infection. Key words: Management, knowledge, respiratory tract infection mothers under five children

Introduction: Respiratory tract infection refers any number of infectious diseases involving the respiratory tract. A infection of this type is normally classified into upper respiratory tract infection and lower respiratory tract infection. Although some disagreement exist on the exact boundary between the upper respiratory tract and lower respiratory tract. The upper respiratory tract is generally considered to be the airway about the glottis or vocal cord. World health organization (WHO) recognized respiratory diseases as the second important cause of death of children under five years in 2013 Pneumonia was diagnosed approximately 156 million children in 2013 (151 million in developing countries and 5 million in developed countries) and led to 1.4 million deaths (28-34% of all deaths in those younger than 5 years of age). More than 20 million patients with severe disease, out of 156 million new cases of pneumonia need hospital admission yearly. WHO report shows that, in developing countries demonstrate acute respiratory infection incidence rate of 15-21% in children younger than 5 years old. In developing countries, respiratory tract infection accounts for more than 2 million deaths yearly. WHO estimated that Acute respiratory infections causes 4 million of child deaths per year in India, in that 2.6 million are infants
0-1years) and 1.4 million are of 1-4 years. In 2012 WHO report shows that respiratory tract infection caused 30% of all childhood death. WHO result shows that occurrence of respiratory infection was found to be 22%, it was lower in urban area (17.2%) as compare to rural area (26.8%). In India acute respiratory infection (ARI) constitute a major public health problem and is the most important contributor to mortality and morbidity in under five, accounting for (15-34%) of all childhood deaths. India accounted for 28% of the mortality and 30% of Disability adjusted life years (DALYs) lost due to ARIs stated in the world health organization on world health report, 2013.

Problem Statement
“A Study to Assess the Knowledge Regarding Management of Respiratory Tract Infection among Mothers of Under Five Children in Kakatur Village at Nellore District”.

Objectives
❖ To assess the knowledge regarding management of respiratory tract infections among mothers of underfive children.
❖ To find out association between the knowledge regarding management of respiratory tract infection among mothers of underfive children and the selected Socio demographic variables.

Assumption
Mothers of under five children have some knowledge regarding management of respiratory tract infection.

Delimitations
The study is delimited to,
❖ The mother’s residing in Kakatur Village at Nellore only.
❖ Sample size of 100 mothers of under five children only.
❖ 2 weeks of data collection period only.

Projected Outcome
The study helps to determine the level of knowledge of mothers regarding management of respiratory tract infection.

METHODOLOGY:
Research Approach: A quantitative approach.

Research Design: The Non-experimental Cross sectional descriptive design.

Setting of Study: Kakatur village at Nellore District

Target Population: The target population for the present study were the mothers of under five children.

Accessible Population: The population for the present study were the mothers of under five children in Kakatur at Nellore District.

Sample: The samples for the present study include all the mothers who had at least one under five children and who met the inclusion criteria.

Sampling Technique: Non-probability convenience sampling technique.

Sample Size
The sample size for the present study was 60 mothers of under five children.

Criteria for Sample Selection
Inclusion criteria-
The inclusion criteria for the present study are the following
❖ The mothers of children with age group of 0-5 years at Kakatur village.
❖ The mothers of under five children, who can read and speak Telugue or English.

Exclusion Criteria-
❖ Mother of under five children, who are not willing to participate in the study.
❖ The mothers of under five children who are not available at the time of data collection.
❖ The mothers of under five children, who do not know Telugue or English.

Variables of the Study
Variables of the study are research variables and Demographic variables.
❖ Research Variables- The knowledge of mothers regarding management of respiratory tract infection.
❖ Demographic Variables- The demographic variables such as age, educational status of mother, occupation of mother, family income per month, religion, source of knowledge regarding respiratory tract infection, place of awareness classes attended regarding prevention of respiratory tract infection.
Description of the Tool
The tool was developed with the help of extensive review from various text books, journals and the net sources; the tool was developed to assess knowledge regarding management of respiratory tract infection among under five children in Kakatur village at Nellore. The tool was consists of two parts.

Part I: Deals with Demographic variables.
It consists of 7 items seeking demographic variables such as age, educational status of mother, occupation of mother, family income per month, religion, source of knowledge regarding respiratory tract infection, attended any awareness classes regarding prevention of respiratory tract infection.

Part II: Deals with Structured Questionnaire.
Structured questions consist of 40 questions. Each correct answers, scored as ‘1’ and wrong answers scored as ‘0’, total score was 40. It was to assess the knowledge of mothers regarding management of respiratory tract infection.

Pilot study
After obtaining formal permission from the concerned authority of the primary health center, the Pilot study was conducted for 3 days in Kakatur village at Nellore District. Samples were selected by using convenience sampling technique. The confidentiality of shared information was assured and consent was obtained from subjects. The investigator selected 6 mothers of under five children. Structured Questionnaire was administrated to the subjects. It took nearly 30 minutes to complete the Questionnaire for each mother. They were able to understand the questionnaire. The data was analyzed by using the descriptive and inferential statistics. Based on the Pilot study result revealed that it was found feasible to conduct the main study.

Data Collection Procedure
The data collection procedure was done for a period of 2 weeks after obtaining formal permission from the Medical officer of Primary health center. Data collection was started. 60 samples were selected by Non- probability convenience sampling technique. Mothers of under five children who fulfilled the inclusion criteria were included for this study after obtaining informed consent from them and the confidentiality of shared information was assured. For the present study structured questionnaire based interview method was adopted to collect the data, it took 30 minutes to complete the questionnaires for each mother. Data were organized and presented in the tables and figures.

Plan for Data Analysis
Analysis of data was done by using the data by using descriptive and inferential statistics.

<table>
<thead>
<tr>
<th>Data Analysis</th>
<th>Method</th>
<th>Remarks</th>
</tr>
</thead>
</table>
| Descriptive statistics | Frequency, Percentage, Mean and standard deviation | - Distribution of demographic variables  
- To determine level of knowledge regarding management of respiratory tract infection among mothers of under five children |
| Inferential statistics | Chi-square test | - To find out the association between the levels of knowledge regarding management of respiratory tract infection among mothers of under five children with demographic variables |

Results:
- In relation to age, 30(50%) are between 24 - 29yrs.
- Pertaining to education, 34(56%) are completed primary school.
- Related to occupation of mothers, 47(78.3%) are house wives.
- About family income, 25(41.7%) are earning family income Rs. 5001- 7000 per month.
- Relates to religion, 48(80%) are Hindus.
- On sources of information, 40(66.6%) got information from Grandparents and parents.

Level of knowledge on management of respiratory tract infection among mothers of under five children

Table No 1: Frequency and percentage distribution of the level of knowledge regarding management of respiratory tract infection among mothers of under five children in Kakatur village
Table No 1- shows that, among 60 samples 12 (20%) mothers have inadequate knowledge, 44 (73.33%) mothers have moderately adequate knowledge and 4 (6.67%) mothers have inadequate knowledge regarding management of respiratory tract infection.

Table No 2 - Mean and standard deviation of levels of knowledge regarding management of respiratory tract infection among mothers of under five children.

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Moderately adequate</td>
<td>44</td>
<td>73.3</td>
</tr>
<tr>
<td>Adequate</td>
<td>4</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

Table No 2 shows that mean and standard deviation level of knowledge regarding management of respiratory tract infection among mothers of under five children in Kakatur village, the mean is 25.7 with standard deviation is 4.57.

Linus A. S (2010) conducted a study on evaluation of acute respiratory tract infections controlled program in Gujarat slum with objective of effective early domiciliary management and health seeking behavior in care of appearance of danger sign in acute respiratory infection. 300 mothers of young children selected for this study in Gujarat slum. Structured interview schedule was used for data collection. The result showed that one or more danger sign were known to 80% of mothers. Only 16% of mothers aware that acute respiratory infections are mostly mild or self limiting.

Association between the level knowledge of mothers regarding management of respiratory tract infections and the selected socio demographic variables.

Age and Family income per month has significant association with level of knowledge regarding management of respiratory tract infection among mothers of under five children.

Education status of mother, Occupation of mother, Religion, Source of knowledge regarding respiratory tract infection and Attended any awareness classes regarding prevention of respiratory tract infection have no significant association.

Dale Berg (2006) conducted a study to correlate acute respiratory infection among under five children in selected area of Karana district. 212 mothers and infants above three months were selected for this study. Structured interview schedule was used for data collection. Majority of children 70.7% had acute respiratory infection 5- 7 times in past three months. During one month observation maximum number of children (58.8%) had at least suffered from acute respiratory infection once.
NURSING IMPLICATIONS: The most effective way to improve the knowledge of mothers regarding respiratory tract infection by continues education and awareness program.

- Educate the parents about respiratory tract infection and prevention.
- Encourage the parents trying to change the unhealthy life style.
- Educate the parents about deep breathing exercise, steam inhalation and treatment of respiratory tract infection.

Nursing Services
The best method of preventing the care of acute respiratory infections among the children is to promote breast feeding, avoiding contacts with infected persons, proper hand washing technique, health check up and health education.

Nursing Administration
- The number of health care organization that provides family education is to prevent acute respiratory tract infection.
- The local health department that have established competent heath promotions and acute respiratory infection and prevention programs.
- The in service training to all health personal is to be assured.

Nursing Education
Awareness programmes discussion, Health camps, Seminars and role plays can be conducted for improving the knowledge attitude, management and practice regarding respiratory tract infection among mothers of under five children.

NURSING RESEARCH
Researcher should aims on the knowledge regarding management of respiratory tract infection among mothers of under five children and more studies can be done to improve attitude, practice and knowledge regarding management of respiratory tract infection among mothers of under five children.

Nursing practice
- Nurse has been responsibility to educate the prevention of respiratory tract infection.
- Nurse should be providing adequate nursing care to such respiratory tract infection affected children.

RECOMMENDATIONS FOR FURTHER RESEARCH
- The similar study can be conducted to a large number of samples in different settings.
- The study can be conducted in the sample having respiratory tract infections multiple setting as hospital, rural community and urban community.
- A comparative study can be done knowledge of respiratory tract infection among mothers of under five children in the rural and urban community area.
- Education programme can be designed to create awareness among under five children.

Conclusion:
The findings of the study reveal that Majority of mothers have Moderately Adequate Knowledge. Educational programme to be organized on prevention of respiratory tract infection to improve the knowledge of mothers of under five children to reduce the prevalence of respiratory tract infection.

References:
A study to assess the knowledge regarding infected wound dressing among staff nurses and student nurses in NMCH, Nellore.

Anjumol V.T.
Staff Nurse

Abstract: A wound is a serious consequence and a common cause of delayed wound healing. An infected wound is one in which pathogens have invaded and overcome the body’s first line of defense, producing clinical sign of infection. It is also called as septic wound. The aim of the present descriptive study to assess the level of knowledge regarding infected wound dressing among staff nurses and student nurses in NMCH, Nellore. The study was conducted by descriptive design, the total number of 15 staff nurses and 15 student nurses were selected through purposive sampling technique. The study was conducted for a period of two weeks from 1-5-15 to 15-5-15 after obtaining the formal permission from the nursing dean and ethical committee data collection was collected. The students who fulfill the inclusion criteria were included for study after obtaining consent from them, confidentially of the shared information was assured. The data was collected by using semi structured questionnaire to assess the level of knowledge regarding infected wound dressing. Finally the data was analyzed by using descriptive statistics and inferential statistics. Knowledge regarding infected wound dressing among staff nurses, with regard to level of knowledge 1 (6.7%) staff had inadequate knowledge, 10 (66.6%) staff had moderately adequate knowledge and 4 (26.7%) staff had adequate knowledge. Knowledge regarding infected wound dressing among student nurses, with regard to level of knowledge 1 (6.7%) students had inadequate knowledge, 6 (40%) students had moderate knowledge and 8 (53.3%) had adequate knowledge. The study concluded that majority of staff and student nurses have inadequate knowledge regarding infected wound dressing. Conclusion: The study concluded that majority of staff and student nurses have inadequate knowledge regarding infected wound dressing.

Key words: Knowledge, infected wound, dressing, staff nurse, nursing students

INTRODUCTION

“The effect of knowledge is having it up to apply it, not having it, unto-confess your ignorance ...”

A wound is a serious consequence and a common cause of delayed wound healing. An infected wound is one in which pathogens have invaded and overcome the body’s first line of defense, producing clinical sign of infection. It is also called as septic wound.

Infection is often due to lack of blood supply, lack of oxygen, auto contamination or exposure to environmental pathogens. Clinical manifestations of wound infection include increased bloody discharge, erythema around the entire wound, increasing pain, fever, leukocytosis and general malaise. The infected wound is slow to heal and may open cultures can be used in the diagnosis of wound infection.

A dressing is a protective covering applied to a wound. The goal of the wound care is to promote tissue repair and regeneration, so that skin integrity is restored.

Application of wound dressing allows control of the affected skin environment and remains important in the treatment of wound, ulcer and recalcitrant dermatitis. Historically in the primary role
of wound dressing has been protection. Today’s the role of dressing is to create an environment that promote skin healing. Dressing limits the exposure of infected skin to dirt, mechanical trauma and irritants.

Wound irrigation may be ordered for an open infected wound. The physician orders the appropriate irrigating solution. Fluids that are often including sterile normal saline, hydrogen peroxide diluted with sterile water, acetic acid. The wound packed with dressing moistened with one of these solutions.

Wet dressings are often used for the infected wound to soften the discharges and to promote drainage. A wet dressing is also used to supply heat to the tissues. Moist heat is more penetrating than dry heat. Therefore, moist heat is more beneficial to localizing the infection into an area.

Septic wound may be surgical or otherwise should be dressed with special care and in proper aseptic way. A surgical septic wound should be dressed atleast in ward after doing other dresses

AIM: A study to assess the knowledge regarding infected wound dressing among staff nurses and student nurses in NMCH, Nellore.

OBJECTIVES
❖ To assess the level of knowledge regarding infected wound dressing among staff nurses.
❖ To assess the level of knowledge regarding infected wound dressing among student nurses.
❖ To compare the level of knowledge between staff nurses and student nurses regarding infected wound dressing.
❖ To find out the association between level of knowledge regarding infected wound dressing among staff nurses with their selected socio demographic variable
❖ To find out the association between level of knowledge regarding infected wound dressing among student nurses with their selected socio demographic variable.

METHODOLOGY:
RESEARCH APPROACH: The quantitative approach was adopted for this present study.
RESEARCH DESIGN: The descriptive research design was used for this present study.

SETTINGS: The study was conducted in Narayana Medical College Hospital, which is 8 kilometers from Nellore, located in urban area, Chinthareddy palem. There is 1750 bedded hospital with all specialties with skilled staff and specialized equipments. The selection of the setting is done on the basis of geographical proximity, feasibility of study and availability of sample.

TARGET POPULATION: The target population for the present study includes staff nurses and nursing students.

ACCESSIBLE POPULATION: The staff nurses and nursing students who are posted in NMCH.

SAMPLE: Sample consist of staff nurses and student nurses in Narayana Medical College Hospital, Nellore.

SAMPLE SIZE: The sample size consist of 30,15 staff nurses and 15 student nurses in Narayana Medical College Hospital, Nellore.

SAMPLING TECHNIQUE: Non-probability purposive sampling technique is adopted for this study.

CRITERIA: For sample selection

INCLUSION CRITERIA:
❖ Staff nurses and student nurses who are working in NMCH, Nellore.
❖ Staff nurses who are willing to participate in the study.
❖ Students who are willing to participate in the study.

EXCLUSION CRITERIA:
❖ Staff and student nurses who was sick at the time of data collection.
❖ Staff and student nurses who was not available at the time of data collection.

DESCRIPTION OF THE TOOL: The tool was developed with the help of related literature from various text books, journals, websites, and guidance from experts in the field of nursing. The tool was divided into 2 parts:

PART-I: Socio demographic variables of staff nurses and student nurses.

Section: 1 - Demographic variable of staff nurses includes Age, Sex, Educational status, Year of experience in postoperative ward, Source of
information, attended any CNE or workshop on wound care.

Section: II - Socio demographic variable of the student nurses such as Age, Sex, Qualification, and Training experience in postoperative ward, source of information.

PART-II: This consists of structured questionnaire to determine the knowledge regarding infected wound dressing.

SCORING KEY AND INTERPRETATION:
The questionnaires consist of 30 questions. Each correct answer was rewarded by 1 mark and wrong answer was rewarded as 0 mark based on the score the knowledge level was assessed.

INTERPRETATION OF KNOWLEDGE

<table>
<thead>
<tr>
<th>Level of Knowledge</th>
<th>score</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
<td>&lt;15</td>
<td>&lt;50%</td>
</tr>
<tr>
<td>Moderately Adequate</td>
<td>15 -21</td>
<td>51 - 70%</td>
</tr>
<tr>
<td>Adequate</td>
<td>&gt;21</td>
<td>&gt;71%</td>
</tr>
</tbody>
</table>

CONTENT VALIDITY:
The content validity of the tool was obtained from experts in nursing department.

RELIABILITY: Reliability of the study done with the help of split half method, and Karl Pearsons correlation Co-efficient r= 1.

PILOT STUDY: After getting consent form the ethical committee of Narayana Medical College Hospital, Principal of Narayana Nursing Institution and formal permission from the concerned authority the pilot study was conducted among 3 staff nurses and 3 student nurses who fulfill the inclusion criteria. The written consent was taken. Data was collected by administering structured questionnaire to assess the knowledge regarding preoperative care of adult.

DATA COLLECTION PROCEDURE: After obtaining formal permission from ethical committee of NMCH, medical superintendent and nursing dean the study was conducted. The 15 Staff nurses and 15 nursing students who fulfill the inclusion criteria are selected by using purposive sampling technique after obtaining. Consent from the staff nurses and nursing students the data was collected by using self administered questionnaire. Procedure proceed for 2 weeks as per place nearly 30 mts was spent for collecting data about each sample from the students and staff nurses. 5 samples were completed per day. Confidentially of the data was maintained.

DATA ANALYSIS AND INTERPRETATION

MAJOR FINDING OF THE STUDY
- With regard to age, 9(60%) of nursing staff are between the age group of 22-23 years and 15(100%) of student nurses are between the age group of 20-22 years.
- In relation to educational qualification, 12(80%) of staff nurses are B.Sc(N) and 15(100%) all student nurses are B.Sc(N).
- Pertaking to source of information, 13(86.6%) of staff nurses got knowledge from all the above sources and 9(60%) of students got knowledge through all the above sources.
- With regard to CNE programme, 9(60%) of staffs are attended and 13(86.7%) of student nurses are attended CNE programme.
- Related to gender, 14(93.3%) of staff nurses are female category.
- In relation to year of experience 11(73.3%) of staff are <1 year of experience.
- With regard to year of studying, 10(66.7%) of students studying in 3rd year.

SECTION -II

Table No: Level of knowledge regarding infected wound dressing among staff nurses and student nurses.

<table>
<thead>
<tr>
<th>Level of knowledge</th>
<th>Staff Nurses(n=15)</th>
<th>Student Nurses(n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fre</td>
<td>Per</td>
</tr>
<tr>
<td>Inadequate</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Moderately Adequate</td>
<td>10</td>
<td>66.6</td>
</tr>
<tr>
<td>Adequate</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100</td>
</tr>
</tbody>
</table>

Table no-1: shows with regard to comparison of level of knowledge on infected wound dressing among 15 staff nurses and 15 student nurses in that 1 (6.7) staff nurses and 1(6.7%) student nurses are having inadequate level of knowledge, 10(66.6%) staff nurses and 6(40%) student nurses are having moderate level of....
knowledge. 4(26.7%) staff nurses and 8(53.3%) student nurses are having adequate level of knowledge.

SECTION - III

TABLE-12: COMPARISON OF MEAN AND STANDARD DEVIATION OF KNOWLEDGE SCORE BETWEEN STAFF NURSES AND STUDENT NURSES. (n=30)

<table>
<thead>
<tr>
<th>Sample categories</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Nurses</td>
<td>19.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Student Nurses</td>
<td>20.06</td>
<td>2.46</td>
</tr>
</tbody>
</table>

Table no: 12 shows that the staff nurses mean value is 19.9 and standard deviation of 3.4 and the student nurses mean value is 20.06 and standard deviation of 2.46.

SECTION-IV

Table-13: Association between and level of knowledge regarding infected wound dressing among staff nurses with their selected socio demographic variables (n=15)

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Chi-square</th>
<th>Degree of freedom</th>
<th>Table value (9=0.05)</th>
<th>Level of significance (0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.63</td>
<td>4</td>
<td>9.49</td>
<td>Non Sign.</td>
</tr>
<tr>
<td>Gender</td>
<td>0.14</td>
<td>2</td>
<td>5.99</td>
<td>Non Sign.</td>
</tr>
<tr>
<td>Education</td>
<td>0.18</td>
<td>2</td>
<td>5.99</td>
<td>Non Sign.</td>
</tr>
<tr>
<td>Experience</td>
<td>0.15</td>
<td>2</td>
<td>5.99</td>
<td>Non Sign.</td>
</tr>
<tr>
<td>Source of information</td>
<td>0.08</td>
<td>4</td>
<td>9.49</td>
<td>Non Sign.</td>
</tr>
<tr>
<td>Attending any CNE Programme</td>
<td>0.04</td>
<td>2</td>
<td>5.99</td>
<td>Non Sign.</td>
</tr>
</tbody>
</table>

Table - 13: Association between the level of knowledge regarding infected wound dressing among student Nurses with their selected socio demographic variables (n=15)

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Chi-square</th>
<th>Degree of freedom</th>
<th>Table value (9=0.05)</th>
<th>Level of significance (0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of studying</td>
<td>0.38</td>
<td>2</td>
<td>5.99</td>
<td>Non Sign.</td>
</tr>
<tr>
<td>Source of information</td>
<td>1.07</td>
<td>4</td>
<td>9.59</td>
<td>Non Sign.</td>
</tr>
<tr>
<td>Attending any CNE Programme</td>
<td>0.16</td>
<td>2</td>
<td>5.99</td>
<td>Non Sign.</td>
</tr>
</tbody>
</table>

DISCUSSION

Knowledge regarding infected wound dressing among staff nurses, related to level of knowledge 1(6.7%) staff had inadequate knowledge, 10(66.6%) staff had adequate knowledge and 4(26.7%) staff had inadequate knowledge.

Knowledge regarding infected wound dressing among student nurses, with regard to level of knowledge 1( 6.7%) students had inadequate knowledge, 6(40%) students had moderate knowledge and 8( 53.3%) had adequate knowledge.

Comparison of level of knowledge regarding infected wound dressing between staff nurses and student nurses. In staff nurses the mean score is 19.9 and standard deviation is 3.4. Where as in student nurses mean score is 20.06 and standard deviation is 2.46. The calculated value is lesser than tabulated value.

Association between knowledge of staff nurses regarding infected wound dressing with their selected demographical variables, such as age, gender, total professional experience, source of information, CNE attended are non- significant there is no statistical value.

Hallet C.E. (2001) in his study on 136 nurses regarding nursing practices on wound dressing procedure., UK, revealed knowledge of nurses after education programmes, has improved from 42.2% to 77.7% well designed clinical teaching have demonstrated that aseptic techniques reduces the incidence of infection in high risk surgical patients by two thirds with a corresponding reduction in mortality from wound infection. The wound care resolution has occurred due in part Dr. winter Discovers in the 1960s.

Hinman and maibach paralleled these findings of faster resurfacing in partial thickness wounds in Human. Aseptic technique is one infection control method used to prevent contamination by bacteria from all sources, during dressing, operation and throughout the healing process. Bacteria can never be absolutely eliminated from the operating field, but practicable aseptic measures can reduce the risk of contamination to an acceptable level. It includes
appropriate use of skin disinfectants, personal hygiene practices, hand washing before and after patient contacts.

Anjani Devi N and Athira Saju (2017) study concluded that compare the level of knowledge between the staff nurses and nursing students regarding the post-operative care in adult. Staff nurses had moderately adequate knowledge than the nursing students regarding postoperative care in adult.

**NURSING IMPLICATION**

The scientific knowledge and skills regarding infected wound dressing help to improve the management of infected wound. The use of questionnaire was accepted as one of the best way to know regarding infected wound dressing.

**NURSING PRATICE**

- The study helps the staff and student nurses to determine the level of knowledge regarding infected wound dressing. Present study motivates to improve their level of knowledge.
- By following these findings the quality of nursing practice can be enhanced and there by the profession itself.
- The study helps to nurses the enable to assess the level of knowledge regarding infected wound dressing by providing them with scientific accurate information.

**NURSING EDUCATION**

- Staff nurses and student nurses have to update their knowledge regarding infected wound dressing, which are practical by different countries.
- Nursing curriculum can provide opportunities to the student nurses by planning to conduct health education programme for various age groups regarding various infected wound dressing in hospital settings and other health care agencies.
- The faculty has motivates the students regarding infected wound dressing through seminar, conference, and group discussion.

**NURSING ADMINISTRATION**

- The administrators should plan continuing the nursing educational programme to staff nurses and student nurses should include such topic to enhance the knowledge of nurses.
- Nurse administrator should provide adequate training to nursing students regarding infected wound dressing.

**NURSING RESEARCH**

- More research studies stimulate recommended, reorganizes and supports the physical and mental and its transition into clinical practice.
- To assess the level of knowledge regarding infected wound dressing and therefore more research studies can be conducted in their area.
- The study be valuable reference and pathway for future researcher.

**NURSING RECOMMENDATIONS FOR FUTURE RESEARCH**

On the basis of the findings of the study the following recommendations have been made,

- A similar study can be replicated on large sample size, in different settings, with in different population as longitudinal study.
- A similar study can be conducted as comparative study between staff and student nurses.

**CONCLUSION**

The study concluded that majority of staff and student nurses have inadequate knowledge regarding infected wound dressing.

**BIBLIOGRAPHY**

F-Test: An “F Test” is a catch-all term for any test that uses the F-distribution. In most cases, when people talk about the F-Test, what they are actually talking about is The F-Test to Compare Two Variances. However, the f-statistic is used in a variety of tests including regression analysis, the Chow test and the Scheffe Test (a post-hoc ANOVA test).

**General Steps for an F Test**
1. State the null hypothesis and the alternate hypothesis.
2. Calculate the F value. The F Value is calculated using the formula $F = (SSE_1 - SSE_2 / m) / SSE_2 / n-k$, where $SSE = \text{residual sum of squares}$, $m = \text{number of restrictions}$ and $k = \text{number of independent variables}$.
3. Find the F Statistic (the critical value for this test).
4. Support or Reject the Null Hypothesis.

**F Test to Compare Two Variances**
A Statistical F Test uses an F Statistic to compare two variances, $s_1$ and $s_2$, by dividing them. The result is always a positive number (because variances are always positive). The equation for comparing two variances with the f-test is:

$F = s_2^2 / s_1^2$

If the variances are equal, the ratio of the variances will equal 1. For example, if two data sets with a sample 1 (variance of 10) and a sample 2 (variance of 10), the ratio would be $10/10 = 1$.

**F Test to compare two variances by hand: Steps**
1. Find standard deviations step 2 find variances to compar.
2. Square both standard deviations to get the variances. For example, if $\sigma_1 = 9.6$ and $\sigma_2 = 10.9$, then the variances ($s_1$ and $s_2$) would be $9.6^2 = 92.16$ and $10.9^2 = 118.81$.
3. Take the largest variance, and divide it by the smallest variance to get the f-value. For example, in two variances were $s_1 = 2.5$ and $s_2 = 9.4$, divide $9.4 / 2.5 = 3.76$.

**Why?** Placing the largest variance on top will force the F-test into a right tailed test, which is much easier to calculate than a left-tailed test.

**Step 4:** Find degrees of freedom. Degrees of freedom is sample size minus 1. As two samples (variance 1 and variance 2), there is two degrees of freedom: one for the numerator and one for the denominator.

**Step 5:** Look at the f-value calculated in Step 3 in the f-table. Note that there are several tables, so it need to locate the right table for the alpha level.

**Step 6:** Compare the calculated value (Step 3) with the table f-value in Step 5. If the f-table value is smaller than the calculated value, than can reject the null hypothesis.

The difference between running a one or two tailed F test is that the alpha level needs to be halved for two tailed F tests. For example, instead of working at $\alpha = 0.05$, use $\alpha = 0.025$; Instead of working at $\alpha = 0.01$, use $\alpha = 0.005$.

With a two tailed F test, it just wants to know if the variances are not equal to each other. In notation: $H_a = \sigma_1^2, \sigma_2^2$
01. Which nursing approach would be best for a client with symptoms of severe depression?........
Ans: d. Give the client a choice of recreational activities.

02. A patient who is overweight is referred by the physician to the nurse for diet counseling. What action would the nurse take?....
Ans: d. Put the patient on a diet with very limited number of calories so he or she will have an immediate weight loss.

03. The nurse is aware that the main function confabulation serves in clients, especially those with dementia, is to:
Ans: b. Protect their self-esteem

04. A nursing care plan for a hospitalized hyperactive client in a manic episode must include:....
Ans: c. Protection against suicide.

05. In paranoid disorder, the part of the personality that is weak is called ther:....
Ans: a. Id

06. A key consideration in planning the general care of clients with dementia is that:
Ans: c. Team effort be aimed at increasing their independence

07. One therapeutic nursing attitude is to be accepting and permissive. To convey this attitude most therapeutically, the nurse might:
Ans: d. Meet the client at his or her level of functioning.

08. Which nursing intervention is inappropriate with a person who is expressing anger?
Ans: b. Assisting the person to describe the feelings.

09. A client states, “The nofas are coming.” In response to this neologism, it would be best for the nurse to:
Ans: d. Try to interpret what the client means.

10. Which nursing approach is important in depression?
Ans: d. Deemphasizing preoccupation with elimination, nourishment, and sleep.

11. Which characteristic should the nurse recognize as common in a person engaged in gradual self-destructive behavior (such as in obesity, drug addiction, and smoking)?
Ans: c. Ability to control own behavior.

12. What will the nurse most commonly note in the clinical picture of dementia?
Ans: a. Memory loss for events in the distant past.

13. A patient refuses to eat meals in the hospital, stating that the food is poisoned. The nurse is aware that the patient is expressing an example of:
Ans: d. Negativism

14. What is the nurse likely to note in a patient being admitted for alcohol withdrawal?
Ans: a. Perceptual disorders

15. In explaining the goal of therapy in crisis intervention to a new colleague, the nurse states that the goal is to:
Ans: a. Restructure the personality

16. The crisis nurse explains to a colleague that the focus of treatment in crisis intervention is on the:
Ans: a. Present and on restoration to the usual level of functioning

17. Which feeling is the nurse likely to identify as antecedent of self-destructive behavior?
Ans: c. Low self-esteem

18. The most common coping mechanisms used in somatoform disorders are:
Ans: c. Substitution and displacement

19. In crisis intervention therapy, the nurse plans her or his goals based on the principle that crises:
Ans: d. Are related to deep, underlying problems.

20. Which nursing intervention is effective when clients are severely anxious?
Ans: a. Encourage group participation
### Questions for Qualifying Examinations

**Department of Mental Health Nursing**

01. The primary emergency of the personality is demonstrated around the age of:
   - a. 6 Months
   - b. 9 Months
   - c. 24 Months
   - d. 48 Months

02. The relationship that is of extreme importance in the formation of the personality is the:
   - a. Peer
   - b. Sibling
   - c. Parent-child
   - d. Heterosexual

03. For an emotional balance the individual always needs:
   - a. Family, work and play
   - b. Security and social recognition
   - c. Biologic satisfaction and social acceptance
   - d. Individual recognition and group acceptance

04. The basic emotional task for the toddler is:
   - a. Trust
   - b. Industry
   - c. Identification
   - d. Independence

05. The level of anxiety that best enhances an individual's power of perception is:
   - a. Mild
   - b. Panic
   - c. Severe
   - d. Moderate

06. Another term for the superego is:
   - a. Self
   - b. Ideal self
   - c. Narcissism
   - d. Conscience

07. Autism can usually be diagnosed when the child is about:
   - a. 2 years of age
   - b. 6 years of age
   - c. 6 months of age
   - d. 1 to 3 months of age

08. The goal of the therapeutic psychiatric environment for the elderly, confused client is to:
   - a. Help the staff to help the client
   - b. Assist the client to relate to others
   - c. Make the hospital atmosphere more homelike
   - d. Help the client become popular in a controlled setting

09. Hard drugs easily cause dependence because of their ability to:
   - a. Ease pain
   - b. Blur reality
   - c. Clear sensorium
   - d. Decrease motor activity

10. For clients with alcoholism, the primary rehabilitator is the:
    - a. Client
    - b. Nurse
    - c. Physician
    - d. Entire health team

11. When a client makes up stories to fill in blank spaces of memory, it is known as:
    - a. Lying Denying
    - b. Denying
    - c. Rationalizing
    - d. Confabulating

12. Mental illness is evidenced when an individual:
    - a. Has difficulty relating to others
    - b. Has difficulty completing activities
    - c. Experiences frequent periods of high anxiety
    - d. Expresses little desire for work or social activities

13. Functional mental illnesses are mainly the result of:
    - a. Social environment
    - b. Genetic endowment
    - c. Infection and inflammation
    - d. Deterioration of brain tissue

14. The major reason for treating severe emotional disorders with tranquilizers is to:
    - a. Reduce the neurotic symptoms
    - b. Prevent secondary complication
    - c. Prevent destructiveness by the client
    - d. Make the client more available to psychotherapy

15. The affect most commonly found in the client with schizophrenia is one of:
    - a. Anger and hostility
    - b. Apathy and flatness
    - c. Happiness and elation
    - d. Sadness and depression

16. When a client openly masturbates, the nurse should most appropriately:
    - a. Not react to the behavior
    - b. Put the client in seclusion
    - c. Restrain the client's hands
    - d. State that such behavior is unacceptable

17. Feelings of self-effacement are best demonstrated by a client's:
    - a. Lack of initiative
    - b. Quiet and monotonous voice
    - c. "No one listens to me" attitude
    - d. Inappropriate gestures and affect

18. A positive nursing action when caring for a middle-aged, depressed client is to:
    - a. Play a game of chess with the client
    - b. Allow the client to make personal decisions

19. The nurse can best minimize psychologic stress in an anxious client by:
    - a. Learning what is of particular importance to the client
    - b. Explaining in fine detail the procedures and therapies being used
    - c. Avoiding the discussion of any areas that may be emotionally charged.
    - d. Confidently advising the client that the nurse is in charge of the situation

20. A phobic reaction will rarely occur unless the person:
    - a. Thinks about the feared object
    - b. Absolves the guilt of the feared object
    - c. Introjects the feared object into the body
    - d. Comes into contact with the feared object
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