Repaying the Senior Citizens, Who We Owe So Much

As the preparations for the XXVI TNAI (75th) Biennial Conference, scheduled this month during 15-19 October 2016 in Jaipur (Rajasthan) are near complete, we at TNAI look forward to a new concept, some unthought-of perspective to emerge at the long-awaited mega event that could infuse fresh inputs towards achieving our mission and vision. I suggest the participants to do advance spade work so as to derive maximum mileage from the Conference with reference to the theme (Nurses: A Force for Change – Improving Health Systems Resilience) or sub themes. I reassure the participants, the Jaipur Conference shall be a wonderful opportunity to be academically, professionally and otherwise enriched through its various session.

As TNAI Bulletin has been the flagship media of communication with TNAI Members, we were concerned with complaint of some members about non-receipt of this monthly. Delving into issue, we discovered that mailing address of many Members continues to be their college left long ago and copies of Bulletin, being mailed at college address were just being dumped. We suggest Members to send us their current address to which the Bulletin could be mailed.

International Day of Older Persons: About a tenth of Indian population comprises of persons above 60 years of age. A significant number of them are constrained to lead a life of financial and social deprivation. It is to draw attention of nations and communities towards contribution of elderly persons that the International Day of Older Persons is celebrated on 1 October at the instance of World Health Organisation every year. Studies have shown that older people with negative attitude towards aging live 7.5 years shorter than those with positive attitudes, and also take longer to recover from disability and disease. Their perception as burden on others put themselves at risk of depression and social isolation. The theme of the International Day of Older Persons for 2016 is, Take a Stand against Ageism.

World Mental Health Day: The epidemic of Mental Illness is endemic in both developed and developing countries rising at alarming rates all around. WHO predicts that a fifth of India’s population will suffer from mental illness by the year 2020, a situation we are not equipped to handle. At moment, there are just 3,500 psychiatrists for the 20 million Indians with mental illnesses. Organised by the World Federation for Mental Health (WFMH), World Mental Health Day on 10 October annually raises public awareness about mental health issues and promotes open discussion of mental illnesses.

That persistent efforts towards a noble cause pay off, has been vindicated once again in TNAI’s legal battle in apex court for proper salaries and better working conditions of nurses in private hospitals in States/UTs. Through a recent advisory, the Government of India has asked States/UTs to follow relevant guidelines and submit compliance report by 10 October 2016. Kudos to all Nurses!

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Mental illness is an age-old problem of mankind, recorded in the old literature all over the world. Historically mental illness was regarded as demonic possession, the influence of ancestral spirits, and the result of violating a taboo or neglecting a cultural ritual leading to spiritual condemnation. A mention of mental illness has been made in Bible where king Soul during the 4th century BC was suffering from abnormal irritability, great suspiciousness and uncontrollable impulses following some disturbed behavior early in life.

Antipsychotics are the group of drugs used in the treatment of psychosis and psychotic symptoms. The drugs that are used to treat psychosis are of two types: typical or conventional antipsychotics and atypical or newer antipsychotics. The general principle is that the more the patient understands about his or her illness and the reason that the medications have been chosen to treat the illness, the more compliant the patient will be. Failure to devote adequate time to patient information and instruction prior to the prescription of a medication may result in poor compliance, leading to the requirement, at a later stage, of extensive professional time and effort (Talbott, Etalles & Yodofsky, 2000).

Providing care to the patient with mental illness is an exhausting task for family members. They are people who always are with the patient and their roles are very important. Many a time the immediate blood relatives or those who care for these patients are unaware of the importance of continuing medications. They are also ignorant about the side effects of these medications and importance of follow-up. Failure to take prescribed medications is thought to be the biggest cause of subsequent relapse, and this fact must be made absolutely explicit. The patient’s family members may be helpful in promoting long-term medication compliance if they are fully informed (Brooking, Ritter & Thomas, 2002)

Objectives

The study sought to: assess the (a) level of knowledge and (b) attitudes among the family members of psychotic patients regarding drug compliance; seek the relationship between the knowledge and attitude of family members of the psychotic patients regarding drug compliance and find out the association be-

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Guide: Ms Kalpana Mandal, Principal, Nightingale Institute of Nursing, Noida (UP).

Abstract

A study was conducted to assess the knowledge and attitude of family members of the psychotic patients regarding drug compliance and its relationship with the selected factors in selected hospital of Delhi. The conceptual framework adopted for the study was based on system model. Descriptive survey approach was adopted; convenient sampling was used for selecting the hospital and purposive sampling technique was used to select a sample of 100 family members of psychotic patients. The tool developed and used for data collection was structured interview schedule and a likert type attitude scale. It was found that in majority of the family members of psychotic patients had good level of knowledge. There was significant relationship between knowledge and demographic factors in educational qualification and no significant relation between knowledge and selected factors like age, sex, religion, occupation, marital status, monthly income and duration of illness. There was significant relationship between attitude and demographic factors in educational qualification and no significant relationship between attitude and selected factors like age, sex, religion, occupation, marital status, monthly income and duration of illness.
between (a) knowledge and (b) attitudes of the family members of psychotic patients regarding drug compliance with selected demographic factors.

**Review of Literature**

Literature related to psychotic disorders, drug compliance and knowledge and attitude of the family members regarding drug compliance was reviewed.

According to Dr Zillur Rohman Khan Ratan (Oct 2010), mental health is a neglected issue in our country, as in many other developing countries, because of the negative attitude and lack of awareness of mental illness. WHO incorporates mental aspects as integral part of Health. It is about half a century since mental health gradually became an essential component of Health. Patients suffering from mental illness were often stigmatized. He pleaded for creating awareness among people about mental health and mental illnesses.

Warden SR (2003) stated that a substantial proportion of psychiatric and non-psychiatric chronic illnesses fail to take medication as prescribed. Many studies suggest that 50 percent or more of individuals with psychotic disorders are non-compliant, taking only a portion of their prescribed medication. Non-compliance is a major factor contributing to relapse in psychotic patients. Other reasons contributing to non-compliance include medication side-effects, the severity of psychotic symptoms, impaired cognition and an inadequate understanding of the role of medication for preventing relapse. In addition both patients and clinicians overestimate patient compliance.

William AB (2006) observed that non-compliance is common across all populations. The percentage of patients who fail to administer as prescribed is somewhere between 20 to 80 percent.

Dettann L, et al (2004) conducted a study on knowledge and attitudes of mother towards the illness of their child prior to psychiatric treatment and towards start of treatment. About 57 percent of the mothers did not think that their child suffered from a psychotic disorder and believed that this disorder was caused by use of street drugs. About a third of the mothers thought that the reluctance of patient to acknowledge that they needed help was the major obstacle in initiating the psychiatric treatment. More than half of mothers perceived factors related to delivery of professional care as problem in initiating treatment. Mothers emphasised that a more active approach by professional caregiver could reduce treatment delay.

**Table 1: Distribution of family members of psychotic patients by their demographic characteristics (n=100)**

<table>
<thead>
<tr>
<th>S.No</th>
<th>Demographic characteristics</th>
<th>Category</th>
<th>Frequency</th>
<th>Percentage (%)</th>
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<td>21-30 years</td>
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<td>51-60 years</td>
<td>18</td>
<td>18</td>
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<tr>
<td></td>
<td></td>
<td>Female</td>
<td>52</td>
<td>52</td>
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<td>3</td>
<td>Religion</td>
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<td></td>
<td>Muslim</td>
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<td>No Basic Education</td>
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<td></td>
<td>Below class 5</td>
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<td>Class 5 to 10</td>
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<td></td>
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<td>Service</td>
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<td>Business/Self Employed</td>
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<td></td>
<td>Labourer</td>
<td>10</td>
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<td></td>
<td>Unemployed/House wife</td>
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<td>29</td>
<td>29</td>
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<td></td>
<td></td>
<td>&gt; 15,000</td>
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<td>70</td>
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<td></td>
<td>Widowed</td>
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<td>3-5 years</td>
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<td></td>
<td></td>
<td>&gt; 5 years</td>
<td>22</td>
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</tbody>
</table>

**Methods and Materials**

The conceptual framework of the study is based on System Model, a guide for development, utilisation and evaluation. This model consists of 3 phases: Input, Process, Output. Research design adopted for the study was descriptive co-relational design. The study was conducted at Guru Teg Bahadur Hospital, Delhi. The population consisted of family members of psychotic patients under the age group of 20-60 years. The sample consisted of 100 family members of psychotic patients. Convenient sampling was used for selecting the hospital and purposive sampling technique was used to select a sample of 100.

Criteria for sample selection: Family members of psychotic patient aged 20-60 years who were available during the time of data collection, willing to participate in the study and who can understand Hindi or English.

**Study tool:** The tool consisted of three sections:

**Section I:** Demographic data of the subjects such as relationship with the patient, age, sex, religion, educational qualification, occupation, marital status, monthly income, duration of illness.
Section II: Structured knowledge interview schedule consisted of total 25 knowledge items, designed to assess the knowledge of the family members of psychotic patients regarding drug compliance. Score interpretation: 18-25: Good Knowledge, 9-17: Fair Knowledge, 1-8: Poor Knowledge

Section III: Assessment of attitude was done by the 5-point Likert scale which has 15 items.

Scoring key- Each item has five answers: strongly agree, agree, undecided, disagree, and strongly disagree. The range of score on the attitude scale lies between 15-75.

Score interpretation: Above mean - favourable attitude; Below mean - unfavourable attitude.

Results

Table 1 shows that majority of the family members i.e. 43 (43%) belonged to the age group 21-30 years. Out of 100 family members 52 (52%) were females while only 48 (48%) were male. Majority i.e. 83 (83%) were Hindu. Majority of the subjects (n=34) had attained Graduation (34%). The distribution according to the occupation of the family members show that majority of family members i.e. 38 (38%) were in service. Monthly income of the family members denoted that 49 (49%) belonged to the group of per capita income of Rs 5001-10000. Majority of the family members 70 (70%) were married. The distribution regarding the duration of illness shows that an equal number (31 each) of the patients have duration of illness i.e. of < 1 year and 1-3 years (31%).

Table 2 shows that most of the family members i.e. 70 percent had good level of knowledge score and 30 percent had fair level of knowledge regarding drug compliance. Distribution of Knowledge score of 100 family members showed range of score from 14-24 with mean 21.1, median 23 and standard deviation was 3.17. In Figure 1, area wise knowledge score shows that rank order is highest in area of knowledge regarding drug compliance and lowest in the area of side-effects of drugs.

Table 3 shows range score from 54-66 with mean 59.65, median 59 and standard deviation was 2.87. This indicated that family members had more favourable attitude regarding drug compliance i.e maximum 72 (72%) had favourable attitude towards drug compliance and only 28 (28%) had unfavourable towards drug compliance.

Chi square values obtained to seek the association between level of knowledge of the family members and selected demographic factors showed that there is significant relationship between knowledge and selected factor like educational qualification. There is no significant relationship between knowledge and selected factors like age, sex, religion, occupation, marital status, monthly income and duration of illness.

Chi square values obtained to seek the association between attitude of the family members and selected demographic factors showed significant relationship between attitude and selected factor like educational qualification. There is no significant relationship between knowledge and selected factors like age, sex, religion, occupation, marital status, monthly income and duration of illness.

Discussion

The present study showed that family members with good edu-
cational qualification experienced good level of knowledge and favourable attitude regarding drug compliance and others experienced fair as well as poor level of knowledge and no favourable attitude regarding drug compliance.

Similar study conducted by Warden SR (2003) suggests that 50 percent or more of individuals with psychotic disorders are non-compliant, taking only a portion of their prescribed medication. Non-compliance is probably the most important element contributing to relapse in psychotic patients.

The present study shows that negative knowledge and attitude of the family members of psychotic patients regarding drug compliance results in non-compliance in the psychotic patients. Similar results were reported by Redenbacher MA, et al (2004) that Knowledgeable Carers were able to reduce non-compliance by enhancing the patients’ knowledge about the illness and antipsychotic medication and by carrying out regular benefit/risk discussions concerning the treatment plan, thereby improving the patients’ attitude towards pharmacological treatment.

Dettann L, et al (2004) found that parents especially mothers, have a critical role in initiating psychiatric treatment for their child with first episode of psychosis. Knowledge and attitudes of mother towards psychiatric treatment and towards start of treatment is essential for the development of interventions for reducing duration of untreated psychosis.

The findings on the knowledge and attitude of family members showed that the knowledge of the family members of psychotic patients had range score 14-24, mean score 21.1, median score 23 and standard deviation 3.17 and attitude of the family members of the psychotic patients had range score 54-66, mean score 59.65, median score 60 and standard deviation 2.87. These revealed that there is a positive relationship between the knowledge and attitude score of the family members of psychotic patients regarding drug compliance. Further, there is a significant relationship between knowledge and attitude with demographic factor like educational qualification.

**Conclusion**

There is significant positive correlation (0.45) between the knowledge score and attitude score of the family members of psychotic patients regarding drug compliance at 0.05 level of significance; significant relationship between knowledge score and selected demographic variable like educational qualification. Thus, the knowledge of the family members of psychotic patients in terms of drug compliance is dependent on educational qualification.

**Implications**

Nursing personnel working in psychiatric units should be equipped with the knowledge and skills and must possess a positive attitude regarding antipsychotic drugs and their compliance which will enable them to deal with the psychotic patients and their family members so as to enhance their knowledge and improving their attitude regarding drug compliance.

As the revised curriculum of basic Nursing education is based on preventive and promotive aspects of health hence the students must learn identifying the risk group, history taking with regard to non-compliance, early diagnosis, prevention and management of psychotic patient’s poor compliance.

The nursing administrators should encourage the nursing staff to be alert to detect poor compliance while caring for the patients in hospital as well as in community.

There is a need for extended and intensive research in the area of educating the family members of psychotic patient’s about mental illness and managing their mentally ill patients at home to promote recovery from illness and prevent relapse.

**Recommendations**

Similar study can be replicated on larger samples, to validate the findings and make generalization; similar study can be done with pre-test post-test control group design. A study can be conducted to assess the problems faced by the family members in adhering to the treatment regimen. A comparative study can be done to evaluate the effectiveness of the PTP and teaching strategies like information booklet.

**References**

2. Axelrod S. Factors associated with better compliance with psychiatric after care. Psychiatry Hospital and Community Psychiatry 1989, 40(4): 397-496
5. Boyd MA. Psychiatric Nursing, Contemporary Practice. 3rd edn, Philadelphia; Lippincott, Williams & Wilkins, 2005, pp 265-308
Effect of Structured Teaching Programme regarding Collection of Cord Blood for Stem Cell Therapy in terms of Knowledge among Staff Nurses in Selected Hospitals of Bangalore

Vivitha S Pinto¹, Pushpaveni NP²

Abstract

In the present study evaluating the effectiveness of structured teaching programme (STP) regarding collection of cord blood for stem cell therapy in terms of knowledge among staff nurses in selected hospitals of Bangalore, a pre-experimental design, with convenient sampling method was used. Information was collected from 50 staff nurses regarding collection of cord blood for stem cell therapy using the structured knowledge questionnaire. STP was implemented and post-test was conducted after 7 days to find the effectiveness. The pre-test knowledge scores were found to be 43.05 percent and after STP the post-test knowledge scores of staff nurses was found to be 77.45 percent which enhanced by 34.4 percent with the t-test value 25.96 and Chi-square value 80.18 which is significant at 5 percent level. The result proved that STP was effective in improving the knowledge of staff nurses on collection of cord blood for stem cell therapy.

Good health is not only about not being ill, it is about being happy and feeling whole from a physical, mental and spiritual points of view. The study of human body and related health issues helps to understand how humans function, and the application of that knowledge to improve health and to prevent and cure diseases.

Umbilical cord blood is rich in stem cells, which are the building blocks of the blood and the immune system. These biologically unique cells have the ability to develop into other cell types within the body. Stem cells collected from the umbilical cord have the ability to replace bone marrow and to produce various blood and immune cells.

Stem cells have the remarkable potential to develop into many different cell types in the body during early life and growth. In addition, in many tissues they serve as a sort of internal repair system, dividing essentially without limit to replenish other cells as long as the person or animal is still alive.

As it is a new approach in medical science most of the patients and their relatives are unaware about this clinical entity (Katz et al, 2011; Dinc & Sahin). The nurses also lack adequate knowledge about this new innovative approach (Walker et al, 2012). In most of the situations nurses at duty find it difficult to provide such information to the patients who come to seek guidance. It has been established that patients tend to trust the nurses and follow their instruction. There is lack of accurate and detailed information about collection of cord blood for stem cell therapy among nurses and only few studies have been conducted on the knowledge of nurses on collection of cord blood for stem cell therapy which implies that there is lack of knowledge regarding the same. Hence the investigator felt the need to assess the knowledge and provide a structured teaching programme for nurses regarding collection of cord blood for stem cell therapy.

Objectives

The study sought to (i) assess the knowledge of staff nurses regarding collection of cord blood for stem cell therapy before and after conducting structured teaching programme regarding collection of cord blood for stem cell therapy, and (ii) find an association between post-test levels of knowledge of staff nurses regarding collection of cord blood for stem cell therapy and their selected personal variables.

Hypotheses

H₁: There will be a significant increase in the mean post-test knowledge scores of staff nurses working...
in selected hospitals at Bangalore regarding collection of cord blood for stem cell therapy.

**Hypothesis:** There will be a significant association between post-test knowledge scores regarding collection of cord blood for stem cell therapy and the selected personal variables among staff nurses working in selected hospitals at Bangalore.

**Review of Literature**

In a descriptive study on awareness and acceptance of public cord blood banking among practicing obstetricians in United States in 2009, 80 percent of affiliated obstetricians feel confident discussing cord blood options with their patients. However, 49 percent indicated that they had insufficient knowledge of cord blood donation to effectively answer patients’ questions about donation. The study concluded that obstetricians are generally familiar with the utility of donated cord blood in transplantation, but could benefit from additional information regarding how cord blood is used in transplantation. Furthermore, obstetricians play an important role in encouraging women to donate their baby’s cord blood to a public CBB, are willing to do so, and indicate a desire for more information so they can effectively educate their patients.

A cross-sectional survey was conducted to assess the knowledge on commercial cord blood banking for their offspring (CCBB) among 2,000 pregnant women in antenatal clinics of two major public maternity units in Hong Kong. The survey explored knowledge about the use of self-stored umbilical cord blood (UCB) stem cells and attitude towards CCBB. The majority (78.2%) had no idea that there was the chance of using self-stored stem cells. Only 20.3 percent of women knew that stem cells are available from the Red Cross in case their children need hematopoietic cell transplantation. The study revealed inadequate knowledge on UCB stem cell banking and its applications among most of pregnant women. The government and clinicians should combine efforts to provide accurate information on utilisation of UCB stem cells during antenatal care.

**Methodology**

The conceptual framework of the study parameter is based on Imogene King’s goal attainment model shown in Figure 1.

Structured Teaching Programme regarding collection of cord blood for stem cell therapy was developed based on review of literature. The initial draft of
STP was given to 10 experts in the field along with the tool. To assess the content validity of STP, a criteria checklist was used, which consisted of criteria for two areas. Against each criterion four responses were given and a column was provided for their remarks. The suggestions were incorporated in the STP.

After validation, the tool was subjected to test for its reliability. The structured knowledge questionnaire was administered to 5 samples. The reliability of the tool was computed by using split half Karl Pearson’s correlation formula (raw score method). The reliability of Split Half test was found by using Karl Pearson correlation by deviation method. Spearman Brown’s Prophecy formula was used to find out the reliability of the full test.

The reliability co-efficient of structured knowledge questionnaire was found to be 0.96 and validity co-efficient worked to be 0.97 for knowledge questionnaire revealing that the tool was feasible for the main study, since the knowledge reliability co-efficient for the scale was \( r > 0.70 \). The tool was found to be reliable and feasible.

Pre-experimental one group pre-test and post-test design was used to conduct the study in Vanivilas Hospital, Bangalore with the permission of authority. The sample of this study comprised of 50 staff nurses working in Vanivilas Hospital, Bangalore who were attending continuing nursing education classes employing convenient sampling method (Polit & Hunger, 1999).

The pre-test was conducted to by using structured knowledge questionnaire; approximately 45 minutes were spent for collecting data. The investigator gathered staff nurses in a comfortable room and conducted STP. After 7 days post-test was given with the same structured knowledge questionnaire.

**Results & Discussion**

Majority (48%) of the respondents fell between the age of 21-30 years; majority (88%) were female. Majority of the respondents (88%) were Hindu, the professional qualification of 66 percent of the respondents was graduation; majority (50%) of respondents fell between 0-5 years of experience; majority (92%) were working in OBG ward. Majority of the respondents (80%) were not exposed to collection of cord blood procedure. An overwhelming majority (94%) of subjects had no in-service education regarding collection of cord blood for stem cell therapy, half of respondents (50%) got information regarding collection of cord blood for stem cell therapy from mass media (Table 1).

Pre-test knowledge scores were found to be 43.05 percent and after STP the post-test knowledge scores of staff nurses was found to be 77.45 percent which was enhanced by 34.4 percent, with the t-test value 25.96 and chi square value 80.18 which is significant at 5% level (\( p \) significant at 5% level) (Table 2).

The present study confirms that the overall knowledge in pre-test is 43.05 percent, which is less. This
shows that there is lack of information among staff nurses regarding collection of cord blood for stem cell therapy. Yet some staff nurses had moderate knowledge (26%), and majority of them had inadequate knowledge (74%) regarding collection of cord blood for stem cell therapy. There was a considerable improvement of knowledge after the STP on collection of cord blood for stem cell therapy and is statistically established as significant. The overall post-test score was 77.45 percent with 34.4 percent mean percentage knowledge enhancement.

This study was supported by similar study conducted to assess the health professionals’ knowledge of umbilical cord stem cell, collection, preservation and utilisation at selected maternity hospitals in Coimbatore. The study results showed that post-test score (mean: 39.6%, 2.57) was higher than that of pre-test score (mean: 13.23%, 3.88) and concluded that the STP was effective in enhancing the knowledge of health professionals regarding umbilical cord blood stem cells collection, preservation and utilisation and the teaching programme had a role in improving the knowledge of the health professionals (Kumaraswamy & Muthulakshmi, 2010).

Implications

Nursing education: This study can be utilised by nursing professionals to educate staff nurses as well as their family members regarding collection of cord blood for stem cell therapy.

Nursing practice: Updating the knowledge of staff nurses is a very important task which helps the staff nurses to impart their knowledge and motivate the pregnant women and their family to store the cord blood of their babies for future use.

Nursing administration: The nurse administrator should arrange continuing education programme for nursing personnel as it helps to encourage the nurse to use proper techniques of collection of cord blood for stem cell therapy.

Nursing research: The study will motivate the new researchers to conduct same study with different variables on a large scale.

Recommendations

1. The present study can be replicated with a larger population.
2. A similar study can be conducted on pregnant women.
3. Manuals and information booklets may be developed to enhance knowledge on collection of cord blood for stem cell therapy.

References


Advice to the Contributors

It is observed that some articles/ write ups submitted for publication in Nursing Journal of India (NJI) do not conform to the required instructions so that such articles are not likely to receive priority.

Kindly note that each article/ write-up for publication in NJI must indicate: TNAI Membership number of the Author(s); contact details including Mobile / Landline Number; email id; complete address of institution of the corresponding Author (if working).

Research articles must contain Abstract. The References must be double checked for accuracy of author(s) name(s) and completeness. The name & designation of Guide/ Co-Guide with Institutional affiliation as well as year in which study was conducted must also be mentioned.

ATTENTION MEMBERS!

Although we take utmost care in checking the veracity of facts mentioned in the advertisements, yet readers are requested to make appropriate enquiries and satisfy themselves before acting upon any advertisement.

- Chief Editor
If millions of nurses in a thousand places articulate the same ideas and convictions about primary care, and come together as one force, they could act as a power house for change. According to the International Council for Nurses - 70 countries including Asian countries like South Korea, Singapore and Thailand have established Nurse Practitioners (NPs) / Advanced Practice Nurses (APN) roles. At present, there are about 200,000 NPs in US and INP was started about 80 to 100 years back.

One of the resolutions passed by Indian Nursing Council in the year 2001-2002 is that “Nursing is an Independent Profession”. In India to strengthen the quality of MCH services, the National Commission on Macroeconomics and Health (2005) had suggested that one Independent Midwifery Practitioner should man each Community Health Centre. This has led to the concept of Nurse-Midwifery Practitioners.

West Bengal was the first state in India (in 2002) to start Nurse Practitioner in Midwifery (NPM) course followed by Gujarat (in 2009) by giving 18 months specialised training to prepare trained nurses to function as Independent Midwifery Practitioners. In Gujarat, 25 posts for nurse midwife practitioner were sanctioned. The trained nurses are competent but still waiting to be appointed as NPs. The policy process was delayed for several reasons; being a state driven policy, there was less push and shared vision, many were unconvinced about developing an autonomous cadre of midwives who can displace doctors, it was seen as a competition by obstetricians, there was less space for open dialogue and the main actors to push the policy forward were less powerful within the government.

Kerala Health Policy, 2013 states that the potential of nursing cadre as an independent professional needs to be identified and propagated.

In India, due to unemployment or under-employment, many graduate nurses are waiting to migrate to foreign countries with many already migrated and working successfully as NPs in countries like US, UK, Singapore. In US, as per the Affordable Care Act (ACA-2014), known as Obamacare, 30 million people will soon obtain health care coverage and NPs are an answer to an acute shortage of primary care.

There is an increased need for NPs because of increasing health problems and significant health disparities. According to census of India 2011, 83.3 crore (70%) live in rural areas, while 37.7 crore stay in urban areas where 75 percent of Indian medical practitioners are positioned.
The favourable circumstances needed for implementation of the programme are clearly defined role descriptions, support from physicians, employer, profession and the local community, active participation of stakeholders in the early stages of implementation NP programme and the practitioner’s personal characteristics like passion and hard work. The odds are: lack of support and understanding of the NP role, challenging work environment, the unwillingness of specialists to accept referrals from NPs, lack of trust on nursing capabilities, and threats to General Practitioners status, including job and financial security. There can be inconsistent team acceptance, uncertainty in establishing the NP role and feelings of isolation from the part of NP.

The studies show that the patient outcome with NPs is equal or better than that of physician-managed cases. NPs provide effective and high-quality patient care, with reduced length of hospital stay, patient waiting times, reduced cost of care, better management of serum lipid levels, and increased management of pain and risk factors. They also reduced the avoidable consumption of medicines.

**Objectives**

This study attempted to assess the awareness of general public and health care professionals regarding Independent Nursing and assess the opinion of general public as well as health care professionals regarding the prospects and challenges of Independent Nursing Practice.

**Operational Definitions**

**Opinion** - views of general public and health care professionals about prospects and challenges of INP in India; **General public** - includes the common people who are the consumers of health care. **Health care professionals** - includes doctors, nurses and administrators of the health care settings. **Prospects** - chances or opportunities for success of Independent Nursing Practice in India. **Challenges** - effort and determination needed for implementing Independent Nursing Practice in India. **Independent Nursing Practice** - the system in which graduate nurses acquire advanced knowledge, decision-making skills, and clinical competencies for expanded practice beyond that of an RN, and the characteristics of which would be determined by the context in which he or she is credentialed to practice.

**Assumptions:** General public and health care professionals have some awareness regarding INP although both the groups have different opinion towards developing an advanced nursing role in general practice.

**Methods**

Quantitative approach and non-experimental descriptive survey design were used for the study. Selected private hospital and nursing college and urban areas in Kottayam district were selected. The study population consisted of general public and health care professionals. Non-probability convenient sampling was used.

**Sample size:** General Public - 50, Nurses - 30, Doctors - 20 (total - 100).

**Inclusion criteria:** Educated people (graduates) like social workers, lawyers, teachers from different community settings between the age group of 25 to 75 years and both sexes were included.

**Exclusion criteria:** Cognitively impaired and those who were not willing to participate.

**Tools and Techniques**

Section A was the Demographic data.

Section B had 2 parts: **Part-I** - Assessment of awareness about Independent Nursing Practice by using structured questionnaire; **Part-II** - Semi structured questionnaire to analyse the opinion of general public and health care professionals regarding the prospects and challenges of Independent Nursing Practice.

**Procedure for Data Collection**

A combination of structured questionnaire and semi structured questionnaire was used for data collection. The data was collected from 25 September to 2 October 2014. The medical and nursing superintendents of the selected hospital were personally contacted. The objective and nature of the study was explained and consent was sought to carry out the study. All the doctors and graduate nurses and PG nurses of the selected hospital and College of Nursing was tried to be included in the study. The completed questionnaires was collected and analysed.

**Results and Discussion**

Among the samples 68 percent were post graduates and 32 percent of them were graduate. Among them were: nurses (30%), doctors (20%), engineers (10%), teachers (20%) and other categories like social work-

<table>
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<tr>
<th>Awareness about NP programme</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
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<tbody>
<tr>
<td>General public</td>
<td>13%</td>
<td>40%</td>
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<tr>
<td>Nurses</td>
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<td>Doctors</td>
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ers (20%). None of them were having previous work experience with NPs. Most of the samples (80%) were having relatives as nurses.

Table 1 shows that only 13 percent of doctors were having average awareness about INP which is even less than that of general public (40% average awareness) which indicates that doctors are rather reluctant to accept the scope of NPs.

All nurses (100%) and among the public and doctors, 80 percent and 50 percent had the opinion that it is possible to have NPs in India whereas 35 percent of the doctors felt that it was not possible (Table 2).

Among the nurses, public and doctors 88 percent, 60 percent and 45 percent respectively had the view that NP can reduce the disparities in health care delivery system. Majority of the subjects agreed that nurses can do health screening and referral services.

Around 50 percent of the nurses, doctors and general public had the opinion that doctors will collaborate with NPs. Among nurses 65 percent had the opinion that there will be support from the nursing profession, clients, administrators, and policy makers; 33 percent of nurses opined that the profession and TNAI is taking necessary steps for implementing NP programme, while 33 percent opposed it and 34 percent were not having any particular opinion. Among the samples 48 percent, 35 percent and 24 percent of the nurses, doctors and public respectively showed that NPs were not a threat to doctors in the job and financial security while 65 percent of the doctors were not knowing.

As the doctors lack role clarification about NPs many of them were reluctant to complete the awareness questionnaire and the results shows doctors had less awareness than general public. Still 50 percent of the doctors and 80 percent of the public agreed that NP programme can be started after modification of the curriculum and can reduce the health disparity. Studies show that doctors from China and Japan after working with NPs in US want to have NPs in their country also.

The major challenges identified in this study are with regard to the following which are congruent with the previous studies: lack of role clarity, lack of understanding of NPs role by doctors and general public, lack of proper regulatory environment and legislative support and uncertainty about client acceptance and lack of support from policy makers.

Many of the nurses opined that the INC, State Nursing Council and TNAI working in collaboration can influence policy makers and administrators in implementing the NP programme.

**Conclusion**
After modification of the curriculum and the qualifying examinations and open discussions, NP programme can be implemented in India. Many among the general public opined that NPs are not a threat to doctors because their nature of work is different from that of a doctor and they have limitations. They also share and reduce the work load of doctors. With more utilisation of the mass media like TV, newspapers there will be larger awareness among the general public about the scope and practice of NPs, and support and collaboration from administrators and doctors.

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Editor

Economic Plan for Acquiring TNAI Membership

With a view to make the TNAI Membership more attractive, the TNAI Council (vide Minutes No. EC/CL/2015/4) have decided to offer an attractive alternative Membership plan which is more simplified and economic for students.

A student opting for the new Membership Plan has to pay just a lump sum Rs. 2,000/- (inclusive of SNA subscription for 4 years, Scholarship Fund and SNA to TNAI Membership fee) and he/ she shall become a full TNAI Member automatically after completion of the course, thus saving substantially and avoiding to pay annual fee every year.

Under the existing rules, at the time of becoming SNAI Member the student pays Rs. 150/- per year plus Rs. 50/- (towards Scholarship Fund) for 1st year, and Rs. 150/- yearly for 2nd, 3rd and 4th years. Again, after completion of the course he/ she is required to pay the TNAI Membership Fee of Rs. 2,200/- to become SNA to TNAI Member.

The new Membership Plan shall be applicable from the academic year 2016-17 although the existing rules for SNA membership shall also remain valid. The Institutions are free to choose either of the Membership plans.

Secretary-General, TNAI
Parents have the responsibility to prevent adolescents from internet addiction disorder despite the immense benefits, its excessive use has potential for leading to pathological/problematic negative consequences with addiction. Children are “digital natives” while parents are usually not. Children are growing up online. Digital media is the air they breathe. For many parents, the Internet is a thing of utility. For their kids, the Internet is a place for community. The Internet provides a cloak of secrecy for kids to see or seek out all kinds of inappropriate material (Chou et al, 2005). We live in an age where cyber-stalking, online predators and identity theft have become legitimate threats. Law enforcement officers at all levels, Internet crime experts, child psychologists, and other authority figures are increasingly urging parents to monitor the online activities of their children as well as communicate to them the importance of safeguarding their online presence (Darling & Steinberg, 1993).

Experiences in the Internet cyberspace have expanded in daily life, especially among adolescents and young adults. The usage, speed, interactivity, and access to internet over the past decade have a tremendous increase. An ASSOCHAM survey suggested that 73 percent kids between the ages of 8 - 13 years use social media in India. The India Teens and Technology 2014 report by Internet security firm McAfee showed that 52 percent of respondents accessed social media accounts at school, even though most schools ban the use of mobile phones (Maqsood, 2015).

Every parent feels that kids need to learn computer technology. And the fact is that children do need to learn using computers and be comfortable with the ever changing and emerging forms that the technology develops. In their world, educational and career opportunities will be strongly linked to the ability to navigate through layers of technology. But if you, as a parent, don’t even know how to turn on a computer or have never received or sent an e-mail message, you are in the dark about the workings of the Internet and how your child is being introduced to and interacting with it. You might feel that he / she is doing something educational in internet rather than wasting time in front of the television. So you don’t get involved, don’t ask many questions and don’t monitor on-line time and activities. You shrug your shoulders and say to yourself: “My kid knows more about this stuff than I do.”

“A young girl with learning disability had disclosed to a stranger online that her parents were on vacation. Three days later, four men robbed the house. Safety and health are two very important things which might be exposed to abuse on social media,” said by a child psychiatrist (Social Media Usage, 2014).

I know one teenager who tells me that he knows, when and all, his father monitors him with this monitoring software. That shows if the kid is very tech-literate, he will figure out works around. There are ways for kids to get around monitoring, or they may go to a friend’s house where rules are more relaxed. So we cannot totally rely on these monitoring apps. It’s really better to communicate with them and help them develop their own critical thinking, because what we can do with technology is very limited. There is no technology that can really help us parent, and there is no law that is really going to help us protect our kids. Our kids have to protect themselves first and foremost, and we can help them. We can really be their best backup, but they’re the ones who are protecting themselves. Counsellors and child psychologist warn that tools should not replace the human touch. “Parents are so busy tracking and checking electronic devices that there is no time left for conversations. These devices, howsoever advanced, keep the kids indoors and take away the joys of running in the park and playing in the colony compound, which are an important part of the child’s physical and social development (Maqsood, 2015)

Parents can play an important role in managing the adolescence leisure activities to avoid the Internet addiction. Parents can alter maladaptive behaviours of adolescents; parents can play a central role in family management (Darling & Steinberg, 1993; Chou et al, 2005) Today’s parents face two common obstacles to teaching their children about Internet safety: (1) they don’t feel like they know enough about the subject, and (2) they’re not sure

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how to best communicate their concerns to their children, so they remain silent.

Parents know that if stranger calls their house on the phone, your kid shouldn’t talk to them on the phone for two hours. This common sense could be made as cyber sense. Things we already know — don’t talk to strangers; don’t tell secrets to strangers; don’t take candy from strangers - all of these things apply exactly online. They don’t need a class on this stuff. They just need to stop panicking, talk to their kids, and be in charge. In today’s day a child knows more about the digital world than the parents. They are exposed to new ways online through friends or other acquaintances. Therefore, it is necessary that you are as updated as your child is.

**Parenting Styles**

Diana Baumrind broadly created four parenting styles:

1. **Authoritative Parents** so called ‘assertive democratic’ or ‘balanced’: who are both demanding and responsive. They provide rules and guidance without being overbearing.
2. **Authoritarian Parents**: who are demanding but less or not responsive. They tell their children exactly what to do.
3. **Permissive or Non-directive Parents**, so called indulgent. Responsive but less or not demanding. They allow their children to do whatever they wish.
4. **Rejecting- negligent Parents**: who are neither demanding nor responsive. They disregard the children, and focusing on other interests (Maccoby & Martin, 1983)

With authoritative and permissive parenting on opposite sides of the spectrum, most conventional and modern models of parenting fall somewhere in between (Holt et al, 2009). The parenting style is one of the factors in childhood and adolescence that can have a great deal with the life stylish habitual behaviours in the life spans. Indeed, those parents low in kindness while being highly controlling (authoritarian), provided little supportive and appropriate structure. This result is consistent with the findings of Maccoby & Martin, and also supports the self-determination theory, which states that in autonomy-supportive families, children are more self-determined and motivated than those in controlling families (Holt et al, 2009).

Many studies conducted in the USA and other countries not only supported this idea that the authoritative parenting style is always associated with optimum youth outcomes, but also compared to that, a neglectful parenting style, corresponded with children’s poorest performance (whereas authoritarian and indulgent parenting occupied an intermediate position), school integration, psychological well-being, adaptive achievement strategies, self-enhancing attributions drug use, and accuracy in perceiving parental values. Research suggests that certain parenting styles are linked with the propensity for substance abuse among adolescents. For example, alcohol abuse was higher among adolescents who perceived low parental control, and the children of authoritative parents were less likely to use illicit substances than those of neglectful parents. Another found that adolescents who rated their parents more highly on these dimensions had lower tobacco, alcohol and ‘other drug’ consumption (Holt et al, 2009).

**Dangers associated with Internet use**

These dangers are so rampant and perilous that the television industry has taken noticef numerous local, national, and cable networks have aired news-talk shows, or documentaries about children and the Internet. These dangers are exacerbated when children have unrestricted and unsupervised access to the internet, when there are no restrictions or boundaries to what they may or may not do online, and when parents rely solely on the computer as the after-school babysitter.

These are some of the dangers: Cyber-Paedophiles; Access to Pornography; Inappropriate Content - violent material, hate sites, torture, and other things, such as how to make a bomb; Cyber bullying; Online gambling; Violent games; and Internet addiction.

Like addiction to drugs, alcohol, cigarettes, or caffeine, internet addiction is marked by symptoms of increasing tolerance, withdrawal, mood changes, and interruption of social relationships. Research on problematic internet use shows that overuse of the internet and problematic / pathological internet use or the internet addiction have a significant relationship with such factors as loneliness, low self-esteem, depression, the symptoms of antisocial tendencies and external control ; psychological symptoms, shyness, social disinhibition, low social support and pleasure with the internet. As per a study conducted in Turkey there were significant differences between the students’ Internet addiction scores and the presence of physical behaviour problems (going to bed late, skipping meals, eating meals in front of the computer) and psychosocial behaviour problems (suffering from conditions such as restlessness, anger, heart

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pallitations, or tremors when they could not connect to the Internet, decreased relationships with family and friends, feelings of anger, arguing with parents, and finding life boring and empty without an Internet connection (Alvarez et al, 2003).

**Self Help Tips for Parents**

- The best defence as a parent is to have frequent and open conversations with kids about the challenges of being online.
- Become computer literate and be actively involved in your children’s online experiences.
- Place computers in high-traffic areas, not a child’s room.
- Use screening software.
- Read unfamiliar e-mails. Monitor telephone and modem changes. Check out unfamiliar phone numbers and e-mail addresses.
- Show you care: spend some time with the child. Reassure him that you are concerned about him.
- Provide enough attention to the child. Spent time with the child for conversation.
- Don’t allow children to spend long periods of time on the computer, especially at night.
- Set reasonable rules: Allow perhaps an hour per night after homework, with a few extra weekend hours.
- Help children understand that online users may not be who they claim to be or who they seem to be. Get to know your children’s Internet friends.
- Tell children to report anything they come across online that seems strange or makes them uncomfortable especially if they are ever asked personal questions or invited to personal meetings.
- Tell children to report to you suggestive, obscene or threatening e-mail or bulletin board messages. Forward copies to your ISP (Internet Service Provider) and insist they help deal with the problem.
- Be concerned if children mention adults you don’t know, become sensitive, or appear to have inappropriate sexual knowledge.
- Post the Internet Safety Rules for Kids by your computer.

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Swachh Bharat Abhiyan is a national campaign to have Clean and Healthy India. It includes all the measures to be adopted by Indian public to assure healthy Indian citizens. Everyone is directly or indirectly involved to maintain and promote one’s health. All health team members provide health care at primary, secondary and tertiary care settings. Nurses form major component of health team to provide incidental and planned health care to their clients. Besides giving direct care, they adopt preventive measures, counsel a client, a family on matters pertaining to health.

Prime Minister of India, Mr Narender Modi launched a campaign, Swachh Bharat Abhiyan on 2 October 2014 to fulfil Mahatma Gandhi’s vision of “Clean India”. He invited many public figures to this national campaign. In this campaign, the focus was on cleaning of environment.

To achieve the goal of clean and healthy India, nurses play vital role to provide comprehensive health care to individuals (sick or well), families and community at large. While providing care, she aims at prevention of disease, promotion and restoration of health. Enormous changes have occurred in the delivery of nursing care to the clients. Nursing entails the nurse meeting the client’s needs whatever the situation. They are with clients more frequently than other health professionals.

Nursing play vital role in improving health at primary, secondary and tertiary level in following ways: Provide safe environment and safeguard a client in health care setting: Health and quality of life are greatly affected by the influence of the environment. Disease is the consequence of the interaction of mind and body with the environment. Healthy environment fosters healthy and happy people. Nurses can educate the clients and significant others: waste segregation and make public aware about use of different colour dustbins; damp dusting in all health centres; noise free and well ventilated environment (which enhances client’s recovery); proper lighting in the wards and wash rooms in order to avoid falls; repair of any cracks in walls and floors to get rid of rodents; keeping the client’s lockers clean, dry and lined, use of naphthalene balls to protect from moths and cockroaches; clean water supply in the wards; use bedrails for small children, elderly, unconscious, comatose post-operative and other critically ill clients; using hot water bag cautiously for small children, elderly, comatose and other clients with loss of sensation; keeping drugs and chemicals away from client zone under lock and key; providing right drug and right dose to right client at right time. Avoiding slippery floor by getting it dry mopped; checking for any loose switches and electric connections; checking the hospital equipment for any defect and getting it repaired; checking wheel chair, trolley and client beds for movable condition.

Avoid cross infection: Transmission of infection can be prevented by following measures: Making hand washing mandatory for all health team members, to be performed before and after touching a client or when entering a client zone, touching any client equipment, performing any procedure, when exposed to client’s body fluids. Hands can be washed with soap and water. While washing, rub hands vigorously together to cover all surfaces, rinse with water and dry with clean towel. Else sanitizer can be used for cleaning hands by health team members and clients and their attendants; cutting short nails because long nails give roost to dirt and microorganisms; isolating infectious cases. This zone should have limited en-
try of visitors. Health care workers entering this zone must follow barrier nursing techniques; cleaning the isolation unit daily with disinfectants like phenyl or savlon; following the principles of surgical asepsis by keeping sterile equipment above table or waste level and keep these dry. Avoid sweeping and dusting when sterile field is on.

**Meeting the nutritional requirement of a client:**
Encouraging clients to wash hands before and after meals; checking that the meals provided to the clients is clean and as advised.

**Provide health education:** With the increased focus on prevention, promotion and independence in self-care activities, today’s health care system mandates the education of consumers to a greater extent than ever before. Health education is concerned with establishing or inducing changes in personal and group attitudes and behaviour that promote healthier living. Nurse educates a client, family or community people on following grounds:

**Nutrition:** The nurse guides people to choose optimum and balanced diets which contain nutrients necessary for energy in recovering clients, growth of muscles and repair of tissues in injured and post-operative clients; encourages intake of balanced diet by children, pregnant women, lactating women and elderly people; uses visual aids in simple language which focuses on various food groups and their sources; encourages intake of supplements like iron, folic acid, calcium etc. She guides on precautionary measures to be followed while taking supplements.

**Hygiene & Immunisation:** She guides and teaches on the aspects of personal and environmental hygiene, including bathing, clothing, cleaning of teeth, hands, feet, cutting short nails and toilet training; environmental hygiene includes domestic hygiene, use of soap and water, need for fresh air, light and ventilation, hygienic storage of food, hygienic disposal of waste, need to avoid pests, rodents and insects. She gives health teaching during pre-natal and post-natal period about various vaccinations necessary for safeguarding pregnancy and prevention of diseases in children.

**Use of health services:** She informs the public about the health services that are available in the community and how to use these services, and encourages people to participate in various national health programmes designed to prevent disease and promote health.

**Follow up:** Clients and their relatives require lot of information once the client is discharged from hospital. Essential information regarding home care, follow up need to be informed by nurses.

Through health education, hospitals and other health care institutions can contribute to important health care goals such as improved quality of client care, better utilization of out-patient or community health care services, fewer admissions and readmissions to hospitals, shorter length of stay, fewer complications from treatments and reduced health care costs.

Florence Nightingale once said that nurses can do more good in home than in the hospital. Public health nurses, health visitors and health inspectors are visiting hundreds of homes; they have plenty of opportunities for individual health teaching. Today lot of research is being done to evaluate the effectiveness of planned teaching programmes, use of prepared health modules, use of audio-visual material on knowledge, skill and attitude of people towards health aspects and these are found very effective in health set ups, communities, schools etc. in improving their health outcome.

Thus nurses can prove as clinicians, general practitioners, advocates and counsellors for their clients. They are an asset to improve health of an individual. They have multipurpose roles not only in hospital but in community, in schools, in industries and can fulfill aim of Prime Minister’s campaign of Swachh Bharat Abhiyan. We are really going to have healthy and clean India, if we feel client’s feeling, if we possess soft heart and give care with our gentle hands.

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Progress in TNAI’s Legal Battle for Fair deal for Nurses

The Trained Nurses Association of India (TNAI) has finally had its say. That truth triumphs has been vindicated by Government of India, Ministry’s order No. Z-29011/15/2013-N dated 24.02.2016 agreeing to the pro-nurses recommendations drafted and presented by the Committee (with TNAI as Member) in its latest advisory dated 20 September 2016 to all Principal/Chief Health Secretaries of States/UTs.

To recapitulate, in 2011 TNAI filed a case in Supreme Court regarding the welfare of nurses by enhancing the salary structure and working conditions of the nurses. Consequently, in 2013 the Supreme Court issued a notice to Union of India and all the state governments. On 29 January 2016, the apex court ordered Government of India to set up a Committee to investigate the working conditions and salary structure of nurses working in private hospitals. A Committee was formed on 24 February 2016 to study and submit its recommendations.

The first meeting of the Committee was held on 18 April 2016 under the chairpersonship of Dr. (Prof.) Jagdish Prasad, DGHS.

As per the Committee decision, TNAI conducted a survey of various states/UTs regarding working conditions and salary structure of nurses working in Private Hospitals all over the country and submitted its report to the Committee.

The report, based on the information collected from various states and collated, and presented in the second meeting of the Committee on 30 June 2016 at the office of DGHS in Nirman Bhawan, New Delhi, revealed glaring anomalies in pay of Nurses and their pathetic working condition. It suggested concrete action to be taken to uplift the nurses’ standard of working conditions.


1. Salary:
   - In case of more than 200-bed hospital, salary given to private nurses should be at par with the salary of State Govt. nurses given in the concerned State/UT for the similar corresponding grade.
   - In case of more than 100-bed hospital, salary given to private nurses should not be more than 10% less in comparison of the salary of State Govt. nurses given in the concerned State/UT for the similar corresponding grade.
   - In case of 50-100 bedded hospital, salary given to private nurses should not be more than 25% less in comparison of the salary of State Govt. nurses given in the concerned State/UT for the similar corresponding grade.
   - Salary given to private nurses should not be less than Rs. 20,000/- p.m. in any case even for less than 50-bedded hospitals.

2. Working conditions:
   - Working conditions viz., leaves, working hours, medical facilities, transportation, accommodation etc. given to nurses should be at par with the benefits granted to State Govt. nurses working in the concerned State/UT.

3. Steps should be taken by all States/UTs for formulating legislation/guidelines to be adopted for implementation of the above recommendations in case of Nurses working in private hospitals/institutions.

The TNAI State Branch Presidents and Secretaries are requested to pursue the matter of implementation of relevant guidelines with concerned State Government/Private hospitals and inform the Hqrs about progress on this issue.
Breastfeeding is nearly universal in India and continues for most children beyond infancy. It brings joy to the mother and the baby which cannot be expressed in words. The feeling the mother gets when she continues to nourish her baby at her breast and sees the baby grow and thrive on breast milk is awesome. Babies are young, their digestive tracks are not fully developed and feeding times can lead to many instances of discomfort. Burping is the technique to remove the excessive air, and an important aspect of neonatal care and of digestion, which often gets overlooked (Pillitteri, 1999).

Mothers of newborns experience tremendous breastfeeding problems while feeding their baby. They are not aware of the various aspects and their lack of knowledge not only creates incompetency among them but also puts their baby at various risks. The newborn health challenge faced by India is more formidable than that experienced by any other country in the world.

Neonatal period is a highly vulnerable time for an infant, who is completing many of the physiologic adjustments required for extra-uterine existence. Neonatal care is now our focus. A new born centralised scheme, if we could roll out one, would be a real game changer that could promote better child care practices including better hygiene.

Objectives

This study attempted to (i) assess the existing knowledge and practice regarding burping techniques of newborn among mothers; (ii) evaluate effectiveness of planned teaching on knowledge and practice regarding burping techniques of newborns; (iii) compare the knowledge and practice of burping techniques of newborn with selected demographic variables; and to (iv) correlate the knowledge and practice regarding burping techniques of newborn among the mothers after planned teaching.

Review of Literature

Bundypadhay SK (2002) in his study on elevated breastfeeding practice in rural West Bengal on 1502 mothers of less than 2 years of children showed that 8 percent of mothers practiced demand breastfeeding, 6 percent of mothers burped the child properly after feeding and 8 percent of children were fed within an hour of birth, 62 percent within 1-6 hours, and 18 percent in 6 to 2 hours.
In a cross-sectional study on breastfeeding practices among lactating mothers in Mysore city, Jeetender Singh (2009) found that a significant number (23.97%) of mothers were not aware about the significance of burping.

In a study on various aspects of breastfeeding Devendra Sareen (2008) found that only a minority (36.84%) initiated breast feed soon after birth, practiced exclusive breastfeeding (22.10%) had knowledge regarding burping (41.05%) and had been against practicing prelacteal feed (22.1%). He recommended development of training programmes and providing information on breastfeeding during antenatal visits to disseminate scientifically proven facts regarding advantages and essentiality of breastfeeding with particular emphasis upon exclusive breastfeeding for first six months of life.

Mohamed Asif Padiyath (2009) reported that the technique of burping was described by 48 percent of the mothers when asked what they would do when the child regurgitates after breastfeeding. The study indicated that awareness and attitude of postnatal mothers towards neonatal care has lots of lacunae especially in those who belong to the lower socio-economic status.

Field T and Diego M (2010) conducted a study on depressed mothers and infants. Depressed and non-depressed mothers and their 3-month-old infants were videotaped during breastfeeding and bottle feeding interactions. No differences were noted between the depressed and non-depressed mothers. Several breastfeeding versus bottle feeding group effects were observed. The breastfeeding mothers showed less burping and less intrusive behaviour during the nipple-in as well nipple-out periods.

Neil M Martin et al (2012) in their study on breastfeeding practices among mothers showed that mothers mostly learn more of breastfeeding from the health workers, especially the nurses. Mothers also let their babies burp after breastfeeding. Most of the select mothers made sure that the baby’s chest was directly to theirs. Moderate relationship between attitude and practice, but knowledge showed a highly significant relationship with the practices among select mothers.

**Methodology**

A pre-experimental design, one group pre-test – post-test design was adopted for the study.

**Variables:** Independent variable was planned teaching on burping techniques of newborn while the dependent variable was knowledge and practice of mothers regarding burping techniques of newborn.

The sample had 60 mothers of newborn of selected hospitals of Nagpur city. Non probability convenient sampling was found to be more appropriate for this study feasible.

**Inclusion criteria:** Mothers willing to participate in this study; those who were available during data collection; and those who had newborn babies included. **Exclusion criteria:** Mothers who were from health professional background and had attended a similar programme earlier were excluded. Content validity of tool was done by various experts in the field.

**The tools:** The tool was divided under three sections. Section A consisted of demographic profile of the mothers; Section B was a questionnaire on knowledge regarding burping techniques of newborn; each question carried 1 mark; total number of questions was 20 and total score was 20 marks. Section C was an observation checklist to evaluate the practice of the techniques of burping of newborn. Each step consisted of maximum 1 mark and minimum 0 mark. Total numbers of steps were 15 and total score was 15 marks.

**Pilot study:** The pilot study conducted from 26-30 September 2012 had a sample of 6 patients; it did not show any major flaw. Karl Pearson correlation coefficient formula was used for reliability of the questionnaire and (r) was 0.86. The inter rater technique was used for the observational checklist and (r) was 0.835.

In this study ‘input’ refers to the information obtained from the subjects about their demographic variables, conduction of the pre-test for the knowledge and practice and preparation of the planned teaching. ‘throughput’ refers to the planned teaching that is being given to the subjects and ‘output’ refers to assessment of the effectiveness of planned teaching by conducting the post-test for the knowledge and practice. The scores are further graded into the five categories of excellent, good, average, poor and very poor.

**Data collection:** Permission was obtained from the hospital authorities and before giving the questionnaire self-introduction, the purpose of the study was mentioned by the investigator and consent was obtained. The pre-test was conducted with the tool pre...

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**Table:**

<table>
<thead>
<tr>
<th>Sample</th>
<th>Pre-test</th>
<th>Intervention</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers of newborns</td>
<td>O₁</td>
<td>X</td>
<td>O₂</td>
</tr>
</tbody>
</table>

**Keys:** O₁: Pre-test, X: Planned teaching, O₂: Post-test
pared and the planned teaching was given on the same day. On day 4, the post-test was conducted with the same.

**Results**

The demographic profile of study participants is shown in Table 1. Out of 60 mothers in pre-test, 37 (61.66%) had poor knowledge, 12 (20%) had very poor knowledge, whereas 10 (16.66%) had average knowledge, while only 1 mother (1.66%) had good knowledge. In practice it was revealed that all 60 (100%) of mothers had poor practice. After the planned teaching in post-test it revealed that 37 (61.66%) of mothers had good knowledge, 13 (21.66%) had average knowledge, 10 (16.66%) were in excellent knowledge; in practice it was revealed that 34 (60%) had excellent practice, 24 (40%) of mothers had good practice. It was also revealed that there is high association between knowledge and practice score with age, religion, education, occupation, source of information and position of child and no association with awareness of burping. The correlation of the knowledge and practice score revealed moderate positive correlation in the pre-test with the value of 0.79 and 0.49 in the post-test.

**Discussion**

Asha Varghese (2006) conducted a comparative study on knowledge and practice of primi parous and multiparous mothers regarding post-natal care in Mangalore where she found that only 43.33 percent primi mothers and 66.66 percent multi parous moth-

---

Table 1: Demographic variables of subjects

<table>
<thead>
<tr>
<th>S No</th>
<th>Demographic variables</th>
<th>Frequency (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18-22</td>
<td>19</td>
<td>31.66</td>
</tr>
<tr>
<td></td>
<td>23-27</td>
<td>32</td>
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<tr>
<td></td>
<td>28-32</td>
<td>8</td>
<td>13.33</td>
</tr>
<tr>
<td></td>
<td>33-37</td>
<td>1</td>
<td>1.66</td>
</tr>
<tr>
<td>2</td>
<td>Religion</td>
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<tr>
<td></td>
<td>Hindu</td>
<td>45</td>
<td>75</td>
</tr>
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<td></td>
<td>Christian</td>
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</tr>
<tr>
<td></td>
<td>Muslim</td>
<td>2</td>
<td>3.33</td>
</tr>
<tr>
<td></td>
<td>Buddhists</td>
<td>10</td>
<td>16.66</td>
</tr>
<tr>
<td></td>
<td>Others</td>
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<td>1.66</td>
</tr>
<tr>
<td>3</td>
<td>Educational qualification</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Illiterate</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Primary education</td>
<td>15</td>
<td>25</td>
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<td></td>
<td>Secondary education</td>
<td>28</td>
<td>46.66</td>
</tr>
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<td></td>
<td>Graduation</td>
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<td>18.33</td>
</tr>
<tr>
<td></td>
<td>Post-graduation</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home maker</td>
<td>48</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td>7</td>
<td>11.66</td>
</tr>
<tr>
<td></td>
<td>Business</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Labourer</td>
<td>5</td>
<td>8.33</td>
</tr>
<tr>
<td>5</td>
<td>Awareness on burping</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>43</td>
<td>71.66</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>17</td>
<td>28.33</td>
</tr>
<tr>
<td>6</td>
<td>Source of information (n=43)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friends</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Newspaper</td>
<td>1</td>
<td>1.66</td>
</tr>
<tr>
<td></td>
<td>Television</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Relatives</td>
<td>14</td>
<td>23.33</td>
</tr>
<tr>
<td></td>
<td>Health worker</td>
<td>22</td>
<td>36.66</td>
</tr>
<tr>
<td>7</td>
<td>Position of child</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>First child</td>
<td>33</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Second child</td>
<td>22</td>
<td>36.66</td>
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<tr>
<td></td>
<td>Third child</td>
<td>4</td>
<td>6.66</td>
</tr>
<tr>
<td></td>
<td>Fourth child</td>
<td>1</td>
<td>1.66</td>
</tr>
</tbody>
</table>
ers knew about that burping whereas only 40 percent primi mothers and 66.66 percent multiparous mothers knew that burping after breastfeeding prevents vomiting in newborns. As for the right position for burping she found only 26.66 percent primi mothers and 73.33 percent multiparous mothers knew about it. The multiparous mothers had comparatively higher knowledge than the primiparous mothers.

Area wise analysis on this study showed that 39.2 percent knew about burping whereas only 12.5 percent of mothers were aware of various complications if burping was not done. As for the techniques of burping it was found that only 35 percent mothers knew the right techniques. All (100%) had poor practice of burping techniques. Thus the findings of this study were supported by the above studies and explained the need for a planned teaching.

After the planned teaching, 12 (21.66%) of mothers had average knowledge, 37 (61.66%) had good knowledge while only 1 (16.66%) was in excellent knowledge. All 24 (40%) of mothers had good practice and 34 (60%) had excellent practice, the mean of the knowledge score obtained by the subjects was increased to 14.4 compared to pre-test score of 6.3 (Fig 1) while the mean of practice score obtained by the subjects was increased to 12.65 compared to pre-test of 4.43 (Fig 2). The calculated value was greater than the tabulated value at 5 percent level of significance proving that the planned teaching was effective. The finding of significant association with the age and position of the child was supported by that of Mrs Asha Varughese (2006) who concluded that multiparous mothers had higher knowledge compared to primiparous mother.

Salomi Thomas (2005) compared the knowledge and practices of post-natal mothers regarding neonatal care from selected urban and rural settings of Bangalore where she found that there was positive correlation between knowledge and practice regarding breastfeeding and neonatal care.

Although a positive significant correlation was found by Salomi Thomas but in the present study there was slight variation in the correlation value which decreased in the post-test and the knowledge and practice score had a moderately positive correlation in the both pre-test and post-test with the value of 0.79 in pre-test while 0.49 in post-test.

**Conclusion**

The burping techniques for newborn taught to the mothers with the help of the planned teaching strategy did not have 100 percent knowledge and practice regarding burping techniques of new born. However, after the introduction of planned teaching there was increase in knowledge and practice thus proving that planned teaching was effective. The findings suggested that as knowledge levels increase, practice also increases. Thus the knowledge of mothers plays a critical role in their practice.

**Implications**

**Nursing practice**

1. Nurses have a prime role for patient education in hospital and community. She should conduct training programmes and plan health education to promote the well-being of child.

2. Student nurses and community nurses can use planned teaching as ready reference material information during their clinical posting and during their home visits to give health education to the mothers.

**Nursing education**

1. The nursing curriculum is concerned with the preparation of the future nurses. The present study would help the nurses to understand the level of knowledge of mothers.

2. The awareness on the critical situation like the aspiration, colic and the prevention of its untoward effects should be a part of curriculum in paediatric subject.

**Nursing administration**

1. Nursing administration should implement outreach teaching, and make the society aware about the prevailing health and behavioural problems due to improper practice of burping.

2. Nursing administrators can identify the learning needs and problems and organise in-service education for the nurses and programme for mothers in the clinical setting and primary health care centres.

3. Nurse administrators can develop policies, prepare instructional media and organise continuing nursing education programmes.

**Nursing research**

In India, there is scarcity of literature and research on burping techniques of newborn. This underscores the need for greater nursing research in these areas.

**Recommendations**

- A similar study can be replicated on a larger population for a generalisation of findings.

- A comparative study can be carried out to find out the knowledge and practice of mothers re-
garding burping techniques of newborn in urban and rural areas.
- Study can be conducted for the fathers separately as they are also part of the child care as per the present trend.
- A video-assisted study or study using a SIM (self-instructional module) or a pamphlet or booklet can be carried out to assess the knowledge and practice levels of mothers regarding burping techniques of newborn.

References
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   article&op=view&path%5B%5D= 3733
8. http://14.139.159.4:8080/jspui/handle/123456789/3051

Attention Advertisers!

Advertisers of the Admission Notices in The Nursing Journal of India for the academic year 2016-2017 for Schools/ Colleges of Nursing are required to submit the copy of Indian Nursing Council (INC) recognition certificate along with the advertisement matter and payment, otherwise the advertisement shall be summarily rejected.

-Chief Editor

The New Arrival of TNAI Publication

Medical Surgical Nursing: A Nursing Process Approach

Advances in medicine and nursing have led to emergence of medical-surgical nursing as a specialty of choice among nursing students, attracting them in large numbers. It is also being increasingly opted by as career. Considering the importance of the subject, TNAI took up the elaborate project of drafting and publishing a textbook on it.

Highly valuable publication for students of Nursing, this 2-volume text book has 15 units further divided into 47 chapters in both. Unit I dwells on concept of wellness and maintenance of Health including care of the elderly, Unit II, III and IV cover nursing processes, quality management, common problems of nursing practitioners and peri-operative nursing; Units V to XV describe various health disorders in surgical nursing and their management.

The anatomical and physiological aspects essential for grasp of health disorders as well as methods of assessment have been well covered in the book. The chapters of the book have been contributed by different experts acknowledged in their field, so that the information being conveyed through text and illustrations is authentic and relevant to the students.

As the entire book is in multi-colour, the illustrations come out clearly for easy understanding of the students. It is a ‘must’ book for nursing students on all counts: contents, coverage, treatment of subject, clarity of expression and price.

Price: Rs. 2,400/- (for 2 Volumes)
**World Suicide Prevention Day: 10 September**

World Health Organisation (WHO) estimates that over 8 lakh people are killed by suicide each year and those attempting suicide is many times more. This is ironical since suicide is preventable. Normally in heat of moment that lasts 30 seconds, such anti-life decisions are taken. It is to promote positive attitude towards life particularly among those vulnerable to suicide that WHO in association with International Association for Suicide Prevention (IASP) that World Suicide Prevention Day (WSPD) is being held since 2003 on 10 September every year.

Loneliness and non-sharing of vital concerns, especially common in urban areas, has created gaps in our relationship, which is a big problem. So, the theme of WSPD is quite befitting. 'Connect, Communicate, Care', these three words being at the helm of suicide prevention. Involving those who have lost a loved one to suicide or have been suicidal themselves can be helpful in suicide prevention efforts. Individuals, communities and organisations all have a responsibility here, open communication is vital to combat suicide.

Worse, the suicidal tendencies are also witnessed among children who are made by the parents and society to ever excel and stay atop, else there is no life! Such insinuations lead our young ones to resort to extreme step of ending their lives to escape ignominy of failure. It is essential that our young ones are discouraged from active rivalries in academic and other fields.

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**World First Aid Day: 10 September**

Every year, millions of people are hurt and many succumb to death, by injuries that could have been averted but for timely assistance. In most cases, chances of survival can be enhanced or chances of improvement increased by applying appropriate techniques immediately.

The International Federation of Red Cross and Red Crescent Societies (IFRC) organises World First Aid Day on second Saturday of September every year (this year on 10 September) endeavours to raise awareness on how first aid prevents injuries and save lives in routine and crisis situations. First aid training provides more than the knowledge and skills to effectively respond – it also provides the confidence to act when needed.

First aid provider is usually a non-expert and the technique consists of a series of simple and in some cases, potentially life-saving techniques. Any individual can be trained to perform it with minimal equipment. World over, more than 100 Red Cross and Red Crescent Societies organise events and ceremonies on this day to raise public awareness of role of first aid in saving lives. The IFRC believes that First aid is a humanitarian act that should be accessible to all including the most vulnerable, and an integral part of a wider developmental approach.

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**World Alzheimer’s Day: 19 September**

Every year on 21 September Alzheimer’s Disease International (ADI) has been organising World Alzheimer’s Day since 1994 to identify and highlight the challenges and hardships of Alzheimer’s disease and make efforts to enhance the health care and support for Alzheimer’s patients and their close ones. In 2015, there were approximately 48 million people worldwide with Alzheimer’s, a degenerating disease of the central nervous system. According to one estimate, by 2050, there shall be more than 100 million persons battling with Alzheimer’s.

Alzheimer’s is the most common form of dementia i.e. loss of memory and other intellectual abilities serious enough to interfere with daily life; 60 to 80 percent of dementia cases are attributed to Alzheimer’s disease. Common early symptom of Alzheimer’s is difficulty remembering newly acquired information because of changes in the part of the brain controlling the learning. People with memory loss are often unable to recognise that they have a problem.
Being a progressive disease, Alzheimer’s worsens with time and those with the disease lose the ability to carry on a conversation and respond. Those with Alzheimer’s survive an average of eight years after appearance of symptoms. The research for treatment continues although till date there is cure for Alzheimer’s.

**World Heart Day: 29 September**

Organised every year on 29 September since 2000, World Heart Day is the world’s largest platform of World Heart Federation to raise awareness about cardiovascular disease (CVD). World Heart Day was founded in 2000 to inform people around the globe that heart disease and stroke are the world’s leading causes of death, claiming 17.3 million lives each year. Globally, cardiovascular diseases stand atop as cause of death says World Health Organisation (WHO).

The message is disseminated on World Heart Day that not less than 80 percent of premature deaths from cardiovascular disease (CVD) could be avoided if four main risk factors – tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol – are controlled. The campaign of the day plead for such measures as eating more healthily, cutting down on alcohol and stopping smoking to improve health of heart and one’s overall well-being.

Government bodies and voluntary organisations hold and promote World Heart Day with such activities as fun runs, concerts, public talks, and sporting events. Awareness events conducted in 100-plus countries by the World Heart Federation include: Health check-ups, scientific discussions, stage shows, Exhibitions and Sports events, including walks, runs and fitness sessions.

**International Day of Older Persons: 1 October**

In regard of honour, respect and care for the elderly of the world they deserve for their contribution to the world, the International Day of Older Persons is observed on 1 October every year.

According to the United Nations (UN), "one of every 10 persons is now 60 years or older. By the year 2050, one of five will be 60 years or older." However, with little care for their well being by children, they often tend to lead a life of loneliness and neglect, at times bereft of basic facilities. Overlooked for employment, restricted from social services and stereotyped in the media, ageism marginalises and excludes older people in their communities, at the very time of life where enjoyment could be paramount.

WHO has revealed that older people with negative attitudes towards aging live 7.5 years shorter than those with positive attitudes, and have poorer recovery from disability and disease. Older people who feel they are a burden may also perceive their lives to be less valuable, putting them at risk of depression and social isolation. The 2016 theme of the International Day of Older Persons is “Take A Stand against Ageism”.

**World Mental Health Day: 10 October**

Mental Illness is endemic in both developed and developing countries rising at epidemic rates all around. WHO predicts that a fifth of India’s population will suffer from some form of mental illness by the year 2020. India is quite under-equipped to handle mental health issues on such a large scale as there are just 3,500 psychiatrists for the 20 million Indians with mental illness.

Organised by the World Federation for Mental Health (WFMH), World Mental Health Day raises public awareness about mental health issues and promotes open discussion of mental illnesses and investments in prevention, promotion and treatment services.

WHO believes that learning the basic principles of psychological first aid helps to provide support to people who are very distressed, hence the 2016 theme of the day “Psychological First Aid”. Efforts in support of the day will focus on basic pragmatic psychological support by people who find themselves in a helping role whether as health worker, teachers, firemen, community workers, or police officers. Psychological first aid covers both psychological and social support, in fact no mental health care system should consist of psychological first aid alone.
In India both the public and private sector health services co-exist. Unfortunately the involvement of public or government sector in health care is very less and about 50 percent of the inpatient and 60-70 percent of outpatient services in India are provided by private sector. Further, Times of India in 2009 reported that about 70 percent Indians seeking the healthcare from the private sector. The healthcare provided by either public or private healthcare setting constitute two principal components i.e. medical treatment and nursing care. The medical care nearly in every scenario gets the best attention but nursing care which is the most vital and basic of all the activities is being neglected off by most of the health care organisations. Nursing care is a critical facet of health care and has a significant impact on the overall outcome of patient care in a healthcare facility.

It is said, “Patient comes to hospital because of the doctors but only get discharged because of the hard work of the competent nurses; therefore we must understand the importance of nurses in success of a healthcare organisation”. Nursing care is extremely important for a good patient outcome. While physicians plan the treatment and perform the diagnostic and treatment procedures, it is the nurse who spends more time with the patient for caring and looking after all his needs throughout the hospital stay. Nurses provide the majority of direct care to patients and the success of patient care and the reputation of the hospital largely depend upon the extent of efficiency of nursing care being provided by the nursing staff.

In India to practice as a qualified nurse one should have minimum qualification of either a 3 or 3½ year diploma in general nursing & midwifery or a 4 year BSc Nursing degree from a recognised university or State nursing board; further, the person should be registered with the state nursing council as Registered Nurse (RN) and Registered Midwife (RM). The recruitment rules/policy of the government hospitals ensures that only qualified nurses are employed to provide the nursing care; but many private hospitals especially small size healthcare facilities (nursing homes) compromise with the qualification of nursing staff deployed in their settings which can severely affect the quality of care and may be detrimental to the patients. In a pilot project carried out in the US hospital to manage nursing staff shortage by unlicensed nurse assistants, their skills and performance was assessed; however most of them were poor in skills to perform nursing care. Author commented that this model is

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**Abstract**

In this exploratory study, conducted in 53 private nursing homes of randomly selected cities of Punjab State, a total of 218 participants were interviewed face-to-face. Data was analysed and presented using descriptive and inferential statistics. Surprisingly half of the subjects (50.9%) had not obtained any nursing qualification / training. Out of them, 60.3 percent were having lesser than higher secondary qualification, 9.9 percent were academic graduates and 29.7 percent were having paramedical training. Out of all the nurses working in these private healthcare facilities, 18.7 percent of them were not registered with State Nursing Council and only 10.1 percent were having nursing association membership because of the unawareness. Moreover, nurses and nurse quacks were enjoying nearly equal amount of pay wages, allowances and fringe benefits. It is concluded that significant numbers of nurse quacks are practicing nursing in private healthcare facilities. Therefore, it is recommended that either Government of India passes a bill on nurse practice Act or empowers the existing nursing statutory / regulatory bodies such as Indian Nursing Council to control this menace in a country where more than 75 percent people depend on private healthcare facilities.
unsuccessful and could be risky for safety of patients (Newhouse et al., 2007).

Due to the brain drain among nurses people have to compromise to seek the care from unqualified and unskilled nurse quacks, which could contribute to several unexpected adverse healthcare outcomes. Healthcare facilities deploy nurse quacks to perform nursing care to indoor and out-door patients. Further, nurses in healthcare facilities are paid very low wages, allowances and fringe benefits. Therefore, nurses do not stick to these healthcare facilities for longer time and this leads to poor nursing care.

**Review of Literature**

Blegen Mary A et al (2001) conducted a study on the relationships between the quality of patient care and the education and experience of the nurses providing care. A secondary analysis of data, collected in two previous studies of the relationship between nurse staffing (hours of care, staff mix) and the quality of patient care, was used to determine the relationship between nurses’ education and experience and the quality of care provided. Results showed that controlling for patient acuity; hours of nursing care, and staff mix, units with more experienced nurses had lower medication errors and lower patient fall rates. These adverse occurrence rates on units with more baccalaureate-prepared nurses were not significantly better (Blegen et al., 2001).

Lankshear Annette et al (2005) study assessed the evidence for a relationship between nursing workforce and patient outcomes in the acute sector through a review of international research produced since 1990 involving acute hospitals and adjusting for case mix. Twenty-two large studies of variable quality were included. They strongly suggested that higher nurse staffing and richer skill mix (especially of RNs) were associated with improved patient outcomes (Lankshear et al., 2005).

Person Sharina et al (2004) conducted a study on nurse staffing and mortality of patients with acute myocardial infarction in USA. Data of 1,18,940 patients was reviewed from 1994-1995 staffing levels was represented as nurse to patient ratios categorised into quartiles for Registered Nurses (RN) and for Licensed Practical Nurse (LPN). It was found that with RN staffing mortality was lower than that of the LPN staffing nurse patient hours at p<0.001. It was concluded that higher RN staffing levels were associated with lower mortality.

Unruh Lynn (2003) conducted a study on licensed nurse staffing and its adverse effects in hospitals of Pennsylvania (USA) to examine changes in licensed nursing staff from 1991 to 1997 and to assess the relationship of licensed nurse staff with patient adverse events. It was found that nurses’ acuity-adjusted patient load increased from 1991 to 1997. Number of Licensed nurses declined from 1994-1997. Greater incidence of nearly all adverse events occurred in hospitals with fewer licensed nurses. It was found that adequate licensed nurse staffing is important in minimising the incidence of adverse events in hospitals.

<table>
<thead>
<tr>
<th>Table 1: Socio-Demographic profile of the subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socio-demographic variables</strong></td>
</tr>
<tr>
<td>Age (in years)</td>
</tr>
<tr>
<td>18 – 22</td>
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<tr>
<td>23 – 27</td>
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<tr>
<td>28 – 32</td>
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<td>33 – 37</td>
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<tr>
<td>&gt;38</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Marital status</td>
</tr>
<tr>
<td>Unmarried</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Divorced / separated</td>
</tr>
<tr>
<td>Widow / widower</td>
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<tr>
<td>Religion</td>
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<tr>
<td>Sikh</td>
</tr>
<tr>
<td>Muslim</td>
</tr>
<tr>
<td>Christian</td>
</tr>
<tr>
<td>Habitat</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Urban</td>
</tr>
<tr>
<td>Type of family</td>
</tr>
<tr>
<td>Joint</td>
</tr>
<tr>
<td>Nuclear</td>
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<tr>
<td>Extended</td>
</tr>
</tbody>
</table>

Table 2: Educational background of the personnel performing nursing responsibilities in private nursing homes (N=218)

<table>
<thead>
<tr>
<th>Educational qualification</th>
<th>f (%)</th>
</tr>
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<tbody>
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<td></td>
</tr>
<tr>
<td>ANM</td>
<td>41 (38.3)</td>
</tr>
<tr>
<td>GNM</td>
<td>64 (59.9)</td>
</tr>
<tr>
<td>BSc (N)</td>
<td>02 (01.9)</td>
</tr>
<tr>
<td>≤ 10th Class</td>
<td>19 (17.1)</td>
</tr>
<tr>
<td>10+2</td>
<td>48 (43.2)</td>
</tr>
<tr>
<td>Academic graduates</td>
<td>11 (09.9)</td>
</tr>
<tr>
<td>Diploma in OT technology</td>
<td>19 (17.1)</td>
</tr>
<tr>
<td>Diploma in Medical Lab. technology</td>
<td>09 (08.1)</td>
</tr>
<tr>
<td>Diploma in Pharmacy</td>
<td>03 (02.7)</td>
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ANM: Auxiliary Nursing and Midwifery; GNM: General Nursing and Midwifery; BSc (N): Bachelors of Science Nursing; OT: Operation Theatre
Cho, Sung-Hyun et al (2003) conducted a study on the effects of nurses staffing on adverse effects, morbidity, mortality and medical costs in USA using multilevel analysis employed to examine the effects of nurse staffing and patient and hospital characteristics on patient outcome. It was found that an increase of 1 hour work by Registered Nurse (RN) per patient day was associated with an 8.9 percent decrease in the odds of pneumonia and 10 percent increase in RN proportion was associated with 9.5 percent decrease in the odds of pneumonia which was found to be statistically significant. It was concluded that having appropriate nurse staffing is a significant consideration in some cases.

Blegen, Mary A et al (1998) studied how nursing care delivery changes affect staff and organisational outcomes. The correlations among staffing variables and outcome variables were determined, and multivariate analyses, controlling for patient acuity, were completed. An unexpected finding was that the relationship between RN proportions of care was curvilinear; as the RN proportion increased, rates of adverse outcomes decreased up to 87.5 percent. Above the level, as RN proportion increased, the adverse outcome rates also increased. The study concluded that higher the RN skill mix, the lower the incidence of adverse occurrences on inpatient care units.

McCloskey JM (1998) described the relationship between 6 adverse patient outcomes (medication errors, patient falls, urinary and respiratory tract infections, skin breakdown, patient complications and mortality), total hours of nursing care and the proportion of these hours of care delivered by registered nurse with the use of hospital records. Data from every unit of a large university hospital for fiscal year 1993 were analysed. Correlations among staffing variables and outcome measures were determined and multivariate analysis was completed; controlling for patient acuity. It was found that as the RN proportion of care rose to 87.5 percent level it was related to lower incidence of negative outcomes. However, when RN proportion of care went beyond that level, the adverse outcome rates also increased.

**Objectives**

The present study attempted to identify the magnitude of nurse quackery in private healthcare facilities, and find out wages, allowances and fringe benefits provided to personnel performing nursing care in private healthcare facilities.

**Materials and Methods**

This exploratory descriptive study was conducted among 53 conveniently selected nursing homes from the six conveniently selected cities of Punjab state i.e. Amritsar (5), Faridkot (5), Jalandhar (12), Ludhiana (17), Patiala (10) and SBS Nagar (4). The study was approved by the Institutional Ethics Committee and a written informed permission was obtained from competent authority of each healthcare facility. A total of 218 subjects were interviewed for data collection, who were selected using convenience sampling technique. The data was collected using a self-structured interview schedule, which was validated by five experts from the field of nursing, hospital administration and research. The reliability of the data collection instrument was ascertained through test-retest method and using Karl Pearson’s correlation co-efficient formula, which was found to be r=0.9.

The data collection process started with identification of name and location of nursing homes through internet and related local people, followed by proportionally numbering and conveniently selecting the desired number of nursing homes. After obtaining the permission for data collection, an average of 4-5 nursing care providers were conveniently selected during morning shift to carryout face-to-face interview using a self-structured interview schedule. An informed written consent was obtained from each respondent and anonymity of the subjects and confidentiality of the information was assured. SPSS version 18.0 was used for statistical analysis and the data was analysed using descriptive and inferential statistics; p-value less than 0.05 was
considered significant.

Results

In the present study among 53 nursing homes, conveniently selected 218 subjects were interviewed.

Table 1 presents socio-demographic profile of subjects. It was found that 78.5 percent nurses and 64.9 percent non-nurses were in the age group of 18-27 years, while relatively more number non-nurses (14.4%) than nurses (4.7%) were above the age of 38 years. Majority of nurses (96.3%) and non-nurses (89.9%) were the female; while slightly more number of non-nurses was males as compared to the nurses (16.2% vs 3.7%). Nearly same number of nurses and non-nurses were in the unmarried (69.3% vs. 61.3%) and married (30.8% vs 36%) category; few of non-nurses were also the divorced (0.9%) and widow (1.8%). Majority of nurses were from the Sikh religion (72.9%), while majority of non-nurses were either Hindu (46.8%) or Sikh (45.1%) religion. Significant number of nurses (62.6%) were from the rural background, while nearly same number of non-nurses were from the rural (45.9%) and urban (54.1%) background. Significantly, more than half of nurses (56.1%) and nearly two third of non-nurses (63.1%) were from the nuclear family, while 38.3 percent nurses and 27.0 percent non-nurses were from joint family and only few nurses (5.6%) and non-nurses (9.9%) were from the extended family.

About half (50.9%) of the personnel performing nursing responsibilities were non-nurses (nurse quacks), while only 49.08 percent of them proclaimed that they are nurses (Table 2). Furthermore, out of 107 nurses only 1.9 percent were nursing graduates and 59.9 percent had diploma in general nursing and midwifery, while 38.3 percent of them were holding auxiliary nurse and midwifery qualification. Further, out of 111 non-nurses, majority of them were either senior secondary educated (43.2%) or matriculate or less educated (17.1%). A few of them were having paramedical technical diplomas and 2.7 percent were only Trained Dais performing nursing care responsibilities.

It was found that only 59.8 percent of associations were registered with State Nursing Council, while 10.3 percent were not aware whether they are registered or not (Table 3). Another 11.2 percent of them were freshers who have applied for registration. Surprisingly 18.7 percent of them were not registered with State Nursing Council even after obtaining a nursing qualification. Furthermore, only 10.3 percent of 107 nurses were the members of any professional nursing association i.e. Trained Nurses Association of India.

Table 4 represents wages and allowances paid to nurses working in private nursing homes. It was revealed that majority of nurses (82.3%) were paid less than Rs. 5000/- month, while 10.3 percent nurses were paid less than Rs. 2000/- month as salary and only 2.8 percent nurses were given salary of more than Rs. 10,000/- month. Similarly, majority of nurses (69.2%) were not given any annual increments; only 33 nurses got the annual increments, out of which significant number (17) received very less amount of annual increment i.e. less than Rs. 400/- year. Surprisingly more than half of the nurses (52.3%) were given uniform allowance and majority of them (88.8%) did not received ESI allowance. None of the nurses and non-nurses were in the unmarried (69.3% vs. 61.3%) and married (30.8% vs 36%) category; few of non-nurses were also the divorced (0.9%) and widow (1.8%). Majority of nurses were from the Sikh religion (72.9%), while majority of non-nurses were either Hindu (46.8%) or Sikh (45.1%) religion. Significant number of nurses (62.6%) were from the rural background, while nearly same number of non-nurses were from the rural (45.9%) and urban (54.1%) background. Significantly, more than half of nurses (56.1%) and nearly two third of non-nurses (63.1%) were from the nuclear family, while 38.3 percent nurses and 27.0 percent non-nurses were from joint family and only few nurses (5.6%) and non-nurses (9.9%) were from the extended family.
of the nurses were provided with any dearness allowances, house rent allowance, washing allowance, city compensatory allowance, medical allowance or education allowance etc.

Table 5 illustrates that majority of nurses (77.6%) were provided within the campus shared room stay facility. However, majority of them (78.5%) were not having the staff canteen facility in their institution. Majority of the nurses (90.7%) enjoyed the bonus during festival session and similar findings were observed for opportunity for the advance loan facility for the nurses (67.3%) in the institution.

Table 6 shows that majority of nurses (80.3%) worked between 5-8 hours during morning and evening shift, while significant number of nurses (17.8%) worked for a long morning and evening shift i.e. 9-12 hours shift. Some of the nurses (1.9%) worked for 12-24 hours during these shifts. During night shift most of the nurses (82.9%) worked for 12 hours, while there were 17.1 percent nurses who worked even 15-16 hours night shift. About 50 nurses were working in general wards, where majority of them (62%) were caring 5-10 patients in each shift, while 38 percent nurses were caring for 11-25 patients in a shift. A total of 21 nurses were posted in critical care units, among whom only 4.8 percent nurses were working with 1:1 ratio. More than one-third of the nurses (38.1%) were caring for 1:2 to 1:4 patients in each shift in an ICU. Surprisingly 57.4 percent nurses were caring for 5-10 patients admitted in ICUs during an average shift.

Discussion
Present study revealed that half (50.9%) of the personnel performing nursing responsibilities in private nursing homes were non-nurses and only 49.1 percent had obtained nursing qualification. Among non-nurse's 60.4 percent were educated up to senior secondary level only and were dealing with the precious lives of innocent public. This scenario exists in spite of the fact that the minimum qualification prescribed by the INC to work as a nurse is either a 3 or 3½ year Diploma in Nursing or a 4 year degree from a recognised University or State nursing board and registration with the state nursing council as Registered Nurse (RN). A study in which researchers looked at survival rates after surgery in 300 European hospitals, found the highest risk of death after surgery in hospitals where nurses with lower levels of education cared for the most patients. A 10 percent increase in the proportion of nurses holding a bachelor degree was associated with 7 percent lower surgical death rates. As for registration among nurses was concerned, only 59.8 percent were registered with state nursing council and a 10.3 percent were not aware whether they were registered with state council or not.

The present study reveals that majority (72%) drew a salary up to Rs. 5000/- month, whereas 8.7 percent (10.3% nurses) personnel were given salary d" Rs. 2000/- month which is very less than the salary prescribed by the sixth pay commission and minimum wages act 2009.

The findings of our study are also in contradiction with the Sixth pay commission pay scale of Rs. 9300-34,800. The Delhi labour ministry on 1 April 2013 had revised the minimum wages of candidates having graduate and higher qualifications. The new monthly minimum wages has been fixed at Rs. 10,218/- against Rs 9,594/- for candidates having graduation and higher qualifications. It is also in contradiction with the recommendations of Dr S Balaraman Committee (2012), which was appointed to conduct a study on the issues in the nursing sector in Kerala. They recommended Rs 12,900/- as basic salary for nurses in private hospitals. These findings are in contrast to Sixth pay commission recommendations wherein annual increments has been decided as 3 percent of basic pay + grade pay. Our findings are also in contrast to the Balaraman commission recommendation on annual increments of Rs. 250/- for staff nurses and Rs 300/- for senior staff nurses.

ESI allowance was given to a very few personnel (8.26%) only. Benefits provided under this scheme are medical, maternity, sickness benefits to personnel and their dependents in the ESI hospitals. Other allowances like washing allowance (Rs. 300 monthly according to Sixth pay commission), qualification allowance (should be provided accordingly as recommended by Sixth pay commission), nursing allowance (Rs. 4000/- monthly according to Sixth pay commission), special allowance (As per Sixth pay commission, should be suitably paid to person working in special units like ICU, CCU, NICU, OT, dialysis, burn.

Fringe benefit like in-campus housing was provided to 67.9 percent personnel working in nursing homes under study. Provident fund facility was availed by only one third (30.3%) personnel while rest was not provided this. This finding is also in contrast to Punjab government rules which recommends contributory Provident Fund of 10 percent of basic pay + grade pay.

In our study out of 50 nurses working in general wards, 38 percent nurses were caring for 11-25 patients in a shift. A total of 21 nurses were posted in critical care units, among whom only 4.8 percent
nurses were working with 1:1 ratio. More than one third of the nurses (38.1%) were caring for 1:2 to 1:4 patients in each shift in an ICU. Surprisingly 57.4 percent nurses were caring for 5-10 patients admitted in ICUs during an average shift. Every extra patient added to a nurse’s workload increases the risk of death within a month of surgery by 7 percent according to data from 300 European hospitals.

One limitation of our study is that the investigator relied on the information provided by the respondents without verifying the facts. So there may be possibility that some of the nurse quacks falsely claimed themselves as nurses.

**Conclusion**

The present study concluded that a significant population of nurse quacks existed in the healthcare settings. Hence, significant number of nursing personnel working in the private setting are either unqualified or under qualified and are not licensed and registered to practice as nurse. The salary, leaves and fringe benefits provided to nursing personnel in these institution are not as per recommendations by state and central government.

**Recommendations**

Central government must bring private clinical establishment act bill in enforcement at earliest possible to curb such unscrupulous practices to safe guard the rights and health of people. All states must implement the Clinical Establishment Act guidelines in concurrence with as recommendations of Government of India to have uniformity in implementation. Indian Nursing Council (INC) Act 1947 must be revised to empower INC to also regulate nursing services provided at health care facilities in India. Centre and state governments must establish a regulatory body to register and monitor health care facilities, infrastructure, personnel and facilities provided at private health care settings. The nursing associations like Trained Nurses Association of India (TNAI) should take initiatives for public awareness campaign to promote awareness among people about importance of nursing care provided by qualified nurses during their hospitalisation in health care facilities for the safety of people.

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Effect of Mindfulness Meditation on the Quality of Life of Alcoholics in a Selected De-addiction Centre at Mangalore, Karnataka

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Abstract

The aim of the study was to determine the effect of Mindfulness Meditation on the Quality of Life (QOL) of alcoholics. A quantitative experimental evaluative approach was adapted and pre-experimental research design (one group pre-test – post-test design) was used. The sample consisting of 30 alcoholics in the selected de-addiction centre chosen by purposive sampling technique. Tools used were baseline proforma, QOL and Mindfulness Meditation skills rating scales. The data were analysed using paired ‘t’ test, ANOVA for repeated measures, Karl Pearson co-relation co-efficient and chi-square. The study revealed that mean post-test QOL score (101.57±13.7) was greater than the mean pre-test QOL score (121.70±10.02). There was a significant difference between the pre-intervention and post-intervention QOL scores (t 29=8.718; p<0.05). The mean of 15th day of Mindfulness Meditation Skill score (68.13±4.0) was greater than the mean of 5th day (55.53±7.06) and 10th day (60.80±4.7) scores. There was a significant difference between the three different days of assessment (F=89.80, p<0.05). This indicates that the skill in Mindfulness Meditation increases when the number of days of practice progresses. There was a moderate positive correlation between post-interventional QOL and 15th day Mindfulness Meditation skill level (r=0.57). This indicates that there is a significant relation between post-intervention QOL score and 15th day Mindfulness Meditation Skill scores. There was no association between pre-intervention QOL and selected baseline characteristics. The result showed that Mindfulness Meditation had a statistically significant positive effect on the QOL of the alcoholics.

Alcoholism is an all-pervasive ailment; it is a disease as listed in DSM-IV of the American Psychiatric Association. It is a disease of relationships or attachment to other things. It is also a disease of attitudes, reinforcing that being substances (alcohol) free without commensurate change of lifestyle or spiritual awakening, the net result is always relapsing into dysfunctional use (Jeralani, 2005).

Alcoholics experience a lower Quality of Life (QOL) than their non-alcoholic counterparts. A study assessed whether the perceived QOL differed between alcoholics and non-alcoholics. The patients admitted in an urban-based hospital were screened for alcoholism using CAGE questionnaire. Quality of Life scores indicated that alcoholics experienced a lower QOL than non-alcoholics (Welsh et al, 2004).

In India, alcohol addiction is common and de-addiction has been very successful compared to the abuse of other substances. Many addiction treatment options are available in different medical streams for in rehabilitation, referred to as “recovery” or staying sober, outpatient and inpatient programmes are available. Behavioural change does not happen in one step for addictive behaviour.

Fernros et al (2008) conducted a study for improving QOL using compound mind-body therapies. The tool used was Health-related Quality of Life (HRQOL). The scores in the experimental group showed significant changes in items (p<0.01), viz. general health perceptions, emotional wellbeing, cognitive functioning, sleep, pain, role limitations, family function, social, marital and physical function. The study concluded that the group of men and women had improved their HRQOL after the course of practice.

Mindfulness is based on Buddhist philosophy, however it is not a religion, neither is any religious belief necessary to its practice. Mindfulness was initially developed by Jon Kabat-Zinn to assist him in his work with people suffering from a wide range of...
medical problems, ranging from chronic pain to cancer and heart disease. Zinn (1995) showed that most people experienced benefit from the programme, and was likely to continue with their practice in some form after the course ended. Research has demonstrated that their overall QOL, and for those with terminal illness their chance of remaining in remission was significantly improved.

**Objectives**

The aim of the present study was to determine the effect of Mindfulness Meditation on the Quality of Life of the alcoholics. The specific objectives were: (a) to assess the QOL of alcoholics before and after the implementation of Mindfulness Meditation as measured by QOL scale; (b) to assess the Mindfulness Meditation skills of alcoholics after the implementation of Mindfulness Meditation; (c) to assess the effectiveness of the mindfulness meditation before and after the intervention; (d) to determine the relationship between the QOL of the alcoholics and Mindfulness Meditation skills; and (e) to determine the association between the QOL and other selected variables.

**Materials and Methods**

The present study is based on the “Human Becoming Theory.” This theory was introduced by Rosemarie Rizzo Parse in 1981 (Tomey & Alligood, 2000).

An evaluative quantitative experimental research approach was adopted. Pre-experimental one group pre-test – post-test design was used for the study. The dependent variable was Quality of Life of the alcoholics and the independent variable was Mindfulness Meditation (MM). Extraneous variables were the age of the alcoholics, education, occupation, religion, marital status, family income, place of residence years of alcoholism, type of family, and circle of friends, amount of alcohol consumption, and facilities in the institution like provision of medications, counselling, yoga and other teaching sessions.

**Sample and sampling technique:** After the screening process 30 alcoholics, who had fulfilled the sampling criteria were selected for the intervention. Purposive sampling technique was used. The researcher visited all the alcoholics admitted in de-addiction centre during 30 days period and were invited to participate; hand-picked the subjects for screening of alcohol withdrawal symptom and then selected the sample according to the inclusion and exclusion criteria. The subjects selected had mild withdrawal or no withdrawal symptom. Other sampling criteria also met for the selection of samples.

**Tools and measurement:** (a) Alcohol withdrawal symptom screening tool; (b) Tool 2: Baseline proforma; (c) Tool 3: Quality of Life scale; (d) Tool 4: Mindfulness Meditation Skill scale. Validity of the tool was done by 18 experts and Reliability of the QOL status tested by using Split Half Method. Karl Pearson Coefficient of Correlation was used to find out the reliability. Spearman Brown Prophecy formula was used to find out the reliability of full test. The reliability was found to be 0.94 (r=0.94). The reliability of Mindfulness Meditation Skill level tested by using test-retest method and the reliability was found to be 0.94 (r=0.94) by Spearman coefficient of correlation. Alcohol withdrawal symptom scale was tested by inter-rater method and the reliability found to be 0.96 by Spearman rank correlation.

The study was conducted in the Vailankanni Ward at the Father Muller Medical College Hospital, which is a 1050-bedded multi-specialty hospital.

**Mindfulness Meditation Session:** The researcher underwent one month theory and practical course on Mindfulness Meditation. The recorded cassette and CD was prepared by the help of the yoga therapist (naturopathy yoga centre) and modified by a clergyman and musician in the voice recording studio in three languages (English, Kannada, and Malayalam).

The recorded audio programme about Mindfulness Meditation consisted of the genesis of meditation, benefits, guidelines to practice and some tips to promote the motivation in the participants, followed by step by step instruction for the practice, silence, positive thoughts and ended with silent prayer to God. The programme was recorded with the help of background music throughout except at the time of instruction to practice. The participants were allowed to discuss the clarifications, obstructions, doubts about the Mindfulness Meditation as well as about rating of Mindfulness Meditation Skill scale after the practice session.

**Pilot Study:** The pilot study was conducted in the same setting among 10 alcoholics after obtaining formal permission from the concerned. The study was found to be feasible and practical.

**Data collection process:** The alcoholics who fulfilled the sampling criteria were identified. The purpose of the study was explained to them and written consent obtained. The participants were asked to think about their life during the past 2 weeks and pre-test of QOL along with their baseline proforma was administered and the participants were asked to come...
for the meditation practice daily in the morning or evening. A brief introduction about the timings and practice guidelines of Mindfulness Meditation was given to the subjects. The sessions lasted for 20 minutes and continued daily for a 3 weeks duration. On day 5, day 10 and day 15, following the completion of the recorded audio programme, post-test of Mindfulness Meditation was given to them. The sessions lasted for 20 minutes and continued daily for a 3 weeks duration. On day 16, post assessment QOL obtained by requesting them to evaluate their past 2 week period of life and it lasted for half an hour for each individual. The data collected were analysed according to the objectives and hypothesis of the study.

**Results**

Less than half the subjects (40%) were in the age group of 41-50 years and one-fourth of the subjects (26.7%) between 31-40 years. Majority of the samples (60%) were married, from nuclear families (56.7%). Hindu (70%), half of the subjects (50%) were from rural areas and less than half of the subjects (40%) were educated up to primary school.

**Duration of Alcohol Consumption:** The data on the duration of alcohol consumption (Fig 1) reveal that about one-third of the subjects (36.7%) had addiction more than 20 years and 33.3 percent had addiction between 10-20 years duration.

The study revealed that mean post-test QOL score (101.57±13.7) was greater than the mean pre-test QOL score (121.70±10.02). There was a significant difference between the pre-intervention and post-intervention QOL scores (t29= 8.718; p<0.05). Area wise mean post-test score was higher than the mean pre-test scores in all domains. The significant improvement was seen in the psychological (17.75%) and physical functioning (16.18%) respectively. This indicates that Mindfulness Meditation was effective in changing the QOL of the alcoholics. The mean of 15th day of Mindfulness Meditation Skill score (68.13±4.0) was greater than the mean of 5th day (55.53±7.06) and 10th day (60.80±4.7) scores. There was a significant difference between the three different days of assessment (F=89.80, p<0.05) indicating that the skill in Mindfulness Meditation increases when the number of days of practice progresses. Significant improvement was seen in the areas of ‘self-awareness’ (20.8%) and ‘bodily sensations’ (20.75%). There was a moderate positive correlation between post-interventional QOL and 15th day Mindfulness Meditation skill level (r=0.57) indicating that there was a significant relation between post-interventional QOL and 15th day Mindfulness Meditation skills. There was no association between pre-intervention QOL and selected baseline characteristics.

Figure 2 depicts that less than half of subjects (43.3%) were not at all near QOL, 40 percent were a little near QOL, before the intervention. 40 percent-age of the subjects attained almost near QOL, and one-third of the subjects (30%) attained very near QOL after the intervention, while none of them attained QOL.

Table 1 shows that the computed t’ value (t=8.718; p<0.05) was greater than the tabled value (t29= 2.04, p<0.05) implying that there was a significant difference between the pre-intervention and post-intervention scores. Hence the null hypothesis was rejected and research hypothesis was accepted and inferred that there was a significant difference between the pre-test and post-test scores. The null hypothesis was tested using repeated measure analysis of variance (ANOVA f-test).

Table 2 shows that the mean Mindfulness Meditation Skill on the 15th day score was higher than the mean of the 5th and 10th day scores. The computed ‘f’ value (ANOVA for repeated measures, F=89.80, p<0.05) was greater than the tabled value (f2, 58=3.15, p<0.05) which shows that there was a significant difference between the 15th day score from that of the 5th and 10th day scores. Hence the null hypothesis was rejected and the research hypothesis was accepted. This indicates that the skill in Mindfulness Meditation increased when the number of days progressed.

Figure 3 shows that there was moderate positive correlation between post-interventional QOL and 15th day Mindfulness Meditation Skill level (r=0.57). There was no significant association between pre-intervention QOL and selected variables such as age, education, and occupation marital status, type of family, place of residence, family
support, and duration of alcohol consumption at 0.05 levels. Hence the null hypothesis was accepted and research hypothesis was rejected. This shows that there was no significant association between pre-interventional QOL and selected baseline variables.

### Discussion

**Sample Baseline Characteristics:** In this study, less than half of the subjects (40%) were in the age group of 41-50 and one-fourth (26.7%) aged 31-40 years. Majority of the samples (60%) were married from nuclear families (56.7%), 70 percent were Hindu and less than half (40%) were educated up to primary school. Half the subjects (50%) were from rural areas.

**Consistent similar studies:** In a retrospective study done at the de-addiction clinic at Kasthurba Hospital, Manipal, Chauhan et al (2004) found that 85 percent of the samples were married, 82 percent were Hindu and 62 percent belonged to nuclear families, the mean age of the sample was 43.11 (SD=11.46) predominantly male (98%). In another study for substance-dependent women attending a de-addiction centre in North India Grovers et al (2005) reported that the typical subjects (63%) were married, belonged to nuclear families (60%) and more than half (54%) of the subjects educated up to high school.

Some of the baseline characteristics of the present study were congruent with the findings of previous studies indicating that addiction for alcoholism was more prevalent in married people, more chances in nuclear families and more for below high school educational status and also prevalent in Hindu religion.

**Quality of Life Status of Alcoholics:** The mean pre-test QOL score was greater than the post-test QOL score (pre-test=101.57, post-test=121.70, p=0.000) and the Mean percentage (72.55% to 86.93%) QOL score increased after the intervention. The highest mean difference observed in the area of psychological functioning (7.1%, p<0.05) and physiological functioning (4.53%, p=0.05). Less than half of the subjects (43.3%) were in not at all near QOL, 40 percent were in a little near QOL before the intervention; 40 percent of the subjects attained almost near QOL, and one-third of the subjects (30%) attained very near QOL after the intervention, whereas none of them attained QOL. It was based on pre-experimental design without a control group and without clinical control.

A pilot study was conducted on QOL and health of a 5-day care using a course with teachings in philosophy of life, psychotherapy, and body therapy, for patients with alcoholism (Pal et al. 2004). It was based on pre-experimental design without a control group and without clinical control. The group had low QOL, numerous health problems and alcohol dependency in spite of treatment with Antabuse (disulfiram). The study showed an increase in QOL from 57.6 percent before the course to 69.4 percent, three months after the course or an improvement in QOL, self-perceived mental health and satisfaction in health of 11.8 percent, 24 percent and 11.1 percent respectively.

**Effect of Mindfulness Meditation on alcoholics:** The pre-test QOL score was greater than the post-test QOL score (t=8.71, p<0.05) and the mean percentage (72.55% to 86.93%). QOL score increased after the intervention. The significant change observed in the area of psychological functioning (t=6.80, p<0.05) and physiological functioning (t=5.54, p<0.05).
A comparative study of brief intervention in alcohol use based on FRAMES of drinking patterns and QOL conducted in Delhi to evaluate readiness to change drinking pattern and QOL. The repeated measures of analysis of variance (ANOVA) showed a significant improvement in physical (F=5.4, p=0.000) and psychological (F=4.99, p=0.000) domains.

A cross-sectional survey to evaluate the impact of excessive alcohol consumption on the health-related Quality of Life of patients receiving methadone treatment for opioid dependence in out-patient clinics of south-east of England. AUDIT-positive patients reported more physical (p=0.02) and psychological (p=0.034) health problem and poorer QOL (p=0.008) with an estimated effect size of 0.46 and concluded that excessive alcohol consumption may be associated with a distinctive pattern of QOL impairment in methadone patients.

Comparison of Mindfulness Meditation Skills of subjects on 3 different days: The mean of Mindfulness Meditation Skill on the 15th days score was higher than the mean of the 5th and 10th day scores. The computed 't' value (ANOVA for repeated measures, F2, 58 (3.15)=89.80, p<0.05) was greater than the tabled value which showed that there was a significant difference between the 15th day score and that of the 5th and 10th day scores. There was gradual progress in the Mindfulness Meditation Skills of the subjects. On 5th intervention day majority of the subjects (60%) showed good MMS and on day 10 it increased to 80.3 percent whereas majority (86.7%) of subjects had very good Mindfulness Meditation Skills on day 15 of intervention.

In a randomised control study on 144 patients, training in Mindfulness Meditation for patients with stress and chronic illness conducted in Norway to manage stress and chronic illness over the last 25 years. Effect size was highest (Cohen’s d in the range of 0.5 to 0.6) for mental symptom and mental function. This gives a tool to improve their health and QOL by increased understanding and ability to deal with one’s own health and the patients seems to see themselves and their lives in a new way. This method may be suitable for schools and universities in addition to patient education centres (Senbanjo et al, 2006).

Relationship between post intervention QOL and 15th day of Mindfulness Meditation Skills: The present study showed a moderate positive correlation between post interventional QOL and 15th day Mindfulness Meditation Skill level (r=0.57, p<0.05).

Association between pre-intervention QOL and selected based characteristics: There was no association between pre-interventional QOL rating score and variables such as age, education, occupation, family support, type of family, place of residence, duration of alcohol consumption at 0.05 level of freedom. This shows that there was significant association between pre-interventional QOL and selected variables.

Implications in the Nursing Areas

Nursing education: The students should be made aware of these systems in health care and they should be encouraged to learn Mindfulness Meditation technique to overcome daily hassles, negative emotions, tensions, to improve QOL, and to attain self-awareness and actualisation. Alternative therapies should be included in the curriculum for increasing the knowledge in this area. Consideration should be given to include clinical experience in providing and encouraging Mindfulness Meditation in de-addiction centres.

Nursing administration: The nurse administrator should make arrangement for necessary requirements for meditation programme to the patients during their stay in the de-addiction centre, like provision of CD player/tape recorder, mats for practicing meditation, and a hall with good ventilation etc.

Nursing practice: Those working in de-addiction centres have to take care of the alcoholics to enhance motivation, self-awareness and prevention of relapses in very many ways. Mindfulness Meditation can be a remedy for this goal and the nurse has to take initiative.

Nursing research: There is also a great need for research in the area of alcoholism and holistic practices like transcendental meditation, motivational skill training, social skill training, and positive thought sessions in the de-addiction centres.

Limitations: Small number of subjects (30) participated in this study restricted the generalisation of results. The investigator had no control on events that took place between pre-test and post-test of the intervention.

Recommendations

The same study can be conducted on a larger sample over a longer period of time which might yield more reliable results. A similar study could be replicated with a control group. A comparative study can be conducted between Mindfulness Meditation and transcendental meditation. A study can be conducted on the effect of Mindfulness Meditation on wellbeing of nursing students, teaching faculty or for patients with other disease conditions.
Conclusion
Mindfulness Meditation is a simple non-invasive cost effective method that can be used for improving the Quality of Life of the alcoholics without any adverse effects. It can be routinely practiced in all the de-addiction centres with personnel or material assistance or the alcoholics by themselves can practice it at any time without any assistance.

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