IJSN

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Articles

Hyperlipidemia: Primary Prevention Measures to Lower the Risk of Cardiovascular Disease **5**
Pramilaa R.

Standard Precautions and Safe Practices for Patient Care Management **11**
Malarvizhi S., S. Amirtha Santhi

Health: Perceived by Spirituality and Religion **17**
Alex Zacharia C.

Effectiveness of Meditation on Stress among Student Nurses **23**
Jayaprakash S.

Guidelines for Authors **31**

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Hyperlipidemia: Primary Prevention Measures to Lower the Risk of Cardiovascular Disease

Pramilaa R.

Abstract

Hyperlipidemia is a heterogenous group of disorders characterized by an excess of lipids in the blood stream. Hyperlipidemia is a risk factor for coronary disease and platelet reactivity is increased with high cholesterol levels in blood suggesting a prethrombotic risk. It is recognized as a risk factor for ischemic heart disease and coronary mortality. The World Health Organization estimates that almost 20% of all strokes and over 50% of all heart attacks can be linked to high cholesterol. Lowering blood cholesterol levels reduces coronary event among individuals with or without coronary artery disease. This article focuses on primary prevention strategies that when observed can maintain blood cholesterol levels thereby decreasing the risk of cardiovascular diseases. The positive aspect in managing this condition is that it can be entirely controlled with strict adherence to lifestyle modification. It is highly important for every individual to adhere to these preventive aspects to cut the risk of cardiovascular disease.

Keywords: Hyperlipidemia; Cardiovascular disease; Cholesterol.

Introduction

Cardiovascular diseases (CVD) are the major cause of morbidity and mortality in our society with hyperlipidemia contributing significantly to atherosclerosis. CVD in developed countries continue to grow at an epidemic proportion. There are a significant number of young adults with no clinical evidence of CVD but who have two or more risk factors that predispose them to CV events and death. Hyperlipidemia has been closely linked to the pathophysiology of heart disease and is a key independent modifiable risk factor of CVD. The rate of hyperlipidemia is not only high in developed countries but also in developing countries as a result of occidentalization of diet and lifestyle change.[1] In 2002, World Health Organization reported hyperlipidemia is associated with more than half of the global cause of ischemic heart diseases. Estimation of the prevalence of hyperlipidemia ensures proper health control planning actions for all health sectors for the prevention of CVDs.[2]

It is imperative that primary prevention efforts should be initiated at a young age to avert decades of unattended risk factors. Hyperlipidemia had been linked to CVD a century ago. The increased levels of Low Density Lipoprotein (LDL) and low levels of High Density Lipoprotein (HDL) are well known risk factors of CVD in all groups. The new National Cholesterol Education Program (NCEP)/Adult Treatment Panel III (ATP) guidelines have come as to wake up call to clinicians about primary prevention of CVD through strict lipid management and multifaceted risk management approach in the prevention of CVD.[3]

Basic Description of Lipid and Lipoprotein

Lipid is the scientific term for fats in blood. Lipid performs important functions in the body when they are present in normal levels and it causes health problems when their levels are abnormally high. Cholesterol is a fat like substance that is present in cell membranes and is a precursor of bile acids and steroid hormones. Cholesterol travels in blood in distinct particles containing lipids and proteins. Three major classes of lipoproteins are found in serum of a

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fasting individual such as: LDL, HDL and Very Low Density Lipoprotein(VLDL).

LDL makes up 60 -70% of total serum cholesterol. It is major atherogenic lipoprotein and has long been identified by NCEP as the primary target of cholesterol lowering therapy. HDL cholesterol normally makes up 20 -30% of total serum cholesterol. VLDL is a trigyceride-rich lipoproteins but contains 10 -15% of the total serum cholesterol. A fourth class lipoproteins are chylomicrons, triglyceride- rich lipoprotein formed in the intestine from dietary fat and appear in blood after a fat-containing meal.

The term hyperlipidemia means high lipid levels in blood i.e., LDL is above 130mg/dl; HDL is below 60 mg/dl; and triglyceride levels are greater than 150mg/dl. Coronary angiographic trials have demonstrated that cholesterol lowering slows the progression of coronary atherosclerosis and may even induce regression. Studies suggest that reduction in coronary events seen in angiographic trials is greater than would be anticipated for the degree of angiographic improvement induced by cholesterol lowering. Plaque stabilization due to decrease in the lipid content of the lesions most likely to rupture and improved endothelial function are two mechanisms that could partly account for reduction in coronary events with cholesterol lowering. Another mechanism is a decrease in the tendency toward platelet thrombus formation with cholesterol lowering.[4]

Progression of Hyperlipidemia to CAD

Cholesterol comes from two sources: the body and food; either one can contribute to high cholesterol. Some people inherit genes that trigger too much cholesterol production and the remaining population it is mainly caused through diet. Saturated fat and cholesterol are found in animal- based foods including meat, eggs and dairy product made up of milk. Genetic make up is reflected in family history of high cholesterol or heart disease may result in high cholesterol, although diet is carefully taken coupled with exercise.

All individuals possess cholesterol in their blood, when LDL levels become high in the blood, the excess can accumulate on the walls of the arteries. This build-up of cholesterol and other substances called plaque can narrow the artery. When plaque is formed in the coronary arteries that supply blood to heart muscle, it is termed as coronary artery disease. Next consequence of plaque is that when it breaks, it can form a clot. If a clot lodges in an artery and completely impedes that blood supply, the cells become deprived of nutrients and oxygen and ultimately lead to cell death.[5]

Clinical research studies confirm the disastrous consequences of high cholesterol levels. Coronary heart disease developed with great consistency in patients with a ratio of total cholesterol to HDL cholesterol of more than 4.5.[6] Nitric oxide is involved in dilating blood vessels to provide more blood to heart. Nitric oxide tablets are extremely effective for angina patients. DMA inhibitor of nitric oxide synthesis. Chronic hypercholesterolemia stimulates DMA production through elevation of lipid peroxides and contributes to the development of atherosclerosis.[7] In the long term, systolic blood pressure, high cholesterol levels and smoking were associated with an increased risk of carotid stenosis in the elderly population. Cholesterol levels may be associated with endothelial function, thus potentially contributing to the increased risk of macrovascular disease due to elevated cholesterol levels.[8]

Hypercholesterolemia is associated with an enhanced platelet thrombus formation on an injured artery, increasing the propensity for acute thrombosis. Platelet thrombus formation at both high and low shear rates decreased as total and LDL cholesterol levels were reduced with pravastatin. Cholesterol lowering may therefore reduce the risk of acute coronary events in part by reducing the thrombogenic risk.[9]

Elevated levels of blood lipids are well-documented risk factors for CVD. Current classification schemes and treatment levels for hyperlipidemia are based on the NCEP/ATP III guidelines. Extensive research over the past decade has raised the question whether or not ATP III guidelines are sufficiently aggressive. New guidelines from ATP IV are expected to be released in the near future, but in the mean time physicians are faced with uncertainty about how low to target LDL cholesterol whether to pharmacologically treat HDL cholesterol and triglyceride levels and how best to achieve target goals.[10]

Primary Prevention Measures to Lower the Risk of CVD

The American Heart Association recommends all adults age 20 or older have their cholesterol and other traditional risk factors checked 4-6 years. Cholesterol score is calculated using following equation: HDL + LDL + 20% of triglyceride level. A total cholesterol score of less than 180 mg/dl is considered optimal.[11]

Statin Therapy[12]

- Before starting lipid modification therapy for the primary prevention of CVD, take at least one blood sample to measure lipid profile. This includes measurement of total cholesterol, HDL, LDL, and triglyceride concentrations.
- Offer atorvastatin 20 mg for the primary prevention of CVD to people who have a 10% or greater 10- year risk of developing CVD. Estimate the level of risk using QRISK2 assessment tool.
- Start statin treatment in people with CVD with atorvastatin 80 mg and it is used in lower doses when potential drug interactions; high risk of adverse effects; and patient preference.
- Measure cholesterol levels once in three months. If 40% reduction in cholesterol levels are not achieved then discuss adherence and timing of dose; optimize adherence to diet and lifestyle measures; and consider increasing dose if started on less than atorvastatin 80 mg and the person is judged to be at higher risk because of co-morbidities, risk score or using clinical judgment.
- Before starting statin treatment baseline blood tests and clinical assessment and treat comorbidities. Include all of the following in the assessment:

- Smoking status
- Alcohol consumption
- Blood pressure
- Body mass index or measure of obesity
- Total cholesterol
- HbA_{1c}
- Renal function and Glomerular function rate
- Transaminase level
- Thyroid stimulating hormone

A meta-analysis of the use of statins in primary prevention has been performed: seven trials with 42,848 patients were included. The results showed that in patients without CVD, statin therapy decreases the incidence of major coronary and cerebrovascular events and revascularizations but not coronary heart disease mortality and overall mortality.[13]

Dietary Precautions[12]

- Read food labels and choose foods with low cholesterol and saturated trans fat. The American Heart Association recommends aiming for a dietary pattern that limits saturated 5- 6% of daily calories and reduces the percent of calories from trans fat.
- Reduce saturated fat intake to 7% of daily calories
- Reduce fat intake to 25- 35% of daily calories
- Limit dietary cholesterol to less than 200 mg per day
- Limit intake of red meat and dairy products made with whole milk to reduce saturated and trans fat. Choose skim milk, low fat dairy products. Limit fried food, and use of healthy oil such as vegetable oil.
- Increase amount of fiber intake. It can lower cholesterol levels by 10 percent.
- Other foods that can help control cholesterol include cold- water fish such as mackerel, sardines and salmon. These fish contain omega-3 fatty acids that may lower triglycerides. Soy beans, soy nuts and many meat substitutes contain a powerful antioxidant that can lower LDL. A supplement known as psyllium increases soluble fiber intake. Psyllium helps absorb water and cholesterol from intestines and may improve the ratio of HDL to LDL.
- Advise to choose whole grain varieties of starchy food; reduce intake of sugar and food products containing refined sugars including fructose; eat at least 5 portions of fruits and vegetables per day; and eat at least 4 – 5

portions of unsalted nuts, seeds and legumes per week.

Exercise[12]

- Exercise makes up another component in primary prevention of hyperlipidemia. Walking briskly for 20-30 minutes most days of the week. Exercise can lose weight, relieve stress, raise HDL, and lower LDL and triglycerides. Regular checking of weight is essential.
- Advice to do muscle strengthening activities on two or more days a week that work all major muscle groups in line with national guidance for the general population.
- Encourage to perform moderate- intensity physical activity in case of co-morbidities. Also advice about physical activity should take into account the person's needs, preferences and circumstances.

Patient Education[12]

- Explain the risks associated with hyperlipidemia such as heart attack, stroke/ disability.
- Suggest strategies to minimize damage caused by alcohol and nicotine. Men should not regularly take more than 3- 4 units a day and women should not regularly drink more than 2-3 units a day.
- Offer the intensive support service to the population who want to quit smoking
- Support to work with them to achieve and maintain healthy weight
- Emphasize importance of adhering to treatment regimen. Utilize motivational interviewing to promote readiness for treatment and list referral services.

Conclusion

The burden of hyperlipidemia is alarming when considered by the perspective of morbidity and mortality. And it is one of the four established conventional risk factors for CVDs besides cigarette smoking, diabetes mellitus, and high blood pressure. A wealth of knowledge has evolved over the past half century linking atherosclerotic changes to CAD and stroke. Blood lipid abnormalities have been identified as a primary risk factor. Although lifestyle changes can prevent or slow down the progression of CAD, pharmacological management is frequently required. With physical exercise, balanced diet, stop smoking along with medication can control blood cholesterol at a large extent and all individuals who are susceptible should take the aforementioned measures strictly and thus prevent them from coronary events and death.

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Standard Precautions and Safe Practices for Patient Care Management

Malarvizhi S.*, S. Amirtha Santhi**

Abstract

Standard precautions are meant to reduce the risk of transmission of blood borne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions to be used, as a minimum, in the care of all patients in the hospital and community settings. Hand hygiene is very important in standard precautions and one of the most effective methods to prevent transmission of pathogens associated with health care. Along with hand hygiene, the use of personal protective equipment should be used according to the risk assessment and the extent of contact anticipated with blood and other body fluids, or pathogens. In addition to practices carried out by health workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health-care settings. The control of spread of pathogens from the source is key to avoid transmission.

Keywords: Standard precautions; Safe practices; Nosocomial infection.

Introduction

Standard precaution and safe practices for patient care in the hospital are not new and really we are already doing in our daily nursing practices, but it never hurts to be reminded that patient safety is our first concern and should be taken seriously. It includes errors of not doing (omission) or errors of doing (commission), it also includes faults and mistakes of the patient care processes (involving drugs and equipments) or the environment where these processes are carried out. 5-10 percent of patients admitted to acute care hospitals acquire one or more nosocomial infection.[6]

Definition: Standard Precautions

Standard precautions are a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. These measures are to be used when providing care to all individuals, whether or not they appear infectious or symptomatic.[7]

Important Points To Be Followed: (WHO)[8]

- Promotion of a safety climate is a cornerstone of prevention of transmission of pathogens in health care.
- Standard precautions should be the minimum level of precautions used when providing care for all patients.
- Risk assessment is critical. Assess all health-care activities to determine the personal protection that is indicated.
- Implement source control measures for all persons with respiratory symptoms through promotion of respiratory hygiene and cough etiquette.

Standard Precautions[1]

1. Contact Precautions
2. Airborne Precautions
3. Droplet Precautions

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4. Three more elements have been added to standard precautions. They are:
   - 4.1 Respiratory hygiene/cough etiquette
   - 4.2 Safe injection practices
   - 4.3 Use of masks for insertion of catheters or injection into spinal or epidural areas.

1. Contact Precautions

- Clean, non-sterile gloves are usually adequate for routine care.
- Use gloves before providing care to patient.
- Change gloves after contact with infective material.
- After providing care, remove gloves and wash hands.
- Follow proper use of protective gown in case of direct contact with patient with potentially contaminated environmental surfaces and observe hand hygiene.
- Limit the movement or transport of the patient from the room.
- Make sure any infected or colonized areas are contained or covered.
- Ensure that patient care items, bedside equipment and frequently touched surfaces receive daily cleaning.

2. Airborne Precautions

- Used to prevent or reduce the transmission of micro-organisms that are airborne in small droplet nuclei (5 μ or smaller in size)or dust particles containing the infectious agent.
- Place the patient in private room that has negative air pressure, with 6-12 air changes/per hour.
- If not available, cohort with patient with active infection with same microorganism
- Use of respiratory protection.
- Limit movement and transport of the patient.
- Use a mask on the patient if they need to be moved.
- Keep patient room door closed.

3. Droplet Precautions

- Used to reduce the risk of transmission of microorganisms transmitted by large particle droplets (larger than 5 in size).
- Droplets usually travel 3 feet or less within the air and thus special air handling is not required, however newer recommendations suggest a distance of 6 feet be used for safety.
- Place the patient in a private room.
- Use of respiratory protection such as a mask when entering the room recommended and definitely if within 3 feet of patient.
- Limit movement and transport of the patient.
- Use a mask on the patient if they need to be moved and follow respiratory hygiene/ cough etiquette.
- Keep patient at least 3 feet apart between infected patient and visitors.
- Room door may remain open.

4.1 Respiratory Hygiene/Cough Etiquette[4]

- Informing personnel if they have any symptoms of respiratory infection.
- Health educate patients and visitors to cover their mouth/nose while coughing and sneezing Proper disposal of used materials, during coughing and sneezing.
- Use of surgical masks on coughing person when appropriate.
- Providing alcohol-based hand-rubbing dispensers and supplies for hand hygiene and educating patients and staff in their use.
- Encouraging hand hygiene after coughing or sneezing.
- Separating coughing persons at least 3 feet away from others in a waiting room or have separate locality.
- Instructing patients and providers not to touch eyes, nose, or mouth.

- Health care workers should use standard precautions with all patients.

4.2 Safe Injection Practices[4]

- Correct disposal in appropriate container.
- Avoid re-sheathing needle.
- Avoid removing needle.
- Discard syringes as single unit.
- Avoid over-filling sharps container.

4.3 Use of Masks for Insertion of Catheters or Injection into Spinal or Epidural Areas.

Safe Practices in Patient Care [5]

1. Aseptic technique
2. Isolation
3. Safer Handling of Sharps
4. Linen handling and disposal
5. Waste disposal
6. Handling Biological Spills
7. Environmental cleaning
8. Risk assessment
9. Staff health

1. Aseptic technique

- *Medical Asepsis* – Clean technique; procedures used to reduce & prevent spread of microorganisms.

Hand washing

- Hand hygiene procedures include the use of alcohol-based hand rubs (containing 60-95% alcohol) and hand washing with soap and water.
- Alcohol- based hand rub is the preferred method for decontaminating hands, except when hands are visibly soiled (e.g., dirt, blood, body fluids), or after caring for patients with known or suspected infectious diarrhea (e.g., Clostridium difficile, norovirus), in which case soap and water should be used.

Personal protective equipment (PPE)

- Assess the risk of exposure to body substances or contaminated surfaces before any health-care activity.
- Make this a routine!
- Select PPE based on the assessment of risk:
  - Clean non-sterile gloves
  - Clean, non-sterile fluid-resistant gown
  - Mask and eye protection or a face shield.

- *Surgical Asepsis* – Sterile technique, procedures used to eliminate microorganisms.

Use of sterile PPE such as sterile gown, gloves are used in surgical asepsis.

2. Isolation

Source or Protective

- *Source* - Isolation of infected patient is mainly to prevent airborne transmission via respiratory droplets. Patients with SARS, pulmonary tuberculosis etc.
- *Protective* - Isolation of immune-suppressed patient.

3. Safer Handling of Sharps

Prevention Aspects - Handle with much care - correct disposal in appropriate container *Management* - follow hospital policy

4. Linen Handling and Disposal

- Bed making and linen changing techniques.
- Appropriate laundry bags.
- Hazards of on-site ward-based laundering

5. Waste Disposal

- Clinical waste - HIGH risk
- Potentially/actually contaminated waste

including body fluids and human tissue ° yellow plastic sack, tied prior to incineration

- Follow hospital policy

6. *Handling Biological Spills*
   - Cover area with hypochlorite solution for several minutes.
   - Clean area with warm water and detergent, then dry.
   - Treat waste as clinical waste - yellow plastic sack.
   - Follow hospital policy.

7. *Environmental Cleaning[3]*
   - "Hospitals should do the sick no harm" (Nightingale, 1854) A study conducted by Moore *et al*, 2011- High touched sites in an hospital environment.
   - Blood pressure cuff sites: 88%.
   - Bedside rails: 100%.
   - Toilets: 63%.
   - Bedside Table: 63% .

8. *Risk Assessment*
   - No risk - routine care.
   - Low or moderate risk - wear gloves and plastic apron.
   - High risk (Contact/splashing) - wear gloves, plastic apron, gown, eye/face protection.

9. *Staff health[2]*

Risk of acquiring and transmitting infection

Acquiring infection

- Immunization
- Cover lesions with waterproof dressings
- Restrict non-immune/pregnant staff

Transmitting infection

- Advice when suffering infection
- Report accidents/untoward incidents
- Follow hospital policy

Staff Health - Hand Care

- Nails
- Rings
- Hand creams
- Cuts & abrasions
- Skin Problems

Summary

Preferably, all contagious patients are isolated in separate rooms, but when such patients must be nursed in a ward with others, screens are placed around the bed or beds they occupy. The nurses wear gowns, masks, and sometimes rubber gloves, and they observe strict rules that minimize the risk of passing on infectious agents.

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Health: Perceived by Spirituality and Religion

Alex Zacharia C.

Abstract

Now a days, we can see an undoubtedly groundswell support for the idea of spirituality and spiritual care in the area of health care setting. This article emphasis the needs of spirituality, how the rituals influence the health of a person, the importance of knowledge of spirituality among health care givers and the other related factors of spirituality and religions, such as rituals practiced by different religions. Some of the tools and ideas mentioned in this article may help a nurse to assess, plan and implement the health care by including the spiritual dimension of health. So by training our self and clearing all the barriers which obstruct the spiritual-health care, we can render a holistic health care to a patient and his family.

Keywords: Spirituality; Religion; Rituals.

Introduction

Health and illness are the two inevitable experiences that a human being has to face in his life. We can see these two experiences has a direct or an indirect influence to all our other life experiences; if we are healthy we can do our work with perfection, there Will not be any frustrations or resentments and if not it will be just opposite. Obviously, good health is happy and illness has its own bitter experience. Facing a serious illness or disability makes us feel powerless, helpless and a hatred experience of dependency. In such a situation we may loose our control and start to think of our own being, in other words, illness will smack-off our hectic life style and give us time to think about the reality. This is the time were we usually think of god, spirituality, our past life experiences, our loved ones, how much we need them and some times a fear of destiny. In some terminally ill patients or in geriatric patients, we can see a fear of death or an immense desire to meet the spiritual or religious needs. The rituals are the factors that influence person daily activities, as a ritualized diet, dress code or any articles used for prayer/ worship. If and only if a care giver, a doctor or a nurse, understand the rituals and spiritual needs of the patient and picturise the health care plan by keeping it in mind along with the other dimensions of health, they can render a holistic care to the patient.

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Spirituality

Spiritual means relating to people's thoughts and beliefs than to their bodies and physical surroundings. Spirituality is defined as the basic quality in all humans that involves a belief in something greater than the self and a faith that positively affirms life. Spirituality most often refers to personal beliefs transcendent experience and principles.[1]

Religion

A particular organization which belief, worship god or gods and practice the activities connected with this belief such as praying, following special diets, dress codes etc.[1]

Influence of Rituals and Spirituality in Health and Medical Treatment

Optimal health care support of families can be given by recognizing variance between families and ensuring their unique cultural beliefs are incorporated

into care delivery practice (Tradition and science). Seventh Day Adventists is a good example for the religion that promotes a healthy lifestyle, the followers are strictly instructed by their Church not to consume alcohol, smoke, tobacco use and not to eat pork. In a 10 year study of Seventh Day Adventists in the Netherlands, researchers found that Adventist men lived 8.9 years longer than the national average, and Adventist women lived 3.6 years longer. For both men and women, the chance of dying from cancer or heart disease was 60 - 66% less, respectively, the national average. Male circumcision (Brit Milah) is an another example, a Jewish religious ceremony practiced on the eighth day of life by a trained Mohel, which reduces the future risk for infections like HIV and other sexually transmissible *infection* (STI).[1]

Some Christian faith groups avoid conventional medical practices; for example one group is the Church of Christ, the followers promote healing of physical and mental illnesses and disorders through prayer. They do compromise somewhat in the case of broken bones, by setting the broken bones by a physician and then seek healing from a Christian Science Practitioner. Many Christian Scientists do not use medicine or go to doctors; they choose prayer when faced with a medical problem, in themselves or any members of the family. They base these beliefs on the many passages in the Christian Scriptures (New Testament) which describe Jesus Christ or the apostles healing sick people in the first century CE. The Watchtower Society is another group, which refuses blood transfusion; the practice may result in risk of life of a needed patient. All or essentially all other Christian groups belief that the passages refer to dietary laws.[7]

The Hindu religion which follows 'Ahimsa', and traditionally vegetarians has a great respect for medical professionals, but many are quite wary of drugs and pills. If drugs are given, some of the Hindu patient's needs explanation; what it is for and what the effects are. Natural and homeopathic medicine is preferred over drugs and surgery in most cases. Many Hindu diabetics do not take insulin made from animals, so explain what insulin contains before administering it. This means will not consume meat, fish, or eggs. Beef is especially taboo. They usually consume very little garlic, onions, and salt, as these are restricted, but not forbidden. Milk products such as cream and yogurt are well-liked.[8]

Before prayer, a Muslim requires an ablution with water. Washing with water is also required after urination or defecation. A full bath is required after seminal discharge or after menstruation and post-natal bleeding. If washing with water or having a bath is not medically advisable or possible, an alternative method of purification, called Tayammum, can be performed. In Tayammum, the patient strikes the palms of both hands on any unbaked earthly matter e.g. stone or sand and symbolically washes in two simple steps. Muslims are required to follow a halal diet. Halal means lawful and is used to designate food which is permitted in Islam. The food that not permitted is pork and any other pork product, meat and derivatives not killed ritually and alcohol. They usually remove armpit and pubic hair and also follow other hygiene like, keeping nostrils clean and fingernails trimmed and clean.[9]

However, in common all the religion emphasize to follow a good life style, a peaceful heart and good manners. As per researchers, those who practices these religious activities and so with an inner peace, sympathy and empathy towards others have a better chance to live longer than others who did not. Some of the rituals and the spiritual qualities like faith, hope, forgiveness and the use of social support, prayer seems to have a noticeable effect on health because it will alleviate stressful feelings, positively influence the immune, cardiovascular (heart and blood vessels), hormonal, and nervous system. While planning health care module a care giver should keep in mind all the rituals of the patient and his family; otherwise providing health care will result in emotional draining.[1,6]

Barriers to Spiritual Care

Even though technology has got advanced, as we can provide a high tech care now a days, because of poor staffing and economic restraints only a few nurses is being focusing on to the spiritual needs of the patient. Although spirituality is one of the dimensions of health, as because of the above mentioned reasons, nurses are forced to focus on physical needs to the exclusion of spiritual needs.[3]

Some of the barriers that can arise in the path of spiritual care are:

- *Lack of General Awareness of Spirituality*

If and only if a care giver has a wide awareness of spirituality in general, then only an uninterrupted spiritual communication will arise and the spiritual needs of the patient get tuned up. Generally we can see that nurses usually forgot or won't give any importance to spiritual needs of the patient as may because of the lack of general awareness of spirituality. A study conducted by oncology nurses concluded that more than half nurses incorrectly identified the patient's religion and that only 16% included any kind of spiritual assessment into their care.

- *Lack of Awareness of Your Own Spiritual Belief System*

To perform a good spiritual care, a care giver needs more than just theoretical knowledge. You will have to travel a lot in your spiritual path, to conquer the spiritual dimension of the health and to a successful implementation into the health care planning of the patient. First of all, we need to nurture our own spiritual needs to meet the spiritual needs of the patient; otherwise, providing spiritual care will result in emotional draining. We must check were we are standing in the spiritual path; what rituals are we following; how could we feel if our spiritual needs didn't get fulfilled. If we have a good awareness of our own spiritual belief system, it will be much easy to attain in others, especially for a poor helpless dependent patient.

- *Differences in Spirituality between Nurses and Patient*

Each and every individual will stand in different levels in terms of spirituality; individual differences in the ritual practices may make the care giver to take false assumptions. In a health care setting there won't be any guarantee to get a same religious patient for a nurse. The cultural, ritual and spiritual difference, clashes may lead the nurse- patient relationship to an awful situation. Possibility to impose our belief into the patient will make a hostile situation and the nurse- patient relationship outcome will be much worse. To avoid these dangers a nurse should aware and respect of the patient's religion, rituals and spiritual needs and should keep all these things in mind while planning the care.

- *Fear of Where Spiritual Discussion may Lead*

Most of the care givers usually fears to discuss about the spirituality with the patients, as if they fear it may end with some misunderstanding or resentments. The reason that we can see here is, neither care giver don't have a proper answer to the patient's spiritual/ religious questions nor have an answer from their own views only. However, for giving a spiritual advice/ intervention it's not necessary that we should be a chaplain, a nun or have some extraordinary talent to deal with all spiritual matters, you can seek the help of a chaplain, a nun or a spiritual leader and can do the necessities.[3]

Practical Knowledge: Knowing how to Include Spiritual Care in Nursing Process

Hospital forms usually have a question about the religious preference to fill, usually nurses will stop by completing this step; this may be because of the fear of lack of awareness of the needs of the importance of spiritual dimension.[3]

Assessment

Spirituality is one of the dimensions of health and meeting this need is as important as the other dimensions of health. Many nurses are unaware about what spiritual care involves and lack confidence in this area. Assessment will be difficult when patient presents no clues to their spiritual or religious matters or has one which nurses are unfamiliar. However, there are simple, easy-to-use assessment tools that can help us to do quick assessment plans and evaluation.[4,5]

Sources of Spiritual Data

- *Patient's Environment:* You will get hinds from the patients environment, like presence of any sacred books, pictures or any instruments for prayer etc.
- *Patient's Questions:* Patient may ask questions like where he/ she can pray, or they may ask what's you opinion about the making of prayer.

- *Patient's Behavior, Mood and Feelings:* Patients emotion will tell us about the struggling, issues in his/ her life and what they feel about the spiritual needs that they looking forward.
- Nonverbal communication:- patient's body language will give us some hints about the spiritual needs. For example, shaking heads, crossing fingers etc while talking about some spiritual matters.[3]

Spiritual Assessment Tools

Two popular tools are *Hope* and *Spirit*.

Hope

- *H (Hope Sources)*: Here care givers should assess the source of patient's spiritual support, that from any religion, or self.

  For example we can ask, what are your sources of internal support? What spiritual care you usually take to go through your difficult times?
- *O (Organized Religion):* Here we can assess; in which religion does the patient belongs to and how much it supports them to enrich their spiritual dimension of health.

  For example we can ask, do you belong to any particular religious community? In which all aspects your religion is helpful to you?
- *P (Personal Spirituality)***:** In this section we can assess whether a client has any belief in his religion or in God and if so what they are and how it influence there spirituality.

  For example, questions like, do you believe in God? How much your belief helps you to enhance your spirituality?
- *E (Effects on Medical Care and End-of-Life Issues):* Here we can assess whether spirituality has any relationship with patients health and illness.

  For example, we can ask questions like, are you following any special diet or dress code which is prescribed by your religion? Would you like to speak with a spiritual leader? Is there any relation with your rituals and the treatment plan?

Spirit

- *S (Spiritual/ Religious Belief System):* Here care giver can assess the client's belief in sufferings, terminal or chronic illness and relationship between health and illness. Care giver should collect name, address and phone number of any supporting religious organization, were patient has faith.
- *P (Personal Spirituality):*Assess the level of comfort of client, while discussing about spiritual matters and how the client views his spirituality, in time of illness, in a positive or negative way.
- *I (Integration with in a Spiritual Community)***:** Record the name, address and phone number of the religious community and the spiritual leader ands here.
- *R (Ritualized Practices and Restrictions)***:** Here care giver must assess, whether patient is following any special rituals like dressing codes, specific diet, articles for prayer/ worship and any beliefs or needs in lab test, drawing blood or any individual faith that the patient or family encourages.
- *I (Implications for Medical Care)*: While providing care, care giver should keep in mind that what beliefs and practices that the patient and family follows, because certain medications and medical procedures like pain control, abortion, blood products etc have a direct relation with patient's belief or rituals. Also you should not impose any personal belief into the patient that it may result in any kind of resentment.
- *T (Terminal Events Planning)*: Care giver should clarify the patient's/ family wishes for advance directives like Cardio Pulmonary Resuscitation (CPR), Intubation, Ventilator assistance, feeding tubes and the organ donation. Check for any need for religious services like baptism, last rites and funeral planning.

Analysis/ Nursing Diagnosis

Spirituality is an inseparable part in the realm of nursing, so that NANDA has included it as a part of nursing diagnosis.

NANDA – Spiritual Diagnosis

- *Moral Distress:* This is a state where a person feels difficulty to carryout the chosen decision, like powerlessness, guilty etc.
- *Impaired Religiosity:* Impaired ability to participate in rituals and not much exaggerated in their faith, person feel difficulty in exercise reliance on beliefs.
- *Readiness for Enhanced Religiosity*: Here patient is not experiencing a problem but readiness to enhance his spirituality even better.
- *Readiness for Enhanced Spiritual Well-being:* Describes healthy spirituality as "Ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, or a power greater than oneself that can be strengthened".
- *Risk for Impaired Religiosity:* This condition can seen when risk factors are present, like pain, depression, social isolation etc can lead a person to impaired religiosity.
- *Risk for Spiritual Distress:* Risk for altered sense of harmonious connectedness with all of life and the universe in which the self may be disrupted.
- *Spiritual Distress:* Here the patient will express impaired ability to experience and integrate meaning and purpose in life through the connectedness with self, others, art, music, literature, nature, or a power greater than oneself.

Planning Intervention/Implementation

Spiritual nursing interventions are to address the spiritual related problems of the patient illness. Prayer, active listening, accepting client's feelings, referral to a spiritual leader etc are some of the frequently implementing nursing interventions.

By standardized NIC (Nursing Intervention Classification), active listening is one of the major intervention or a quality that a care giver should possess in his/ her career.

Active Listening

Care giver should be an active listener, and so that a trustful relationship can be build up with the patient. You should not impose your ideas into the patient, but should hear, understand what patient says and support them.

Main 4 NIC interventions for active listening are:-

- *Presence:* By NIC presence means, the care giver should present with the patient and their family members and should maintain a sincere communication with them. This will enhance the client's trust in you and ease your implementation.
- *Touch:* NIC describing a caring touch, such as touching in the arm, shoulder may reduce the stress and make the patient feels comfort and ease the communication.
- *Exploring Meaning:* A non-standardized NIC point refers to the concept of finding the purpose of life and a clear understanding of the illness of the client.
- *Reminiscence Therapy:* By NIC, recalling and sharing the past life events will reduces the severity of stress, helps to re-think and take a new supportive decision in life. So in the path of reminiscence therapy the client may express their spiritual/ religious belief and seek spiritual support.

Other spiritual nursing activities:

- Maximize the clients comfort.
- Encourage to express feelings.
- Be an active listener.
- Make adequate referrals.
- Arrange the necessary needs as ritualized diet, articles to pray/ worship, dress etc.[3]

Negative Impact of Spirituality in Health

Spirituality will not guarantee health, but it will support the medical treatment for a fast healing. If people substitute prayer for medical care there will be a chance of delay of medical treatment and so the disease may get worse/complicated. If the religion impose guilt, fear or lowered self worth into a person it may impose a negative impact on health. If the care giver impose their beliefs/ideas in the treatment process and is not acceptable by the patient or his family, it may result in resentment or hostility.[6]

Future of Spirituality in Medical Practice

Now a day, it appears a growing belief in the connection between spirituality and health in the medical practice. Many medical schools in the United States have included the spiritual teaching in there curriculum. Healing the body by including spiritual dimension of health, the mind and spirit is a new area in medical researches. Cunningham (2008) pointed out a self-healing programme for cancer patients, in which the psychological and spiritual practice helps the patient's and their family to cope-up with the disease and stress. He highlighted the importance of this therapy and advocate for research in this area. However, what role a care giver will perform in this area is been remaining controversial. But experts reveal that in future the inclusion of spirituality in health care will be an inevitable part, as it helps the patient and family to attain a holistic health.[5,6]

Conclusion

Addressing spiritual needs and incorporating spiritual care in the treatment module will enhance patient's wellbeing and satisfaction. This article encompasses the needs of the spirituality in nursing care, some of the ways to perform spiritual care and the necessary factors that to be considered in this area. We can see a hand full of innovative examples of spiritual care in Pugh *et al*, 2010; Cunningham, 2008, which could be adapted and apply in healthcare settings. However, the health care modalities will complete only if we met the spiritual dimensions along with the other dimensions of health, so hope the care givers confidently take this challenge and do the necessities.[5]

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Effectiveness of Meditation on Stress among Student Nurses

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Abstract

An experimental study was conducted to find out effectiveness of meditation on Stress among student nurses. The sample size comprised of 40 student nurses. Random sampling technique was used to draw the samples for the study. First pre test was conducted through modified perceived stress assessment scale. After that meditation was demonstrated to the student nurses. After a week post test was conducted through same tool. The effectiveness of the intervention was determined by computing the data with't' test. The calculated't' value was 10.837 that is significant at $p<0.01$ level. Further association of scores with selected demographic variables revealed significant association except age $p<0.05$ level.

Keywords: Stress; Meditation; Perceived stress assessment scale.

Introduction

Nursing students are in the stage of late adolescence or young adulthood in the development phase. It has major problems of adjustment in their social relationship at home, neighborhood and school and college. It has been well documented that nursing students across the world experience stress and anxiety throughout their education and training. Issues that contribute to their stress and anxiety include challenges and technological advances. Financial concerns, interpersonal difficulties, family problems, physical and mental health issues, inadequate support and poor coping skills. Additional stress for innovative nursing students includes cultural adjustments, language issue, social isolation and discrimination.

Further more, during the initial clinical training experience nursing students reported increase in their levels of stress and anxiety. The stress and anxiety levels increase as nursing students learn to apply their critical knowledge to the clinical work with their first patient in new environment while being observed by their clinical instructors and their peers.

Over the past two decades many forms of interventions have been suggested to help nursing students with their stress and anxiety. One study developed a six week individualized stress management program to help to reduce the performance in anxiety of nursing students.[1]

Background of Study

Nursing is a stressful profession and nursing students are exposed to high levels of stress in both theoretical and clinical components of their educational programme. This fact not only affects their academic performance but also may leads to various physical and psychological disorders. From this study mean score of students stress level was 2.96 at the range of 1-5. The highest stress level were related to coping with personal problems (x=3.40), feeling anxious(x=3.34), experiencing anger in facing every problem (x=3.31). Among sources of stress, lack of agreement between theoretical and qualification of job (x=3.40) and attitude and expectation of other towards nursing profession (x=3.30), have most important roles.[2]

Nearly half of the students (43%) experienced high level of stress during clinical practice measured by decision in the tree analysis. The absolute risk of stress was 57% in students with placements in hospital departments as compared to 13% in students with placements in other clinical setting. The risk of stress increased to 71% if the students with placement in a hospital took the national clinical final examination.[3]

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In recent year there is a growing apparition of the stress involved in nursing training. It is important for nursing educator to know the prevalence of psychological distress and psychological well being among nursing students. The present study aimed to assess perceived stress in the under graduate students studying in a nursing college located in north India. The present study indicates high level of psychological disturbance among nursing under graduate students in the middle phases of the course. Hence, there is an urgent need to take measures by the authorities to reduce stress among the nursing students.[4]

Statement of the Problem

A study to determine the effectiveness of meditation on stress among student nurses at selected college, Nainital, Uttarakhand.

Objectives of the Study

- Assess the level of stress among the student nurses in terms of pre test.
- Evaluate the effectiveness of meditation among student nurses by comparing pre test and post test stress scores.
- Find out association between the stress scores and selected demographic variable.

Hypothesis

- There will be a significant decrease in the post test stress scores than pre test stress score.

Material and Methods

The investigator had selected quasi experimental one group pre test and post test design. The setting for the study was Naincy College of nursing nainital. The study was conducted among student nurses. The random sampling technique was used, and sample size for the present study comprised of 40 student nurses. Tools for data collection: In the present study the tool consists of 2 parts. Part-1: Demographic data, Part-II: Comprises of modified perceived stress assessment scale. Researcher collected data after getting permission from the nursing college and approval was obtained to conduct the study. The participants were informed about the purpose of the study and written consent was taken from the participants. The modified perceived stress assessment scale was distributed to the participants. On an average each participants took 15-20 minutes to fill the demographic data and pre test was conducted. After collection of data, meditation was demonstrated by the researcher. The time duration taken was 45 minutes then under the researcher's supervision the participants practiced for a week. On 7th day post test with the same modified perceived stress assessment scale was done.

Analysis and Interpretation

The data collected from student nurses was analyzed and interpreted in accordance to the objectives.

Table 1 represents the data on the percentage distribution of the variables included in the study. Majority of respondents 37.5% was in the age group 21 years, and 10 % were in the group more than 21 years. With regard to the unmarried were 95 % and married were 5%. The data on type of family is 87.5% nuclear family and 12.5% were join family. Regarding the respondents family income majority 70% had family income above Rs. 15000 and 5% had an income less than Rs. 5000.

The mean, mean percentage and standard deviation of pre test were 0.44, 44%, and 7.5 respectively; post test mean, mean percentage and standard deviation were 0.25, 25%, and 7.2. The calculated value was 10.837 which is significant at $p<0.01$. It can attribute to the effectiveness of meditation on reducing stress. Hence H_1 the research hypothesis was accepted.

Table 3 shows that the effectiveness of meditation among 40 student nurses with stress. The pre test shows that among 40 participants 8(20.0 %) had mild stress and 32(80.00 %) had moderate stress. The post test reveals that among 40 participants, 31 (77.5 %) had mild stress, 9 (22.5 %) had moderate stress on post stress.

Table 3 indicates the association between variables and knowledge scores of student nurses regarding stress. The analysis revealed that there is a significant association between marital status, Type of family, Income per month, Medical illness at $p<0.05$ levels and the variable age were not found to be significant.

Table 1: Frequency and Percentage Distribution of Demographic Variables of Student Nurses

N=40

S. No	Demographical variables	Category	Frequency	Percentage (%)
1.	Age in year	19 yrs	9	22.5
		20yrs	12	30
		21 yrs	15	37.5
		>22 yrs	04	10
2.	Gender	Female	40	100
3.	Marital status	Married	02	05
		Un married	38	95
		Widowed	00	00
4.	Type of the family	Joint family	05	12.5
		Nuclear family	35	87.5
5.	Income per month	< 5000	02	5
		5001-10000	04	10
		10001-15000	06	15
		>15000	28	70
6.	Any medical illness	Yes	03	7.5
		No	37	92.5

Table 2: Comparison of Mean and Standard Deviation of Stress Scores of Pre and Post Test Score Meditation of Student Nurses.

N=40

Pre test			Post test			't' test
Mean	Mean%	SD	Mean	Mean%	SD	
0.44	44	7.5	0.25	25	7.2	10.837**

** p< 0.01, # - Independent 't' test.

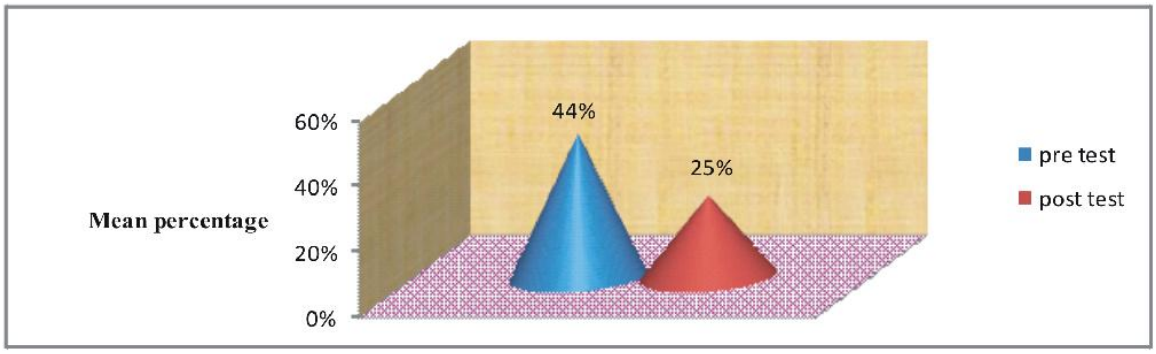

Table 3: Percentage Distribution of Level of Stress among Student Nurses

N=40

Level of stress	Pre test		Post stress	
	Frequency	Percentage	Frequency	Percentage
Mild stress	8	20	31	77.5
Moderate stress	32	80	9	22.5
Severe stress	0	0	0	0

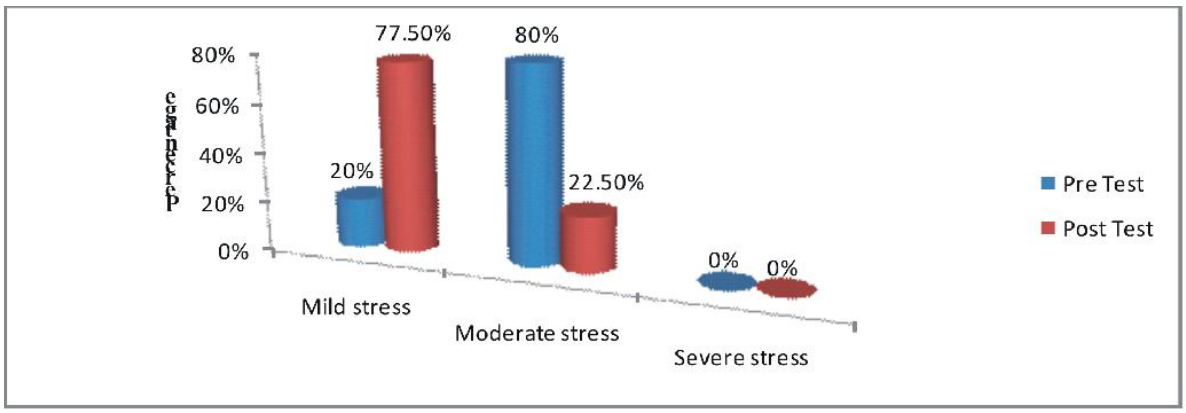

Table 3: Association between the Selected Demographic Variables and the Level of Stress before and after Meditation Student Nurses with Stress.

N=40

Variables	Calculated value
Age	6.6^{NS}
Marital status	32.4^{S}
Type of family	22.5^{S}
Income per month	44^{S}
Medical illness	28.5^{S}

Discussion

The findings are discussed corresponding to the objectives of the study:

Characteristics of Demographical Variable

Majority of the respondents belonged to the age group 21 years 28 (37.5%). Majority of the respondents had unmarried 38 (95%). The data revealed 35 (87.5%) were nuclear family. It was revealed that 28(70%) >15,000. Hence it is the liability of the institution and the health care professionals to implement diversity of meditation in the college or home and this information should be disseminated to the inmates to promote the overall quality of life.

Effectiveness of Meditation on Stress

The mean, mean percentage and standard deviation of pre test were 0.44, 44%, and 7.5 respectively; post test mean, mean percentage and standard deviation were 0.25, 25%, and 7.2. The calculated value was 10.837 which is significant at $p<0.01$. Further, the data was categorized with the level of stress. It showed majority (77.5%) had mild stress in the post test whereas 80% had moderate stress in the pre test. These findings contribute to the effectiveness of the intervention. The analysis revealed that there is a significant association between marital status, Type of family, Income per month, Medical illness at $p<0.05$ levels and the variable age were not found to be significant. Hence H_1 the research hypothesis was accepted. The aim of meditation in daily practice is the realization of our total incorporation in the ground of being through acycle of awareness and return to silence and stillness. A supportive study shown that the major finding of the study revealed that meditation is effective in improving subjective wellbeing status, reducing anxiety and improving study habits among the nursing students.[5]

Implication

Nursing Practice

The findings of the study revealed that the student nurses are having more stress due to the academic performance so for meditation is an effective treatment for stress. All health workers can use this therapy in their settings to treat stress in the group. Especially nurses play a vital role of caring adolescents and early diagnosis of adolescents stress can prevent from harmful consequences.

Nursing Education

With the emerging health care demands and newer trends in field of nursing education must focus on the innovations to enhance the nursing care. The nursing students should be taught the importance of relieving stress and enhance the quality of life of

their own life. Therefore nursing students should be introduced with the alternative methods of treating stress. Student nurses should incorporate the importance of early screening of stress and its management.

Nursing Administration

With technological advances and ever growing challenges of health care, administrators have the responsibility to provide continuing nursing education opportunities to understand the psycho social intervention including meditation.

Nursing Research

The professionals and the students can conduct further studies on stress through various other interventions to promote psychological well being in the college and home.

Recommendations

- Ø The sample study can be done on a larger population for more valid generalization.
- Ø The study can be conducted in the other settings like the community.
- Ø Longitudinal study can be conducted for long term effects of meditation on stress.

Conclusion

The findings of the study revealed that nursing students are having more stress in college and environmental factors such as like clinical practices, financial problems, home sickness; lack of family support, so the meditation is the therapy is the non pharmacological traditional psychological intervention for the treatment of stress.

Guided by

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