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A Study to Assess the Outcome of Self Instructional Module for Nurses on Nursing Management of Patients with Chest Tube Drainage in a Tertiary Care Hospital & Medical Research Centre, Belgaum, Karnataka

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Volume 2, Number 2

Preeti R. Bhupali*, Ramachandra S. Hooli, Sheela Williams*****

Abstract

A pre-experimental study was conducted on 55 nurses working in Intensive Thoracic Unit, Medical Intensive Care Unit & Surgical Intensive Care Unit, to assess the knowledge of nurses on nursing management of the patients with chest tube drainage & the outcome of Self Instructional Module (SIM) for nurses on nursing management of patients with chest tube drainage through knowledge scores at a tertiary care hospital & Medical Research Centre, Belgaum, Karnataka. The conceptual framework used for the study was based on Ludwig Von Bertalanffy's (1980) General System Theory.

One group pretest–posttest design, with an evaluative approach was used for the study. The structured knowledge statements consisting of 65 items with 'true' or 'false' answers were used as an instrument with non–probability, purposive sampling technique for the data collection. The data were collected through structured interview schedule. The Study findings revealed that, out of 55 nurses majority 39 (71%) scored 'Good', minimum 7 (13%) scored 'Average' and remaining 9 (16%) scored 'Poor' in the pre test. Whereas in the post test majority 43 (78%) scored 'Good' and remaining 12 (22%) scored 'Average' and none 0 (0%) were under the 'poor' category. Paired 't' test results showed statistically significant gain in knowledge with the $t_{calculated}$ (24.85*) at ($p<0.001$) after the administration of the SIM.

The study concluded that, overall the pre test knowledge score about the chest tube drainage was poor among the nurses. There was a need for them the SIM on nursing management of the patients with chest tube drainage. The post test results showed the improvement in the level of knowledge concluding that the SIM is an effective method for nurses to increase their level of knowledge about the chest tube drainage.

Keywords: Chest tube drainage; Critical care unit (CCU); Nurses; Nursing management; Knowledge; Self instructional module (SIM).

Introduction

Emergency care of chest trauma has progressed greatly over the past two decades. Factors contributing to this progress include changes in the system for providing emergency medical services; the spread of sophisticated methods of surgical management such as emergency room thoracotomy and thoracoscopic surgery. The vast majority of patients with chest trauma can be managed nonoperatively, with tube thoracostomy, pain control, chest physiotherapy, and medication. It is not unusual for pain relief or a single chest tube to improve a patient's condition dramatically.[1]

Pleural drainage with chest tube insertion for thoracic trauma is a common and often life-saving technique.[2] The evacuation of empyemas first performed centuries ago, marked the beginning of thoracic drainage. The subsequent acquisition of a greater knowledge of the anatomy, physiology, and pathology of the pleural space directed the design of thoracic catheters and drainage systems and the development of the methods by which they are used.[3]

Pleural drainage systems have been around since 1967. Back then the three bottle system was used, and today the system is a single unit.[4] The use of drain in thoracic and cardiac operations is frequent. Every year are placed more than 1 million chest tubes

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in USA, and we can imagine how many drains are used worldwide per year.[5] There is no available data concerning the demographics of chest tube insertion since this is a common procedure performed in emergency rooms and surgical departments.[6]

The systems remove free air and/ or fluid from the pleural space *via* a chest tube. Once a chest tube is inserted one must make sure it is properly connected to the pleural drainage system.[4] Chest drains are a widespread intervention for patients admitted to acute respiratory or cardiothoracic surgery care areas. These are either inserted intra-operatively or as part of the conservative management of a respiratory illness or thoracic injury.[7]

The system should then be checked during routine assessments to make sure it's functioning properly.[4] Although considered a simple procedure, complication rates have been reported to be 2% to 25%.[2] Subsequent management of the Chest tube must be individualized to the patient, taking into consideration the reason for Chest tube placement, whether or not the patient has had pulmonary resection, and whether the patient is mechanically ventilated. Premature Chest tube removal, as well as unnecessary delays in Chest tube removal, leads to increased hospital stays and costs.[8] The presence of chest drains is synonymous of postoperative pain and its withdrawal is a discomfort to the patient. The pain during the removal is characterized as one of the most distressing for patients and some have reported as the worst memory during hospitalization.[5]

Nursing management of chest drains is important. A comprehensive understanding of the operations of the chest drain systems and areas requiring special attention would be important to reduce the complications arising from chest tube drainage.[9] Anecdotally there appears to be a lack of consensus among nurses on the major principles of chest drain management. Many decisions tend to be based on personal factors rather than sound clinical evidence. This inconsistency of treatment regimes, together with the lack of evidence-based nursing care, creates a general uncertainty regarding the care of patients with chest drains.[7]

Once a chest drain is inserted, it is important for the nursing staff to ensure that the patient and the drain are closely monitored. However, wide variations of practice have been observed, which are based on local policies and individual preferences rather than evidence-based protocols (Avery 2000, Charnock and Evans 2001).[9]

A prospective cohort observational study of emergency pleural drainage procedures was conducted by Department of Surgery, Royal London Hospital, London, UK, to validate the indications for pre-hospital thoracostomy and to identify complications from both pre and in-hospital thoracostomies. Data were collected over a 7 month period on all patients receiving either pre-hospital thoracostomy or emergency department tube thoracostomy. Outcome measures were appropriate indications, errors in tube placement and subsequent complications. Ninety-one chest tubes were placed into 52 patients. Sixty-five thoracostomies were performed in the field without chest tube placement. Twenty-six procedures were performed following emergency department identification of thoracic injury. Of the 65 pre-hospital thoracostomies, 40 (61%) were for appropriate indications of suspected tension pneumothorax or a low output state. The overall complication rate was 14% of which 9% were classified as major and three patients required surgical intervention. Twenty-eight (31%) chest tubes were poorly positioned and 15 (17%) of these required repositioning. Pleural drainage techniques may be complicated and have the potential to cause life-threatening injury. Pre-hospital thoracostomies have the same potential risks as in-hospital procedures and attention must be paid to insertion techniques under difficult scene conditions. In-hospital chest tube placement complication rates remain uncomfortably high, and attention must be placed on training and assessment of staff in this basic procedure.[2]

A study by School of Nursing, Dublin City University, Dublin, Ireland, aimed to identify the nurses' levels of knowledge with regard to chest drain management and identify and to ascertain how nurses keep informed about the developments related to the care of patients with chest drains. The data were collected using survey method. The results of the study revealed deficits in knowledge in a selected group of nurses and a paucity of resources. Nurse managers are encouraged to identify educational needs in this area, improve resources and the delivery of in service and web-based education and to encourage nurses to reflect upon their own knowledge deficits through portfolio use and ongoing

professional development.[7] Several service-led options exist with regard to improving knowledge in this area, such as service study days as well as ward-based tutorials. However, in an era of increasing accountability together with the impetus for each nurse to provide evidence-based care, it is crucial for individual nurse responsibility in the pursuit of knowledge in this area. Nurses must be supported by local practice development and through personal portfolio use to identify gaps in knowledge and seek appropriate training and resources.[10]

It is also important that an evidence based approach is applied to both the care of the patient and the maintenance of the drainage equipment. This understanding would help in facilitating support of the patient. In addition the nurses will also be enabled to identify and report developing problems if any at an early stage. This would reduce the risk of serious complications, and improve the arising process of the patient. The investigator during her clinical experience came across many patients with chest tube drainage and she realized, observed that nurses caring for these patient need to update their knowledge and skills sufficiently. Because many of the nurses did not know how to milk the chest tube, how to change the bottle if it is filled up or is broken, or what is to be done if the tubes are kinked, obstructed etc. The investigator felt that nursing management in this regard needs to be obviously improved.So the nurses need to have scientific knowledge and practical efficiency in caring for patients with chest tube drainage. In this way the investigator was motivated to take up this study.

Materials and Methods

A Pre-experminatal, One group pretest–posttest design, with an evaluative approach was used for the study. The independent variable of the study was the Self Instructional Module and the dependent variable was the nurse's gain in knowledge scores. The study was conducted on 55 nurses working in ITU, SICU and MICU at KLES Dr. Prabhakar Kore Hospital & Medical Research Centre, Belgaum. Non–probability, purposive sampling technique was used to collect the data. The structured interview schedule was used to collect the personal data of the samples and the structured knowledge questionnaire consisting of 65 items with options of 'True' or 'False' are used as an instrument for the data collection. The Structured questionnaire had two sections. The section 'A' consisted of 42 items on the knowledge of chest tube drainage comprising various areas like anatomy and physiology of thoracic cavity, terminology, definition, purposes, indications, pain management, knowledge of management of a patient with chest tube drainage. Section 'B' consisted of 23 items on nursing management of chest tube drainage. The tool and the SIM were validated by experts in the fields of Nursing, Physiotherapy, Cardio-thoracic surgery, and Respiratory medicine. There was a 100 percent agreement amongst the experts regarding the items of the tool and the SIM. The reliability of the tool found was r=0.8 with Karl Person's product moment method and the reliability was r1=0.97 with Split half method: applying Spearman's Brown Prophecy formula. The pilot study confirmed the feasibility of the study. The data obtained was tabulated and analyzed in terms of objectives of the study using descriptive and inferential statistics.

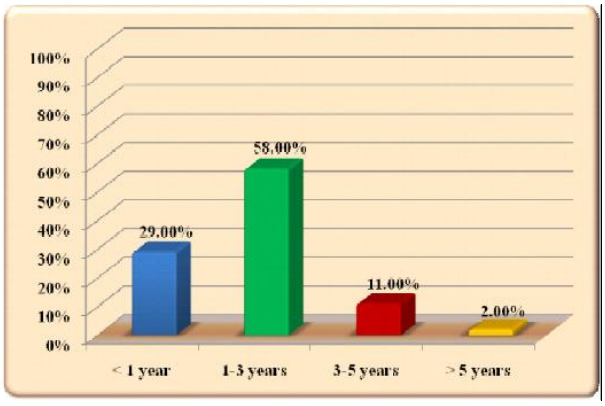
Results

The findings of the study were organized under the following headings:

Findings related to the Socio–demographic Variables of the Nurses

Majority 43 (78%) of nurses belonged to 21-24 years of age, remaining minimal 12 (22%) belonged to 25-28 years of age.

Graph I: Bargraph showing Percentage Distriution of Subjects according to Total Number of Experience



Graph II: Bargraph showing Percentage Distribution of Subjects according to Working Experience in CCU

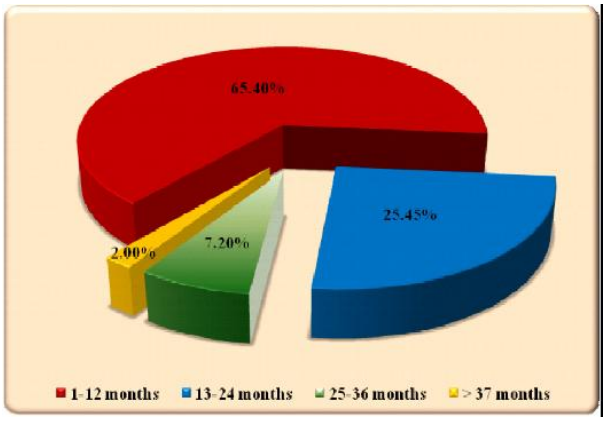


Table I: Pre-test and Post-test showing Mean, Standard Deviation, Range, Median of Knowledge Scores of Nurses on Nursing Management of Patients With Chest Tube Drainage

	Mean	Standard deviation	Range	Median
Pre-test	42.41	4.58	23	42
Post-test	51.12	4.56	20	50

Table III: Pre-test and Post-test Knowledge Scores showing Distribution of Subjects Based on Overall Gain in the Knowledge Level of the Nursing Management of Chest Tube Drainage

Knowledge level Pre-test	Pre-test		Post-test	
	f	%	f	%
Good (48-65)	9	16	43	78
Average (38-47)	39	71	12	22
Poor (<38)	7	13	0	00
Total	55	100	55	100

Majority 44 (80%) nurses were female and remaining 11 (20%) were male.

Majority 42 (76%) nurses had completed GNM course and remaining 13 (24%) nurses had completed B.Sc (N) course.

Majority 32 (58%) of nurses had 1-3 years total experience in clinical setting and minimal 1 (2%) of nurses had 5 years experience in clinical.(Graph I)

Majority 36 (65.45%) of nurses had 1-12 months of working experience in CCU, whereas minimal 1 (2%) of nurses had more than 37 months of working experience in CCU.(Graph II)

Table II: Pre-test and Post-test Knowledge Scores showing Mean Percentage Scores and Actual Gain Scores of the Subjects on Various Areas of Chest Tube Drainage

Sl. No	Areas of Knowledge	Total Score	Mean (%)		Actual gain score
			Pre-test	Post-test	
I	**Section A: Knowledge of Chest Tube Drainage**				
1	Anatomy and physiology of Toracic Cavity	6	65.7	84.8	19.1
2	Terminology	2	70	95.4	25.4
3	Definition	1	89	100	11
4	Purposes	3	78.7	88.4	9.7
5	Indications	2	87.2	92.7	5.5
6	Pain management	3	40.6	63	22.4
7	Knowledge of management of patient with Chest Tube Drainage	25	64	79	15
II	**Section B: Nursing practice on Chest Tube Drainage**				
1	Nursing management	23	64.5	73.7	9.2

Table IV: Pre-test and Post-test Knowledge Scores showing Mean, Standard Deviation and Paired 't' Test Value of the Nurses on the Nursing Management of Chest Tube Drainage

	Mean	Standard Deviation	Degree of Freedom	Paired "t" value	n=55 Result
Pre-test	42.41	4.58			Highly significant at p<0.001 level
Post-test	57.12	4.57			
Mean Difference	8.71	2.6	54	24.85	

Findings on the Knowledge of Nurses on Nursing Management of Patients with Chest Tube Drainage

The pre-test knowledge scores revealed that, nurses had maximum (89%) knowledge scores in the area of definition, followed by (87.2%) knowledge scores in the area of indications and minimal (40.6%) in the area of pain management. It was observed that they had pre-test knowledge scores of (64.5%) on nursing management in regard to the practice on chest tube management.

The post-test knowledge scores revealed that, nurses had maximum (100%) knowledge scores in the area of definition, followed by (95.4%) knowledge scores in the area of terminology, and (92.7%) knowledge scores in the area of indications and minimal (73.7%) knowledge scores in the area of nursing management in regard to the practice on chest tube management. Thus there was a maximum (25.4%) knowledge gain in the area of terminology. The second highest (22.4%) knowledge gain was in the area of pain management. The minimum (5.5%) knowledge gain was in the area of indications. Overall there was a gain in knowledge in all the areas of chest tube drainage.(Table 1)

In the pre–test, a majority 39(71%) of the nurses had an average knowledge scores, whereas 9(16%) of them had a good knowledge scores and minimal 7 (13%) of them had a poor knowledge scores. (Mean = 42.41, Median = 42, Standard Deviation = 4.58)(Table II).

In the post–test, a majority 43(78%) of the nurses had good knowledge scores, whereas remaining all 12 (22%) of them had an average knowledge scores and none 0 (0%) of them had a poor knowledge scores. (Mean = 51.12, Median = 50, Standard Deviation = 4.56)(Table III,Graph III).

There was a significant increase in the post-test knowledge scores. The gain in knowledge score was statistically significant at $p<0.001$ with paired t=24.85. Hence the research hypothesis was accepted. Therefore the findings reveal that a Self Instructional Module on nursing management of patients with chest tube drainage was effective and as such relevant to improve knowledge and proficiency of staff nurses (Table IV).

Discussion

The findings of the study were discussed under the following heads:

Findings Related to Socio-demographic Data of Nurses

The present study showed that a majority 43 (78%) of the nurses belonged to the age group of 21-24 years (who were working in ITU, SICU and MICU). This may be due to the fact that they joined the hospital soon after completing their course of study of their qualification.

In the total sample (n=55) under investigation a majority 44(80%) were females.

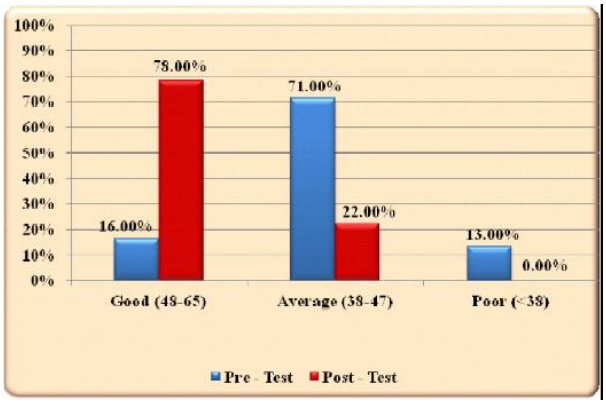
Majority of nurses 42 (76.3%) had completed GNM qualifications. Because nurses with GNM qualified have understanding with Hospital management to serve for two years, where as nurses with B.Sc (N) qualification have understanding to serve for one year.

Majority 32 (58%) of the nurses had total experience between 1-3 years only.

Majority 36 (65.4%) had a working experience of 1-12 months in CCU.

Findings Related to Gain in the Level of Knowledge of Nurses on Nursing Management of Patient with Chest Tube Drainage

Graph III: Bargraph showing Percentage Distribution of Subjects Overall Gain in the Levels of Knowledge of Nursing Management of Patient with Chest Tube Drainage



In the pre-test 7 13%) of nurses had poor knowledge level, 39 (71%) had average level and remaining 9 (16%) had good knowledge level on nursing management of patients with Chest Tube Drainage.

As compared to pre-test scores, in the post-test there was a significant increase in knowledge score. Out of 55, majority 43 (78%) belonged to 'good' category and 12 (22%) belonged to 'average' category and none belonged to 'poor' category. This could be due to the administration of SIM.

There was statistically and significantly increase in the post-test knowledge scores. The gain in knowledge score was significant at $p<0.001$ level and paired 't' test = 24.85. Hence the research hypothesis was accepted, as it was tested and valid.

Similar findings were found in the study by, Verma P, at Nehru Hospital, PGIMER, Chandigarh, India,[11] to assess the knowledge of the staff nurses and to determine the effectiveness of Self Instructional Module (SIM) in terms of gained knowledge regarding nursing management of patients having chest tube drainage. Subjects had poor knowledge related to clamping of chest tubes during transportation (35%), clamping during leak (28%) and about indications for chest tube removal (19%). After introduction of SIM, the scores in post-test increased significantly ($p<0.001$). After introduction of SIM, the number of subjects further increased to 75%, 65% and 74% respectively in these areas. The study concluded that the information given through SIM proved beneficial in improving the knowledge and skill of 100 study subjects.

Conclusion

Based on the findings of the study, the following conclusions were drawn that, overall pre-test knowledge score was not up to the mark for the management of patients with chest tube drainge. There was a need for Self Instructional Module for nurses on nursing management of patients with Chest Tube Drainage. Post-test results showed significant improvement in the level of knowledge of Chest Tube Drainage. Thus it was concluded that Self Instructional Module was an effective method for nurses to increase their level of knowledge about Chest Tube Drainage.

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Sheehan's Syndrome: A Case Study

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A. Maria Therese*, V. Uma**

Abstract

Sheehan's syndrome (SS) is postpartum hypopituitarism caused by necrosis of the pituitary gland. It is usually the result of severe hypotension or shock caused by massive haemorrhage during or after delivery. Patients with SS have varying degrees of anterior pituitary hormone deficiency. Its frequency is decreasing worldwide However; it is still frequent in underdeveloped and developing countries. SS often evolves slowly and hence is diagnosed late. History of postpartum haemorrhage, failure to lactate and cessation of menses are important clues to the diagnosis. Early diagnosis and appropriate treatment are important to reduce morbidity and mortality of the patients.

Keywords: Sheehan's syndrome; Hypopituitarism; Hypotension.

Introduction

While Giving birth, blood loss is normal (less than 500 ml) but excessive loss during or after childbirth can result in ischemia to the anterior pituitary regions leading to necrosis this condition called as Sheehan's syndrome also known as Simmonds' syndrome or Postpartum Hypopituitarism or Postpartum pituitary necrosis.[1,2] The complete concept of the syndrome was well reviewed by the British pathologist Harold Leeming Sheehan in 1937.A recent epidemiological study in Indian subcontinent estimated the prevalence of Sheehan's syndrome (SS) was 10-20 per 100,000 women. In a study of 1034 hypopituitarism adults, SS was the sixth most frequent cause of growth hormone deficiency GHD, being responsible for 3.1% of cases. In a retrospective nationwide analysis, the prevalence of SS in 2009 was estimated to be 5.1 per 100,000 women. The aim of the present case study is to discuss the recent advances in SS.

Case Report

A 46 years old woman ($G_3P_3L_3$) is admitted in the Female Medical Ward, Presented with chief complain of recurrent diarrhoea on intake of non-fibrous diet for the past 22 years. She had 3 full term vaginal delivery of 1 female and 2 male child. After her third child birth she developed Post-Partum Haemorrhage for which she was treated with medications; subsequently she had failure of lactation, amenorrhea, and symptoms of hypothyroidism. On admission, Patient had history of fatigue, head ache, weight loss, Asthenia, Hypoglycaemia, diarrhoea on food intake, amenorrhea for last 22 years. On examination, patient was of thin build with Body Mass Index (BMI) of 17 Kg/cm²; pulse was regular with rate of 86/min, supine blood pressure 90/52 mm Hg with sparse pubic and axillary hairs and normal adult type external genitalia. Per speculum and per vaginal examination detected no abnormality. Investigations revealedanaemia (Hb 9.0 mg/dl), Blood sugar (random) 110 mg/dl.Hormonal profile revealed low levels of, T4, TSH, Cortisol and ACTH. On the basis of history, examination and investigations, final diagnosis of Sheehan's syndrome was made and Patient was put on Tab. Prednisolone 10 mg/day along with Tab.Eltroxin 100µg/day, Tab.Flagyl500 mg tds/day, Inj.Betnesol 4mg IV tds. Following this treatment patient resumedcontrol of diarrhoea and feels healthy.

Definition

"Sheehan's syndrome is a pituitary gland disorder, characterised by the permanent underproduction of essential pituitary hormones (hypopituitarism) which leads to severe blood loss causes deprivation of

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oxygen thereby damaging the vital tissues and organs during or after childbirth in women".[3-6]

Causes

- Postpartum pituitary necrosis
- Hypovolemic shock
- Postpartum hypopituitarism
- Hypotension
- Disseminated intravascular coagulation

Signs and Symptoms

The symptoms depend on the degree of necrosis of the cells.

- *No Symptoms*: in very mild case, there may be any symptoms at all. The woman may complain of vague feelings of ill health or fatigue which are often passed off as the after effects of childbirth, or being due to anaemia, or poor nutrition.
- *First Symptoms after Childbirth:* absence of lactation (Agalactorrhea) and/or difficulties with lactation
- *Later Symptoms after Childbirth:* failed to start menstruating after delivery
- *Symptoms of a Full-blown Sheehan's syndrome:* Slowed mental function, weight gain and difficulty staying warm, as a result of an underactive thyroid (hypothyroidism)
- Features include secondary hypothyroidism with tiredness, intolerance to cold, constipation, weight gain, hair loss and slowed thinking, as well as a slowed heart rate and pressure, Loss of pubic or underarm hair, Low blood pressure, Fatigue , Weight loss.
- Asthenia, Hypoglycaemic
- Atrophy of vaginal mucosa and High cholesterol level.

Complications

- Adrenal crisis, (adrenal glands produce too little of the hormone cortisol),
- Low blood pressure,
- High cholesterol,
- Unintended weight loss,
- Menstrual irregularities.
- Female infertility
- Diabetes insipidus, non-nephrogenic
- Sodium levels raised (urine)

The Outcome of Sheehan's Syndrome

The prognosis depends on the duration of the disease, chances of complications, probable outcomes, and prospects for recovery, recovery period survival rates, death rates, and other outcome possibilities in the overall prognosis of Sheehan Syndrome. Naturally, such forecast issues are by their nature unpredictable.

Investigations

TESTS AND DIAGNOSIS RECOMMENDED	INVESTIGATION DONE FOR THE PATIENT	PATIENTS VALUE	NORMAL VALUE
• Medical history, on childbirth complications • Check for Two key signs of Sheehan's syndrome- absence of lactation and/or difficulties with lactation or failed to start menstruating after delivery. • Mainly diagnosed by low levels of TSH, ACTH, FSH, and LH with low levels of T4, cortisol, and estradiol in the blood. • Magnetic resonance imaging or computerized tomography, to check the size of the pituitary	T3 (µg/dl)	77	77-135
	T4 (µg/dl)	**5.0***	5.4-11.7
	TSH (µIU/ml)	**0.2***	0.34-4.25
	Cortisol2 (µg/24h)	**15***	20-70
	ACTH (pg/ml)	**03***	6-76
	Sr.sodium	135	135-145mg/dl
	Sr.potassium	3.6	3.5-5.5mEq/L
	HDL	35	<35
	LDL	102	100-129
	Sr.T.Cholestrol	**150***	<200
	Hb	**9mg***	10-15mg/dl
	Urea	30	20-40mg/dl
	Random sugar	**110***	120-180mg/dl

Discussion

Sheehan's syndrome is the most common cause of hypopituitarism in underdeveloped or developing countries; its exact pathogenesis is not known. However, increased pituitary size during pregnancy can make the pituitary susceptible against ischemia because of compression of the superior hypophysial arteries.[7,8] Patients may have variable presentations but Failure of postpartum lactation and failure to recommence menstruation after delivery are common symptoms in most patients. The mean duration between postpartum haemorrhage and the subsequent clinical manifestations vary from 1 to 33 years. Treatment involves lifelong hormone replacement therapy and it's essential to replace the hormones that the pituitary gland fails to produce. Hormones like corticosteroids, thyroid hormones (levothyroxine) and oestrogens and medicines to control GI disturbances become necessary to maintain normal functioning of the body.

We report a case with Sheehan's syndrome and deficiency with ACTH, due to the deficiency of this hormone the body would ordinarily produce extra cortisol — a stress hormone which leads to diarrhoea. The purpose of our report is to describe such a rare case of Sheehan's syndrome, which was accompanied by severe anaemia with recurrent diarrhoea and hypothyroidism that significantly improved after adequate therapy with thyroxin and corticosteroid [5,7,8]. Since the signs and symptoms of hypopituitarism are nonspecific the diagnosis of Sheehan's syndrome should be considered to the patients with a history of haemorrhage during delivery, Agalactorrhea, amenorrhea. Anaemia with diarrhoea that develops in Sheehan's syndromeis due to cortisol deficiency.[5,9] Our patient showed severe anemia, which improved after adequate supplement with cortisone andiron treatment.The Patient was put on replacement therapy and subsequently discharged on. Tab.Eltroxin 100µg/day and tab.prednisolone 5 mgs/day.[10]

Summary

Sheehan's syndrome is a condition that affects women who experience life-threatening blood loss during or after childbirth. Severe blood loss deprives your body of oxygen and can seriously damage vital tissues and organs and it is a rare complication of pregnancy, usually occurring after excessive blood loss during or after childbirth. The presence of disseminated intravascular coagulation (i.e., in amniotic fluid embolism or HELLP syndrome) also appears to be a factor in its development.[11,12]

Two key signs of SS involves absence of lactation and/or difficulties with lactation or you failed to start menstruating after delivery.[9] SS is still a common problem in our country, especially in rural areas. Considering the duration of disease, important delays occur in diagnosis and treatment of the disease.

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Managing Changing Environment in Nursing

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Introduction

To get oriented to understand steps to meet environmental challenges and changes with reference to nursing.

Contents:

1. Concept of changing environment
2. Nursing and Environment Safety
3. How to make successful change
4. Pienary sessions on sub themes
5. Steps to meet environmental challenges and change
6. Conclusion

Concept of Changing Environment

Hospital is an institution for the delivery of health care in the modern world offers considerable benefits to the individual and society. Individual point of view, the sick and injured person has an accessibility of centralized medical knowledge and technology on as to render treatment much more thorough and efficiently which mean to say that large number of professionally and technically skilled people apply their knowledge and skill with the help of sophisticated difference and appliance to produce or provide qualitative care to the patient. In view of the stand point of society, hospitalization protects the family from many of the disruptive effects of caring from the diseased person in the home and operates as means of guiding the sick and injured into medically supervised institution where their problems are less distractive or complicated for the society.[1]

Concept of hospital existing in India from ancient time. During the time of Buddha (6th century), there were number of hospitals to look after crippled and the poor. During the 16th century the use of allopathic system of medicine started in India. In 19th century, the first medical school for organized medical training was started in Calcutta followed by one more in Madras.[2]

In late 19th Century, the school for nursing that had began in Madras around 1870 started with training of women for improving nursing care in military hospital. In this period, the nursing services were being established in hospital. In beginning 20th century, some more nursing training centers were started in India. Most of these were started in Bombay, Calcutta and Madras; the nursing services were concerned with patient care services in the hospital.

The Nurse's concern of safe staffing and the interaction between environments has direct influence on changing concept of health care delivery system as well as emerging health problems in the society.

Nurses are always a member of health team. Safe or adequate nurse staffing is influenced by other health care providers. Health care delivery includes a variety of roles and positions. Which are changing in today's concept. It is important to establish the guidelines for certain roles & determine their effectiveness which varies from country to country.

Nursing and Environmental Safety

According to Oxford dictionary "Environment" refers to surrounding condition in which person, animals or plants lives or operates. "Environment" refers to all living - nonliving, material or non material things around nurses and patient in

specific unit of hospitals, which also includes social and economical condition.[3]

According to Oxford dictionary "Safety" refers to condition of being safe.[3] Nursing is a vital aspect of health care and needs to be properly organized. A nurse is in frequent contact with the patients and hence her role in restoring health and confidence of the patients is of utmost importance. The quality of nursing care and the management of the nursing staff reflect an image of the hospital /nursing homes.

This means an appropriate number of staff with a suitable mix of skill levels is available at all times to ensure that patient care needs are met and that hazards free conditions are maintained. Nurse continue to work overtime or work without adequate back up and are therefore prone to greater absenteeism & poor health which results in weakening of health system.

As estimated that, the best defense mechanism exposure to health and safety risks for nurses working in different clinical areas is the current knowledge of existing hazards and effective preventive strategies. However innovation in equipment and procedure occurs almost daily this is not a simple task. Therefore, the nurses should have the knowledge of health hazards on her own and on patients; also she has to know about preventive strategies for improving the quality care given to the patients. Potential health and safety hazards in hospitals have been the focus of increased attention in recent years and in hospital environments. Therefore there is a greater variety and concentration of these problems in each clinical set up.

To maintain the quality care in the work area it is necessary to find out the gaps in the knowledge or awareness among nurses and to improve the knowledge accordingly.

Regardless of environmental influences, the patient is the focus of concern as the personnel seen to maintain the safe environment that will help critically ill patient in his progress towards recovery.

As per the California Nursing Association declared in 2nd Nov 2005 [4]

The patient safety movement is important because it focuses on a variety of care indicators such as; falls, drugs errors, inappropriate surgeries that increase morbidity and mortality of patients. The authors note that experts estimate thousands of people/year die from medical errors occurring in hospitals that is more than the death from motor vehicle accidents, various Cancers or AIDS.

Following recommendation is proposed to reduce medical errors:

- Leadership and knowledge for patient safety
- Errors reporting system
- Protection for nurses reporting adverse events and staffing issues
- Setting performance standards and expectations for patient safety
- Creating safety systems in health care organizations

As per Canadian Nurses Association Nov 2005 [5]

Employers work Environment/Organization should includes as follow:

1. Work environment provide adequate equipment for staff to provide sufficient patient care.
2. Does the work environment have an appropriate physical plant in that staff can carry out their work?
3. Is there clear and influential nursing leadership at the highest levels of decision making?
4. Do Nurses receive adequate compensation for their work?

How to Make Successful Change

Change is important and necessity for the management. It is the key for both the staff and their managers to understand exactly why change is happening and how it will take place.

The word change can trigger filings of uncertainty, it may center around job security as well as concern regarding work load increase and impact on patients care. Most people tend to feel insecure, overwhelmed and as a result will resist that change to greater or lesser extent.

How you as a manager plan, communicate and

deliver change will affect its overall success. Helping your team to understand the answers to the many why? What? When? How? and Who? Questions will pay significant dividance. Answering to these questions gives you confidence and clarity in the decision making. It helps in building the plan of communication strategy with your team.[6]

Challenges facing human resource managers in recruiting and retaining of nurses can be discussed bellow:

1. Qualified skilled nurses are in shortage as environment of increasing demand and decreasing supply
2. Nursing shortages is even more Sever in high acuity areas that required highly skilled and experienced nurses
3. The Nursing work force is aging and few nurses are entering in the profession to replace those are retiring or leaving
4. Nurses report dissatisfaction with many aspects of work environment including staffing levels , heavy work loads , use of overtime , lack of sufficient supportive staff and inadequate wages
5. Nursing leaders however state that shortage of nurses due to negative image of nursing, job dissatisfaction, downsizing , restructuring and turn over of nurses has increased.
6. Changing demographic structure , cost containment strategies and alternative carrier opportunity have major obstacle to enter in nursing

Managing Changing Environment

It has innovative concepts and lending to the need of the time.[7]

1) Ethical issues and Professional Code in Nursing Practice

The Code of Professional conduct for nurses is critical for building professionalism and accountability. Ethical considerations are vital in any area dealing with human beings because they represent values, rights and relationships. The nurse must have professional competence, responsibility and accountability with moral obligations. Nurse is obliged to provide services even if it is in conflict with her/his personal beliefs and values.

2) Health Premises and Security Issues to Promote Patient Safety

Patient safety is an emerging field in health care that has indirectly or directly affected all stake holders of health care delivery system in the last decade the term patient safety encompasses all aspects affecting the safety of the patients in hospital, this is not new concept it emerges from Hippocrates and Nightingale era stating that, “do no harm”[7]

Patient safety is of paramount importance in changing environmental aspects for all health care professional as including nurses. Today there is need to note the taxonomy of patient safety (about 21 points) and knowing the patient safety solution (about 9 points) as per WHO. WHO along with the joint commission internationally set up the WHO collaborating center on patient safety which came out with the “Nine patient safety solutions” in April 2007.[7] WHO has given importance to these topics as they have been shown to be the most common problems associated with the medical management of a patient and are amenable to rectification. Every institution should frame its own list incorporating patient safety related issues for its environment and setting.

3) Impact of Communication in Preventing Medico Legal Cases

Communicating with the patient is both science and art. Art in the sense of presenting yourself and science as far as precision is concerned. Nurses are in position to practice it since it is the need of the time. Eventually medical science and its practitioners are also put under Consumers Protection Act, Nursing being a major part of health care delivery system needs to understand and focus the legal complexities to various medical and surgical specializations. Nurse has to be informed herself that when any medical negligence happens a nurse also becomes party to the negligence of patient care.

As nursing has evolved professionally so has the nurses liability is increased. To minimize legal issues in nursing nurses have to assume authority, responsibility and accountability for their professional practice therefore nurses should have basic knowledge of the legal aspects of nursing practice.

4) Issues Arising Out of Professionalism, Harassment and Abuse at Work

Nurses are professional health workers. Professional worker is a person who confirms to a level of practice that is expert and ethical after completing an authorized educational programme. They are expected to observe professional etiquettes such as being an attentive listeners, keen observer, nor judgmental, empathetic, confident, assertive, disciplined, prompt and efficient.

In spite of having expected positive qualities of professionalism there are evidences of harassment and abuse at work place.

Harassment is any conduct based on age, disability, health status, sex, race, color, language, religion, national or social origin that is unreciprocated or unwanted which affects the dignity of the men and women at workplace.

Nurses should be treated consistently with dignity and respect wherever they work. The work place should be free from undue stress, anxiety, fear or intimidation.

5) Proactive Strategies and Preventive Measures to Reduce Legal Threats

Nursing is profession which is practiced in the society involving people. In every society there are some common as well as statutory laws for protection of the rights of people. Therefore for safe nursing practice one has to understand the law and legal responsibilities to protect the rights of clients as well as to protect nurses from liabilities. Law is code, which regulates human conduct, capable being enforced and binding to all, so as to bring order in society. Thus nurse has a personal and ethical responsibility to be aware of state licensing laws, statutory laws, common laws as well as professional code of ethics for nurses and changes there on occurring. Hence every nurse has to have proactive strategies to understand preventive measures to reduce legal threats essentially of legal responsibility in which they are obliged to obey the law in nursing practice.

Steps to Meet Environmental Challenges and Change

a) Eight Steps Process for Leading Change by Proff. Kotter will Help Organizations Succeed in an ever Changing World.[8]

Step I: Establish sense of urgency, Examine competence and Identify crises.

Step II: Creating the guiding coalition, Assemble group with empowerment,

Encourage for team work

Step III: Developing a change vision; create a vision to help to direct change,

Develop strategies

Step IV: Communicate vision to all team Use every vehicle of possible

Communication, Teach new behaviors by guiding directions.

Step V: Empowering broad based Action, Remove obstacles to change

Change structure or system affecting vision,

Encourage the risk taking non traditional ideas, actions and activities

Step VI: Generating short term wins, Plan for visible performance improvements

Create those improvements, Give recognition to employees.

Step VII: Considering gains and produce more changes, Analyze and Check,

Evaluate yield and Lost, Continue momentum.

Step VIII: Anchoring new approached in the culture, Ensure the change stitches

by creating the history and weaving it into fabrics of organization.

b) How to Deal with Change?[6,9]

Step-I: Plan

- *To Find Out:*Why change? What are you

trying to achieve?

What is the impact on your direction?

What does the change mean for you and your team?

- *To Find Out*:What are the key aspects?

  What has to be done?

  How much ready you are for change?

  Who else to be involved & not to be involved?

- *To Find Out:*When will it happen?

  How are you going to tell?

  How they will react?

- *To Find Out*:Who is involved?

  Who is affected?

  Who do you need to engage outside of the team?

- *To Find Out*:Have you planned appropriately?

  Do you have all the information?

  √ Do you have all the answers?

  √ Can you communicate the plan?

Step II: Communicate with Team Members:

- Be clear about changes and impact
- Explain it will be done differently
- Make time for staff and resolve issues quickly

Step III: Deliver and Execute the Change

- Implementing the plan will take longer than you think
- Monitor and review progress
- Look for unexpected side effect and
- Act immediately if necessary, Keep your team motivated.

Short Term Initiative to Increase Supply of Nurses – Strategies:

1. Sign on – Bonuses, agency use, Government assistance, recruitment higher salaries, non nursing health care employees
2. Relationship marketing between schools to attract teenager to choose nursing as carrier by counselor

Conclusion

Managing changing environment and related issues and dilemmas requires specialized knowledge and skills as also a proper frame of attitude. Medical and nursing ethics is derived from values in health care. It directly and indirectly relates with patient rights, informed consent, confidentiality, competence, advance directives, negligence and many others. All this is concern with the obligations of the doctors, nurses and other professionals in the hospital and society.

It is necessary to be knowledgeable about the legal provisions under the consumer protection acts. There are number of guidelines prescribed by various authorities and statutory bodies which includes State and Central Government act, the International Codes for Nurses, Institutional Rules and Regulations, Standing orders etc.

"Mistakes are a fact of life, It is the response to errors and Learning from the same that matters and counts"

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Book Review: Lewis's Medical Surgical Nursing

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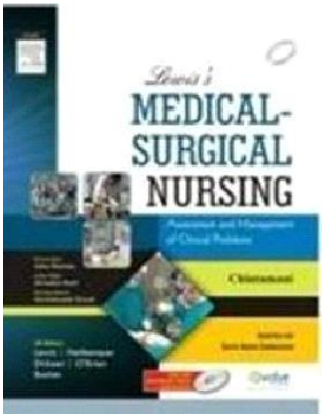
'Lewis's Medical Surgical Nursing' by Dr. Chintamani is a 1930 paged comprehensive textbook and is designed to suit the MSN curricula of South Asian Nations. It is a sincere attempt and enormous effort by the author which is praiseworthy. The book is thus useful for undergraduate student nurses, graduate nurses and teachers as well. The book has got exhaustive content spread outin 12 sections and 46 chapters, section 1 contains 8 chapters, section 2 has 4 chapters, section 3 contains 3 chapters, section 4 also contains 3 chapters, section 5 has 4 chapters, section 6 contains 2 chapters, section 7 also has 2 chapters, section 8 contains 6 chapters, section 9 has only 1 chapter, section 10 contains 2 chapters, section 11 has 7 chapters and section 12 contains 4 chapters.

This book is quite handy & the paper quality is good. The pictures which are given in various chapters are very realistic and are based on Indian Perspective. Syllabus mapper given in the starting of the book will be quite helpful to keep a watch on the syllabus (as per INC) while covering the various topics. The information given in the boxes is an effective way to cover the important things. Learning objectives which are given in the starting of every chapter would be very helpful for the students as well as teachers. The Electronic resources would definitely guide the student to get further information about the topic.NCLEX-RN Exam questions which are given at the end of every chapter can help the students to prepare for competitive exams. The book also contains self-learning illustrations, tables, special boxes and flowcharts which make

Title of Book: Lewis's Medical Surgical Nursing
Author: Dr. Chintamani
Year of Publication: 2011
Publishers : Elsevier Publications
Price: INR 1575



the learning easy for the students.In the entire book the language is simple and description is easy to comprehend by the students. A DVD is also given along with the book. Price of the book is affordable for the students in comparison to other books of Medical Surgical Nursing books.The organization of the content is sequential.

However, there are few lacunae in the book too.

The Index doesn't contain the names of few important diseases e.g. Tonsillitis, Alzheimer's disease so; it can be confusing as well as difficult for the student to find that particular topic. Few chapters lack critical thinking exercises. In addition to it a column or a box with a heading "Nurses notes" or "Nursing Alert" can be added

in all the chapters to highlight the important points from nursing point of view. Many diseases which are covered under various chapters of the book are given in a paragraph only or it lacks diagnostic findings, Medical management. Cast & its types and traction & its types must be discussed in detail because these are very important topics from exam point of view. CPR is given according to the old guidelines.

Few additions can be done in the appendices too e.g.:

- Normal range of various lab tests or drugs.
- Format of NCP as per INC.
- Scales or clinical pathways related to few common diseases.

Guidelines related to few important procedures.

Guidelines for Authors

Manuscripts must be prepared in accordance with "Uniform requirements for Manuscripts submitted to Biomedical Journal" developed by international committee of medical Journal Editors.

Types of Manuscripts and Limits

Original articles: Up to 3000 words excluding references and abstract and up to 10 references.

Original articles: Up to 2500 words excluding references and abstract and up to 10 references.

Case reports: Up to 1000 words excluding references and abstract and up to 10 references.

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Articles can also be submitted online from http://www.rfppl.com (currently send your articles through e-mail attachments)

I) First Page File: Prepare the title page, covering letter, acknowledgement, etc. using a word processor program. All information which can reveal your identity should be here. use text/rtf/doc/PDF files. Do not zip the files.

2) Article file: The main text of the article, beginning from Abstract till References (including tables) should be in this file. Do not include any information (such as acknowledgement, your name in page headers, etc.) in this file. Use text/rtf/doc/PDF files. Do not zip the files. Limit the file size to 400 kb. Do not incorporate images in the file. If file size is large, graphs can be submitted as images separately without incorporating them in the article file to reduce the size of the file.

3) Images: Submit good quality color images. Each image should be less than 100 kb in size. Size of the image can be reduced by decreasing the actual height and width of the images (keep up to 400 pixels or 3 inches). All image formats (jpeg, tiff, gif, bmp, png, eps etc.) are acceptable; jpeg is most suitable.

Legends: Legends for the figures/images should be included at the end of the article file.

If the manuscript is submitted online, the contributors' form and copyright transfer form has to be submitted in original with the signatures of all the contributors within two weeks from submission. Hard copies of the images (3 sets), for articles submitted online, should be sent to the journal office at the time of submission of a revised manuscript. Editorial office: **Red Flower Publication Pvt. Ltd., 48/41-42, DSIDC, Pocket-II, Mayur Vihar Phase-I, Delhi – 110 091, India, Phone: 91-11-22754205, Fax: 91-11-22754205, E-mail: redflowerppl@vsnl.net.**

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The text of observational and experimental articles should be divided into sections with the headings: Introduction, Methods, Results, Discussion, References, Tables, Figures, Figure legends, and Acknowledgment. Do not make subheadings in these sections.

Title Page

The title page should carry

1) Type of manuscript (e.g. Original article, Review article, Case Report)
2) The title of the article, which should be concise, but informative;
3) Running title or short title not more than 50 characters;
4) The name by which each contributor is known (Last name, First name and initials of middle name), with his or her highest academic degree(s) and institutional affiliation;
5) The name of the department(s) and institution(s) to which the work should be attributed;
6) The name, address, phone numbers, facsimile numbers and e-mail address of the contributor responsible for correspondence about the manuscript;
7) The total number of pages, total number of photographs and word counts separately for abstract and for the text (excluding the references and abstract);
8) Source(s) of support in the form of grants, equipment, drugs, or all of these;
9) Acknowledgement, if any; and
l0) If the manuscript was presented as part at a meeting, the organization, place, and exact date on which it was read.

Abstract Page

The second page should carry the full title of the manuscript and an abstract (of no more than 150 words for case reports, brief reports and 250 words for original articles). The abstract should be structured and state the Context (Background), Aims, Settings and Design, Methods and Material, Statistical analysis used, Results and Conclusions. Below the abstract should provide 3 to 10 keywords.

Introduction

State the background of the study and purpose of thestudy and summarize the rationale for the study or observation.

Methods

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Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006;35:540-7.

[2] Twetman S, Axelsson S, Dahlgren H, Holm AK, Källestål C, Lagerlöf F, et al. Caries-preventive effect of fluoride toothpaste: A systematic review. Acta Odontol Scand 2003;61:347-55.

Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone iodine antisepsis. State of the art. Dermatology 1997;195 Suppl 2:3-9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000;71:1792-801.

Unpublished article

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

Personal author(s)

[6] Hosmer D, Lemeshow S. Applied logistic regression, 2nd edn. New York: Wiley-Interscience; 2000.

Chapter in book

[7] Nauntofte B, Tenovuo J, Lagerlöf F. Secretion and composition of saliva. In: Fejerskov O, Kidd EAM, editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. p. 7-27.

No author given

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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