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CONTENT

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Editorial

From Editor's Pen……

It gives me great pleasure to write first editorial note for Indian journal of nursing. The purpose of bringing this journal is to publish work that contributes to the development of nursing knowledge base, and creates a forum for sharing research, practice, education and aesthetic works, both for nurse educators and practitioners.

Today I find it encouraging that more and more students are choosing nursing as their cherished career. Nursing profession is no doubt enabling significant number of Indian women to be empowered, educationally as well as financially. At the same time I think nursing seems to be facing more changes and challenges than ever before.

Nurses are often praised for their strength in helping other people. Needed now is the courage of truth to help themselves. Nurses must be for nursing, supporting its advances in every conceivable manner. If they do this, they will uphold the right of the sick and troubled in mind to be regarded as members of the human race; they will uphold the dignity of their patients, and their own nursing profession.

I strongly feel that we must stop reinforcing divisions between education and practice, between graduate and diploma nurses, between individual nurses and organizations, between specialties considered higher and lower status. It's time to work together to respond effectively and creatively to the challenges of care. The vision that many nurse leaders and educators hold dear to their heart is one where patients are treated with dignity and respect at all times, where systems are designed for the benefits of individual needs, and where the work is performed by the nurses is valued and respected. And I feel without evidence based practice, this is not going to be possible. Nurses need to keep themselves up to date with recent advancement in health science technology and research findings. I assure the readers that this journal will contribute towards the same. Any suggestions to make this journal better is welcomed.

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ORIGINAL ARTICLE

An Exploratory Study to Assess the Quality of Life of Women Diagnosed with Rheumatic Heart Disease (RHD) in Selected Hospitals of Mumbai

Sarika P. Bhange

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Abstract

The study was conducted to assess the quality of life of women with rheumatic heart disease in selected hospitals of Mumbai. An exploratory descriptive approach was used in the study. The sample consisted of 200 women diagnosed with RHD receiving treatment in selected hospitals of Mumbai. The study was conducted at a Municipal and a Government Hospital of Mumbai. Non probability convenience sampling technique was used in this study. The Self reporting technique and Rating scale was used to assess the quality of life of women with rheumatic heart disease. The result revealed that 50 per cent samples belonged to the age group of 15-24 years, , majority of the samples (62%) were Hindus, (72%) were from joint family, (75%) were non vegetarian, Majority of the samples (77 %) were housewives. About 55% of samples were living in chawls. The finding showed that various factors along with disease contribute to good and bad quality of life of women with rheumatic heart disease.

Keywords: Quality of life; Rheumatic heart disease.

Background

The term "Health Related Quality of Life" (HRQOL) was coined as a way of justifying the use of currently available measures under a new banner. The rationale was such that, since they focused on those aspects of existence that were affected by ill health, must also give some indication of the impact of illness on quality of life. Physicians have used HRQOL to measure the effect of chronic illness in their patients to better understand how an illness interferes with a person's day to day life.[1]

Worldwide, rheumatic heart disease remains a major health problem. Chronic rheumatic heart disease is estimated to exist in 5-30 million children and young adults; 90,000 patients die from this disease each year. The mortality rate from this disease remains 1-10%.[2]

It is evident that in RHD the prognosis of females is worse than that of males. According to 'American Heart Association' in RHD the female death rate is approximately double that of male deaths.[3]

This study was aimed at finding out the quality of life of women with Rheumatic heart disease in certain selected parameters which can affect the quality of life.

Objectives

1) To identify changes experienced by women in selected areas of life after the diagnosis of RHD.
2) To compare the quality of life of women with RHD with selected variables such as education, socioeconomic status, marital status, duration of disease and operative status.

Methodology

Research approach

Exploratory descriptive approach was used.

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Sample and sample size

In this study the sample consisted of 200 women diagnosed with RHD receiving treatment in selected hospitals of Mumbai.

Setting of the study

The study was conducted in one of the Government hospital & Municipal hospital in Mumbai.

Sampling technique

Non probability convenience sampling technique was used in this study

Technique and Tool

Self reporting was used to collect data for assessing the quality of life of women with RHD.

Tool used

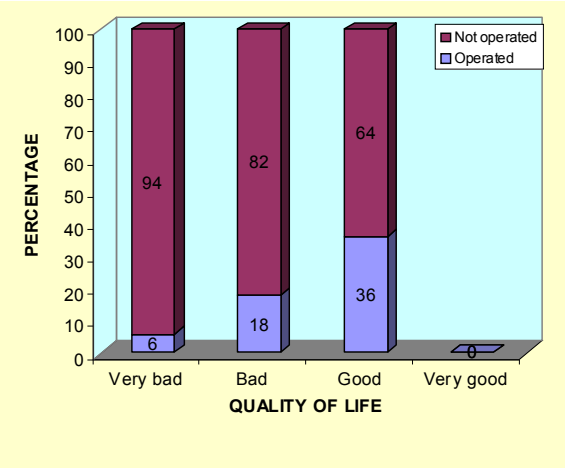
Rating scale was used to assess the quality of life of women with rheumatic heart disease.

Result and Discussion

The findings of study were as follows:

- Twenty four per cent samples were illiterate, 22 per cent had completed primary level education, 26 per cent had completed secondary education, 22 per cent had completed higher education and six per cent were graduates.

Disribution of samples with regard to their quality of life score



Quality of life of the women with RHD related to their physical activity

N=200

Physical activity	f	%
Fatigue		
a) Never	50	25
b) Sometimes (once in a day)	71	35
c) Often (twice in a day)	30	15
d) All the time(whole day feels tired)	49	25
Difficulty in meeting personal needs		
a) Great difficulty	09	05
b) Moderate difficulty	18	09
c) Some difficulty	64	32
d) No difficulty	109	54
Difficulty in doing household work		
a) Greatly affected	15	07
b) Moderately affected	29	15
c) To Some extent affected	74	37
d) Not at all affected	82	41
Rest in between the physical activity		
a) Always	31	15
b) Often	25	13
c) Sometimes	93	47
d) Never	51	25

- With regard to marital status, majority of them (57%) were married and 39 per cent were unmarried.
- Seventeen per cent of the samples had duration of illness less than 2years, 34 per cent had 3-4 years of duration of illness, 24 per cent had 5-6 years duration of illness, 12 per cent had 7-8 years duration of illness, and 13 per cent had duration of illness for more than 8 years.
- Majority of patients (78%) were only on medications and 22 per cent had been operated earlier.

Comparison of significance of difference between the means of quality of life scores of married and unmarried group

It was found that there was significant relationship between the mean score of married and unmarried group at 0.01 level. The mean was higher in unmarried; so quality of life was better in unmarried group than the married group.

Distribution of samples according to quality of scores

Majority of samples (67%) had bad quality of life, eight per cent of the samples had very bad QOL and only 25 per cent samples had good quality of life.

The figure below shows that the quality of life

was better in operated women than the non operated women.

This finding was also supported by WHO study report 2001, where it was mentioned that with operation quality of life improves.

Conclusion

It was found that many of the women's quality of life was changed because of the various factors involved in the disease process as well as from social factors. Women showed their keen interest for participation in the study.

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ORIGINAL ARTICLE

A Study to Evaluate the Effectiveness of Psycho-Education in Improving the Level of Adaptation among Mothers of Mentally Retarded Children with the Application of Health Belief Model in Selected Schools for Mentally Retarded at Nagpur (Maharashtra)

Vandana S. Thangavel

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Abstract

The present study has been designed to enhance the knowledge of mothers about mental deficiency and its management. As improving the knowledge of the mothers, help to have a more positive attitude towards the children who are mentally deficient. If the mothers are educated about the needs of mentally deficient child, they would be better equipped to manage their mentally deficient child and cope up with situation. They would also be sensitized towards exploring existing resources for help and guidance.[1] Study is conducted in Nagpur in Nandanban school for Mentally retarded Children.

Keywords: Psychoeducation; Adaptation; Mental retardation; Health belief model.

Background of the study

"There is only one precious child in the world, and every mother has that."

The term mental retardation is used to indicate a person's intelligence and daily functioning which are expected to be lower than the other people of the same age. Children with mental retardation are important and endearing youngsters with a special style of learning. Most of them are healthy and happy.They learn and show progress, although at a rate slower than the others. While different therapists, educators, and other specialists can provide special training, the best thing mothers can do is include their child in warm and lively family living.[2]

Need of the study

Mental deficiency may be viewed as interplay of several biomedical, sociocultural and psychological factors with practical emphasis on scholastic achievement and adjustment in the society.

The coping strategies used by mothers are likely to be influenced by cultures as could be the informal supports available to mothers from family and friends.

The presence of a child with Mental Retardation in the family creates additional needs. The birth of a retarded child at home is likely to be one of the most traumatic events experienced in a family *(Journal of the Indian Academy of Applied Psychology, July 2008)*. Parents and other children in the family must undergo a variety of changes to adopt to the presence of a disabled member. Most parents expect that their children will be attractive, smart, graceful, athletic, and loving. Parents of a handicapped child not only mourn the loss of unfulfilled expectations but often face enormous strain, pain and stress, shock, realization, retreat and feeling of guilt on their psychological and economic resources. shock, realization, retreat and feeling of guilt on their psychological and economic resources.[3]

There is abundant evidence that parents especially mothers undergo more than the average amount of psychological stress.

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Keeping the above factors, the present study has been designed to enhance the knowledge of mothers about mental deficiency and its management. As improving the knowledge of the mothers, help to have a more positive attitude towards the children who are mentally deficient.

If the mothers are educated about the needs of mentally deficient child, they would be better equipped to manage their mentally deficient child and cope up with situation. They would also be sensitized towards exploring existing resources for help and guidance.[1]

Hence researcher is interested to conduct a study to identify their extend of adaptation of mothers and to develop and assess the efficacy of psycho education on Mental Retardation

Objectives are as follows:

1. To assess the pre-interventional level of adaptation among mothers towards Mentally Retarded children.

2. To evaluate the effectiveness of psychoeducation in improving the likelihood of action in terms of level of adaptation among mothers of Mentally Retarded children.

3. To evaluate the effectiveness of psychoeducation in improving the individual perception in terms of knowledge regarding Mental Retardation among mothers of Mentally Retarded children.

4. To find out the correlation between individual perception and likelihood of action among mothers of Mentally Retarded children

5. To associate pre-interventional level of adaptation with selected socio demographic variables.

6. To find out the relation between difference in means of change in level of adaptation and selected socio demographic variables.

Research design

Sample	Pre test	Treatment	Post test
	Day 1	Day 1	Day 8
Mothers of mentally retarded children	01	X	02

Samplng: Simple Random Sampling

Sample size: 30 mothers

Variable

Dependent

Knowledge and level of adaptation among mothers of the mentally retarded children.

Independent

Psycho-education on mental retardation and its management

Description of the tool

The tool consists of three sections that is Section A, Section B, and Section C.

Section A consists of socio demographic variables like age, religion, educational status, occupation status, income, expenditure over mentally retarded children, type of family, number of family.

Section B comprises of self structured multiple choice questionnaire for assessing Knowledge

Section C comprises 3 point rating for assessing the adaptation of mothers.

Data analysis and Interpretation

Section A

Distribution of study subjects according to socio-demographic variables using frequency and percentage.

Section B

- Question wise analysis on pre and post interventional knowledge of mothers regarding Mental Retardation.
- Question wise analysis on pre and post interventional adaptation of mothers towards Mentally Retarded child.
- Area wise analysis on pre and post interventional adaptation of mothers towards Mentally Retarded child.
- Overall comparison of pretest and post-test level of knowledge as per criteria.
- 't' test to analyze the effect of psycho-education on knowledge of mothers regarding Mental Retardation.
- 't' test to analyze the effect of psycho-education on level of adaptation of mothers towards their mentally retarded child

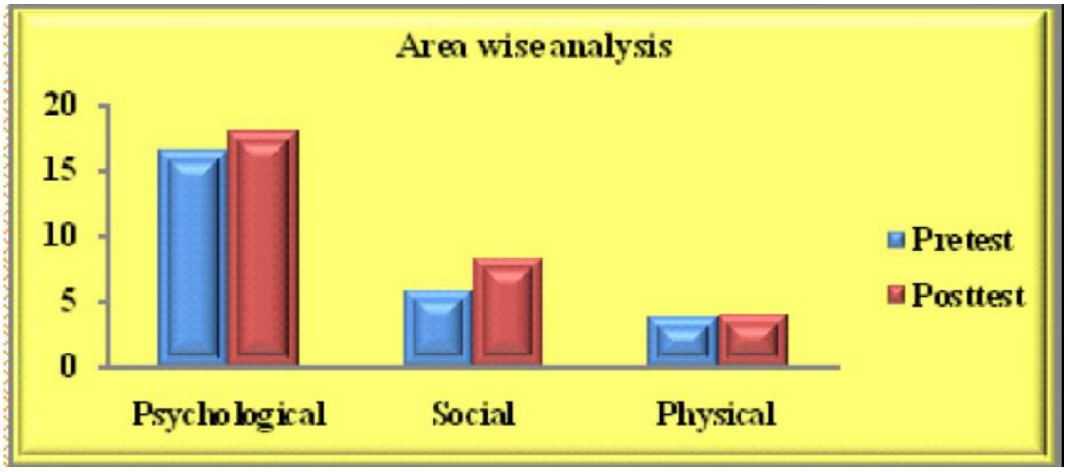
Table: Showing frequency and percentage of mothers who gave correct answers for the questions in pre and post test

S. No.	Parameters on Knowledge of mothers Regarding Mental Retardation	Frequency		Percentage	
		Pre Test	Post Test	Pre Test	Post Test
1	What is Mental Retardation	6	27	20	90
2	Prevalence of Mental Retardation	6	13	20	43.3
3	Etiology of mental Retardation	17	28	56.6	93.3
4	Diagnosis of Mental retardation is	13	26	43.3	86.6
5	Activities of Daily living of a Mentally	22	30	73.3	100
6	Mentally Retarded child can be educable, trainable etc.	19	29	63.3	96.6
7	Mentally Retarded children Educated in	29	30	96.6	100
8	Personnel involved in care of child	25	29	83.3	96.6
9	Facilities in community	20	28	66.6	93.3
10	I can teach simple task to my child	14	25	46.6	83.3
11	Agencies that supports	11	29	36.6	96.6
12	Facilities provided by Mental Deficiency Act	22	30	73.3	100

Area wise analysis on pre and post interventional level of adaptation of mothers towards their mentally Retarded children.

N=30

S. No.	Areas of adaptation	Maximum possible score	Pre Test			Post Test			t test value	Inferences
			Mean Score	Mean Score %	SD	Mean Score	Mean Score%	SD		
1.	**Psychological**	60	49.5	16.5%	0.74	53.7	17.9	0.63	9	Not significant
2	**Social**	18	15.4	5.9%	0.28	19.8	8.30%	0.24	4.5	* Significant
3.	**Physical**	12	11.4	3.80%	0.16	12.06	4.02	0.1	3.1	Not significant



Df=29

Section C

Analysis on correlation between knowledge and adaptation among mothers of mentally retarded children using Karl-Pearson's formula.

Section D

Chi Square analysis to find association between pretest level of adaptation and selected socio-demographic variables.

Section E

"t" test analysis on relation between difference in means of change in adaptation with selected socio demographic variables.

Df=29 Interpretation: This Shows that in pretest social 5.9% As't' value calculated is 4.5, which is greater than table value (2.05) at df = 29 (P>0.05) it is found to be highly significant . The pre test mean score value of Psychological adaptation is 16.5% and in the post test it is 17.9%. Regarding the physical adaptation pre test mean score 3.80% were as the post test value is 4.02.

Interpretation table shows that in the pre test mean score is 36.6%mothers having good adaptation, 63.4% having average adaptation and 0% having poor adaptation regarding Mental Retardation and after the psychoeducation the post test mean score is 90% having good adaptation, and 30% having Average adaptation regarding Mental Retardation.

Figure 12: Scatter diagram showing the correlation between knowledge and adaptation among mothers of Mentally Retarded children.

Table 4.18 and figure 12: Shows the value of calculated ' r' is 0.8 is greater than the tab. value 0.38 (at df 28) at 0.5% level of significance hence it proves a positive correlation between knowledge and adaptation of mothers towards their Mentally Retarded children, and adaptation can be better achieved by improving the knowledge level of parents through psychoeducation.

Result

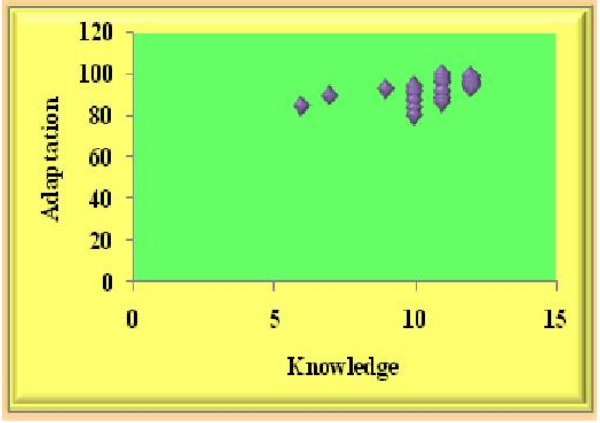
After the data collection and data analysis results and conclusions found:

Table: Overall comparison of pretest and posttest level of adaptaion as per criteria

S. No	Criteria For Measurement	Pretest		Posttest	
1.	Good	Frequency (f)	Percentage %	Frequency (f)	Percentage %
		11	36.6%	21	90
2.	Average	19	63.4%	9	30%
3.	Poor	0	0	0	0
Total		30	100	30	100

Table: Analysis on correlation between knowledge and adaptation among mothers of Mentally Retarded children

S. No.	Variables	Mean Score	Mean %	SD	r
1.	Knowledge	3.9	2.26	1.6	0.8
2.	Adaptation	9.96	30.65	4.91	



Shows clearly that there is significant improvement in the adaptation level of mothers towards their Mentally Retarded child after the administration of psychoeducation. The total mean in the pre-test is 82.86 and in post test is 91.96. The SD in pre-test is 5.65 and in post-test 4.91 is which shows that the data is consistent. As 't' value calculated is 6.30, which is greater than table value (2.05) at df = 29 (P>0.05) it is found to be highly significant. This data signifies that the psychoeducation is effective in improving the adaptation of mothers towards their mentally retarded children.

Pre test mean score is 36.6% and after the psychoeducation the post test mean score is 90% having good knowledge.

Shows clearly that there is significant improvement in the knowledge level of mothers towards their Mentally Retarded child after the administration of psychoeducation.

R is 0.8 and this value is less than 2, shows that there is a correlation between the knowledge and the adaptation among mothers of Mentally Retarded children. Here the hypothesis H_3 that is significant correlation between knowledge and adaptation among mothers of Mentally Retarded children is accepted.

Implications

Since the study reveals that the Psychoeducation on Mental Retardation with the help of Health Belief Model is effective in improving the knowledge and level of adaptation of mothers towards their mentally retarded children. The findings of the present study have implications for nursing practice, nursing administration, nursing education and nursing research.

Nursing practice

Health beliefs are a person's ideas, perception, attitudes, and conviction about health and illness. Hence nurses must be educated the core beliefs of individual in relation to health and illness so that she can put the accurate action to over come with problem faced rather than doing random interventions.

Nursing education

Nurses can organize some educative session for all the individuals wish to seek the health care facilities. Nurses should be aware of the impact of culture on a client's view and understanding of the illness.

Nursing administration

As a manager the nurse has to coordinate the activities of other members of health care team. And as a administrator she must use her critical thinking ability to identify the core beliefs and arrange behavioral programmes, classes on common illness and myths etc. to provide effective care.

Community health nursing

Prevention at all levels, primary, secondary and tertiary is best achieved through psychoeducation. This will improve quality of life of both the affected child and family members.

Nursing research

The study provide basis for further extended and intensive Nursing Research. As there are many more models which can be base of expertise nursing care for the client in any care setting.[4]

Outcome of the study

The present study shows that the mothers of mentally retarded children having less knowledge regarding the actual cause of the mental retardation. Psychoeducation of the mothers of the Mentally Retarded children with the help of health belief model if effective.[3] As the health belief are a person's ideas, conviction and attitudes about health and illness. They may be based on factual information , misinformation common sense myths , reality or false expectations. Because health belief usually influences health behavior, they can positively or negatively affect a client's level of health.

So giving a psychoeducation based on health belief model is not just for the improvement in the knowledge of mothers about the mental retardation

but also for the changing of their attitude, their perception their belief and their behavior for their mentally retarded child.

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ORIGINAL ARTICLE

Telenursing: An Emerging Field

Shaina Sharma

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Abstract

Tele-nursing is the use of telecommunications technology to provide nursing practice at a distance. This can be something as simple as faxing medical records to the more complex delivery of nursing care to patients' home through the use of cameras and computer technologies.Tele-nursing can also provide opportunities for patient education, professional consultations, examination of test results and assisting physicians in implementation of medical treatment protocols. Among its many benefits, tele-nursing may help to solve increasing shortages of nurses; to reduce distances and save travel time, and to keep patients out of hospital. A greater degree of job satisfaction has been registered among tele-nurses. It removes the barriers to health care for people living in remote villages or where adequate health services are not available.

Keywords: Telecommunications; Telehealth; Video-conferencing; Teleradiology.

Introduction

Advances in telecommunications technologies are revolutionizing education and health services globally, including the provision of nursing services. Decreasing time and distance, these advances increase access to health and healthcare, especially to underserved populations and those living in rural and remote areas. They help to manage the demand for services, ensure more effective use of human and health resources and facilitate education and research activities.[1]

Today nurses can offer consultation and comfort to patients whether they are in the same city or thousands of kilometers away. Over the telephone, nurses can calm an anxious parent, evaluate an injury or advise whether a person should go to an emergency unit. Communications technology now also enables nurses to deliver health care in rural and remote locations, and areas without health care services.[1]

Meaning

Tele is a prefix meaning "*at a distance,"* and it is used in terms such as telescope, or telemetry. The prefix tele, when combined with the term scope, has the single clear following meaning: *an instrument to view phenomena at a distance.[2]*

Definition

Telenursing is a component of telehealth that occurs when nurses meet the health needs of clients, using information, communication and web-based systems. It has been defined as the delivery, management and coordination of care and services provided *via* information and telecommunication technologies.[3]

Purposes of telenursing

- To improve access to health care.

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- To provide specialized health care consultation to patients in remote locations.
- To facilitate video-conferencing among health care experts for better treatment & care.
- To provide opportunities for continuing education of health care personnel.
- Reduce ambulance transportation for off-site care.

Technologies used in telenursing may include, but are not limited to:

- telephones (land lines and cellphones)
- personal digital assistants (PDas)
- facsimile machines (faxes)
- Internet
- video and audio conferencing
- teleradiology
- computer information systems
- telerobotics.[3]

Principles of telenursing

Effective telenursing should:

- Augment existing health care services.
- Enhance optimum access, appropriate and necessary, provide immediate access to health care services, improve & enhance the quality of care and reduce the delivery of unnecessary health services.
- Protect the confidentiality/privacy and security of information related to nurse-client interaction.[4]

Registered nurse engaged in telenursing should:

- Established therapeutic nurse-client relationships based on assessment, planning.
- Collaborate with others member of health care team when appropriate to ensure quality care & effective services.
- Determine whether telenursing practice is most effective & appropriate method to provide nursing services consistent.[3]

Systems for admission, discharge, transfer by telenursing

- Information collected through registration should be electronically transmitted to all user who need the data.
- Electronic transmittal assures that uniform data exist at all locations.
- Electronic transmittal decreases the risk of errors associated with duplicate data.
- Registration system assigns a unique identifier to all patients, which has been called the medical record number.
- To access patient records at different sites of care, users must have a way to link all medical record numbers within an enterprise to obtain a longitudinal record of care received by the patient.

Applications of telenursing

- Available in the home, hospital, through telenursing centres and through mobile units
- In home care nurses use systems that allow home monitoring of physiologic parameters, such as blood pressure, respiratory peak flow, and weight, via the Internet
- Patients contact on-call nurses any time and arrange for a video consultation to address any problems; for example, how to change a dressing
- Helps patients and families to be active participants in care, particularly in the self management of chronic illness
- Enables nurses to provide accurate and timely information and support online
- Continuity of care is enhanced by encouraging frequent contacts b/w health care providers, individual patients and their families
- Limited resources can benefit a large population spread over a broad geographical region
- Dearth of adequate opportunities for training or continuing Medical Education for Doctors in Rural/Remote Health facilities
- Inadequate infrastructure in rural/district hospitals.[5]

Benefits of 'telenursing' to the patients

1. More timely information to patients and families

reduces the use of expensive health care services (physician's office, emergency units, hospitals and nursing homes).

2. Limited resources can benefit a large population spread over a broad geographical region.
3. Telenursing can reduce the requirement for, or the length of, hospital stays.
4. Adults with chronic conditions who need frequent monitoring, assessment, and maintenance but do not meet home care criteria or have no money to pay for services can benefit from technology.[3]

Benefits of 'telenursing' to nurses

a) Clinical information can be shared with other professional colleagues including national and international experts. This will help in the development of enhanced nursing roles.
b) The new technologies also increase access to nurse education, particularly continuing education. Examples include teaching off campus, video-conferencing, online learning and multimedia distance education.
c) Clinical skills can be learned and practiced through patient simulation modelling.
d) Telenursing provides opportunities for mature nurses to bring their years of experience back to the clinical arena without enduring the physical burden of 'floor' nursing in hospitals.[3]

Disadvantages of the telenursing

- Lack of professionals with licenses to perform medical procedures
- Changes in the nurse-patient relationship
- Possibility of technological failures
- Patient loses individual properties
- High cost of telemedicine (equipment, technology, expert staff in the maintenance of equipment, training of staff)
- Possibility of misinterpretation of data and images transmitted, depending on the quality of the equipment
- Lack of security and confidentiality of electronic information
- Dehumanizing effects
- Inability for patient to use equipment
- Knowledge base of the nurse
- Equipment malfunction.[3]

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REVIEW ARTICLE

Nursing Management of Patients with Pneumonia: A Nursing Process Approach

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Abstract

Although "Pneumonia" was regarded by William Osler in the 19th century as "the captain of the men of death", the advent of antibiotic therapy and vaccines in the 20th century has seen improvements in survival. Nevertheless, in developing countries, and among all age groups, it remains a leading cause of death. Yet, little attention is paid to this disease. Pneumonia is an inflammation of the lung parenchyma caused by various microorganisms. Sudden onset; shaking chill; rapidly rising fever and pleuritic chest pain aggravated by respiration or coughing are its vital clinical manifestations. The key goals of management of Pneumonia are maintaining adequate gas exchange, clearing the infection and promoting the airway clearance through skilled effective nursing interventions. Monitoring the sputum production, respiratory pattern and characteristics, ABGs and SaO_2 to determine oxygen needs; Providing chest physical therapy and postural drainage and therapeutic Positioning; Administering Oxygen, Bronchodilators, NSAID's, Antibiotics and timely suctioning are the goal directed nursing interventions in effective management of Pneumonia. The best way to prevent pneumococcal disease is by getting vaccinated. The pneumococcal vaccines like Pneumococcal Conjugate Vaccine (PCV13) and Pneumococcal Polysaccharide Vaccine (PPSV23) are helpful to protect against some of the more than 90 types of pneumococcal bacteria.

Keywords: Pneumonia; Pnuemonitis; Pneumococcal infections; Bronchopneumonia; Nursing management; Pneumonia vaccination.

Introduction

Pneumonia kills more children than any other illness – more than AIDS, malaria and measles combined. Over 2 million children die from pneumonia each year, accounting for almost 1 in 5 under five deaths worldwide. Yet, little attention is paid to this disease.[1]

Pneumonia is an inflammatory condition of the lung, affecting primarily the microscopic air sacs known as alveoli. It is usually caused by infection with viruses or bacteria and less commonly other microorganisms, certain drugs and other conditions such as autoimmune diseases.

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Although pneumonia was regarded by William Osler in the 19th century as "the captain of the men of death", the advent of antibiotic therapy and vaccines in the 20th century has seen improvements in survival. Nevertheless, in developing countries, and among the very old, the very young, and the chronically ill, pneumonia remains a leading cause of death.[2]

Definition

Pneumonia is an inflammation of the lung parenchyma[3,4,5,6] caused by various microorganisms, including bacteria, mycobacteria, chlamydiae, mycoplasma, fungi, parasites, and viruses. "Pneumonitis" is a more general term that describes an inflammatory process in the lung tissue that may predispose or place the patient at risk for microbial invasion.[3]

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"Pneumonia" can be defined based on the multiple references as, "the inflammation of lung parenchyma involving the terminal airways and alveoli of the lung, caused by infectious agents, resulting in edema of the interstitial lung tissue and extravasation of fluid into the alveoli, with consolidation and exudation, thus causing hypoxemia".[4,5,6,7,8]

Epidemiology

1. Pneumonia affects approximately 450 million people globally per year, seven percent of population, and results in about 4 million deaths, mostly in third-world countries.[2]
2. Pneumonia remains a leading cause of death for all age groups,[2,3] resulting in 4 million deaths (7% of the world's total death) yearly.
3. Rates are greatest in children less than five, and adults older than 75 years.
4. In the United States, as of 2009, pneumonia is the 8th leading cause of death.
5. It occurs about five times more frequently in the developing world than in the developed world.
6. In 2010, it resulted in 1.3 million deaths, or 18% of all deaths in those under five years, of which 95% occurred in the developing world.
7. Countries with the greatest burden of disease include: India (43 million), China (21 million) and Pakistan (10 million).
8. It is the second most common nosocomial infection and accounts for about 15 - 20% of total nosocomial infections.[2]
9. Leading cause of death for the clients older than 85 years.[8]

WHO response

In 2013, WHO and UNICEF launched the integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD). The aim is to accelerate pneumonia control with a combination of interventions to protect, prevent, and treat pneumonia in children with actions.[9] The goal is to see a drop in deaths from pneumonia to fewer than 3 children in 1000 live births, and from diarrhoea to less than 1 in 1000 by 2025.[10]

Risk factors

1. Chronic illness.
2. Viral respiratory infections.
3. Immunosuppression / Neutropenia
4. Age > 65 years.
5. Impaired gag, cough or swallow reflex.
6. Depressed cerebral function (altered level of consciousness)
7. Tracheotomy or endotracheal tube
8. Organ transplants
9. AIDS
10. Exposure to noxious gas (eg: cigarette smoke, air pollution)
11. Abdominal or thoracic surgery
12. Aspiration of upper airway organisms
13. Crowded living conditions
14. Prolonged bed rest or immobility
15. Malnutrition.[8]

Predisposing factors in elderly

1. Chronic airflow limitation.
2. Congestive Heart Failure
3. Influenza
4. Alcoholism
5. Immobility
6. Reduced cellular immunity
7. Loss of ciliary action
8. Decreased chest wall compliance
9. Decreased muscle strength
10. Poor nutritional status.[8]

Etiology/ classification / the pneumonia syndromes

1. *Community Acquired Acute Pneumonia:*
   - Streptococcus Pneumoniae
   - Haemophilus Influenzae
   - Moraxella Catarrhalis

- Staphylococcus Aureus
- Legionella Pneumophila
- Enterobacteriaceae (Klebseilla Pneumoniae) and Pseudomonas spp.

2. *Community acquired a typical pneumonia:*
   - Mycoplasma Pneumoniae
   - Chlamydia spp. (C. Pneumoniae, C. Psittaci, C Trachomatis)
   - Coxiella Burnetti (Q fever)
   - Viruses : Respiratory Syncytial Virus, Parainfluenza Virus(Children); Influenza A and B (Adults); Adenovirus (military recruits); SARS virus
3. *Nosocomial pneumonia:*
   - Gram–negative rods belonging to Enterobacteriaceae (Klebsiella spp., Serratia Marcescens, E Coli) and Pseudomonas spp.
   - Staphylococcus Aureus (usually Penicillin – resistant)
4. *Aspiration pneumonia:*
   - Anaerobic oral flora (Bacteroides, Prevotella, Fusobacterium, Peptostreptococcus), admixed with aerobic bacteria (Streptococcus Pneumoniae, Staphylococcus Aureus, Hemophilas Influenza, and Pseudomonas Aeruginosa)
5. *Chronic pneumonia:*
   - Nocardia
   - Actinomyces
   - Granulomatous: Mycobacterium Tuberculosis and atypical Mycobacteria, Histoplasma Capsulatum, Coccidiodes Immitis, Blastomyces Dermatitidis
6. *Necrotizing pneumonia and lung abscess:*
   - Anaerobic bacteria (extremely common) with or without mixed aerobic infection.
   - Staphylococcus Aureus, Klebsiella Pneumoniae, Streptococcus Pyogenes, and type 3 Pneumococcus (uncommon)
7. *Pneumonia in the immunocompromised host*:
   - Cytomegalovirus
   - Pneumocystis Carinii
   - Mycobacterium Avium Intracellulare
   - Invasive Aspergillosis
   - Invasive Candidiasis
   - Usual bacterial, viral, and fungal organisms (listed above).[11]

Pathophysiology

Pneumonia results from an infection of the pulmonary tissue, including the interstitial spaces, the alveoli, and often the bronchioles. The pneumonic process begins when pathogens successfully penetrate the airway mucus and multiply in the alveolar spaces. To do this, they must survive the lung's many defenses against microbial invasion. As the pathogenic organisms multiply, edematous fluid forms, and other evidence of inflammation becomes apparent. White blood cells migrate into the alveoli and cause thickening of the alveolar wall. Fluid fills the alveoli, which protects the organisms from phagocytosis and facilitates the movement of organisms to other alveoli. In this way the infection spreads. If the invading organisms obtain access to the blood stream, septicemia results.

The edema of inflammation stiffens the lung, thus causing decreased lung compliance and a decline in the vital capacity (VC) of the lung. Decreased production of surfactant further reduces compliance and leads to atelectasis. Some of the venous blood coming into the lung passes through the under ventilated area. This unoxygenated blood then travels to the left side of the heart. As a result, arterial oxygen tension falls, causing hypoxemia (insufficient oxygen in the blood).

Fever is the systemic response to the infection. The client may develop shaking chills in an attempt to increase heat production and raise the metabolic rate. An increase in metabolic demand causes secondary tachypnea with tachycardia. Blood pressure may fall because of peripheral vasodilation and decreased circulating blood volume secondary to dehydration. Cardiac function may be compromised by hypoxemia and enhanced metabolism. Congestive heart failure or shock may result; cardiac irritability may be enhanced because of inadequate tissue oxygenation, thus causing dysrhythmias.

The extent of pulmonary involvement after the

microbial invasion depends on the defenses of the host. In an immunocompromised host, bacteria can multiply. Tissue necrosis results when multiplying anaerobic organisms form an abscess that perforates the bronchial wall. Pneumonia may occur as diffuse patches throughout both lungs (bronchopneumonia), or it may cause consolidation (solidification, lack of air spaces) in one lobe.[8]

Clinical Manifestations

1. Fever, chills, or both : Sudden onset; shaking chill; rapidly rising fever of 39.5° C to 40.5° C (101° F to 105° F).
2. Cough nonproductive to very productive or purulent.
3. Dyspnea accompanied by respiratory grunting, nasal flaring, use of accessory muscles of respiratory, fatigue.
4. Tachypnea.
5. Tachycardia.
6. Rapid bounding pulse.
7. Pleuritic chest pain aggravated by respiration / coughing.
8. Diaphoresis.
9. Headache.
10. Fatigue.[7]

Dignostic evaluation

1. *History:* Assess for risk factors.
2. *Physical examination findings (in addition to clinical manifestations)*
   - Bronchial breath sounds over the affected area.
   - Whispered pectoriloguy present.
   - Tactile fremitus increased over the affected area.
   - Percussion note dull over the affected area.
   - Unequal lung expansion over the affected area.
3. *Diagnostic studies:*
   - Tests to identify organism responsible: sputum culture and sensitivity, arterial blood gases, blood cultures, (WBC increased).
   - Chest radiograph to define location and extent of pneumonia (affected areas appear white or opaque)
   - Immunologic test for detecting microbial antigens in serum, sputum, and urine.
   - Skin test or tuberculosis.
   - Transtracheal aspiration
   - Bronchoscopy
   - Needle aspiration
   - Open lung biopsy[6]

Management

Goals of treatment:

1. Maintain adequate gas exchange.
2. Clear infection
3. Promote airway clearance.

Pharmacological interventions

1. *Antibiotics therapy:* depends on laboratory identification of causative organism and sensitivity to specific antimicrobials.
2. *Oxygen therapy:* If the patient has inadequate gas exchange oxygen therapy is provided to prevent or treat hypoxemia.[6]

Non-pharmacological interventions

1. Turn, cough, and deep breathing exercises to remove secretions.
2. Aerosols and Humidification: to reduce sputum viscosity and promote mucociliary clearance
3. Perform postural drainage and chest physiotherapy.
4. Ensure proper nutrition to keep immune system functioning properly.
5. Promote activity such as walking as tolerated.
6. Isolate immunocompromised patients to prevent continued exposure to infective organism.

Special Medical Surgical Procedures:

Bronchoscopy to directly visualize the affected areas, to remove sputum by lavage, and to obtain

Drug therapy for various types of Pneumonia

Type of Pneumonia	Drug therapy
Community Acquired Pneumonias:	
• Streptococcus Pneumoniae (Gram +ve)	• Penicillins
• Haemophilus Influenzae (Gram -ve)	• First and second generation Cephalosporins • Tetracyclines • Quinolones • Trimethoprim / Sulfamethoxazole
• Mycoplasma Pneumoniae • Legionella Pneumophila (Gram –ve)	Macrolide antibiotics (such as Erythromycin)
Viruses	• No specific drug for viruses
Nosocomial pneumonias	
• Staphylococcus Aureus (Gram +ve) • Klebsiella Pneumoniae (Gram -ve)	• Broad spectrum Penicillins
• Pseudomonas Aeruginosa (Gram –ve)	• Penicillin with a beta-lactamse – inhibitor added • Second and third generation Cephalosporins • Aminoglycosides • Quinolones • Macrolide antibiotics • Trimethoprim / Sulfamethaxazole • Vancomycin
Fungi	• Antifungals (such as Amphotericin B or Flucanazole [Diflucan])
Other pneumonias	
• Pneumocystis Carinii Pneumonia	• Trimethoprim / sulfamethoxazole • Pentamidine
• Aspiration Pneumonia (usually anaerobes such as Bacteroides)	• Clindamycin (Cleocin, Dalacin) • Second generation Cephalosporins[8]

tissue biopsies.[6]

Complications

1. Hypoxemia
2. Respiratory failure
3. Abscess formation
4. Empyema
5. Pleural effusion
6. Pleurisy
7. Bacteremia
8. Septicemia
9. Pulmonary edema
10. Atelectasis
11. Arthritis.[6]

Nursing Management

Nursing Assessment

Subjective data

Important health information:

Past health history: Lung cancer, COPD, cigarette smoking, alcoholism, diabetes, chronic debilitating disease, AIDS, exposure to chemical toxins, dust or allergen.

Medications: Use of antibiotics, corticosteroids, chemotherapy, or any other immunosuppressants.

Surgeries and other treatment: Recent abdominal or thoracic surgery, splenectomy, any surgery with general anesthesia.

Functional health patterns:

Health perception – health management: Recent URI, fatigue, malaise.

Nutritional metabolic: Anorexia, nausea, vomiting, fever, chills.

Activity exercise: Prolonged bed rest or immobility, weakness, dyspnea, cough (productive or dry).

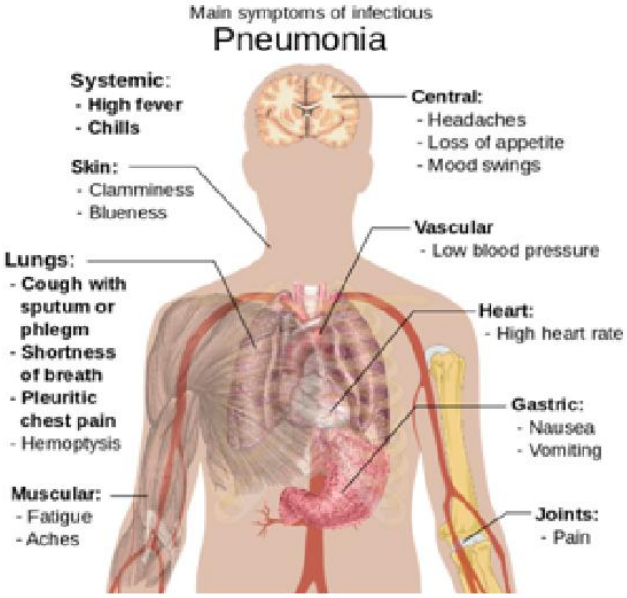
Cognitive perceptual: Pain with breathing, chest pain, headache, myalgia.

Subjective data

General: Restlessness or lethargy; splinting of affected area.

Integumentory: Diaphoresis or dry skin with poor turgor; pallor, flushing, or circumoral and nail bed

Figure 1: Main symptoms of infectious pneumonia



Reference: Pneumonia. Wikipedia: The free encyclopedia. [online] 2013 Aug 28 [cited 2013 Sep 2]; Available from URL: http://en.wikipedia.org/wiki/File:Symptoms_of_pneumonia.svg

cyanosis.

Respiratory: Tachypnea; pharyngitis; asymmetric chest movements or retraction; decreased excursion; nasal flaring; use of accessory muscles (neck abdomen); grunting; crackles, ronchi, bronchial or absent breath sounds, pleural friction rub on auscultation; dull over consolidated areas, tactile fremitus; pink, rusty, purulent, green, yellow, or white sputum (amount may be sent to copious) on percussion.

Cardiovascular: Tachycardia

Neurologic: Changes in mental status; confusion to delirium

Possible findings: Leukocytosis; abnormal ABG's with decreased or normal PaO_2, increased $PaCO_2$, and decreased $p^{H;}$ positive sputum gram stain and culture; nonsegmental consolidation with air bronchograms and patchy or diffuse infiltrates on chest X- ray.[5]

List of nursing diagnosis

1. Ineffective airway clearance related to copious sputum production.
2. Ineffective breathing pattern related to chest pain, tachypnea and hypoxia.
3. Impaired gas exchange related to ventilation perfusion mismatch.
4. Pain related to effects of inflammation of the parietal pleura and frequent coughing.
5. Hyperthermia related to increased metabolic rate, dehydration.
6. Impaired nutritional status, less than body requirements related to inflammatory and infectious condition.
7. Activity intolerance related to decreased oxygen levels for metabolic demands.
8. Fluid volume deficit related to fever, diaphoresis, and mouth breathing.
9. Impaired oral mucous membrane related to mouth breathing and frequent coughing.
10. Sleeping pattern disturbance related to pain, dyspnea, unfamiliar environment.
11. Knowledge deficit related to treatment regimen and preventive health measures.
12. High risk for potential complications of super infections related to pleural effusion, lung abscess, bacteremia.

Vaccination

Vaccination prevents against certain bacterial and viral pneumonias both in children and adults. Influenza vaccines are modestly effective against influenza A and B. The Center for Disease Control and

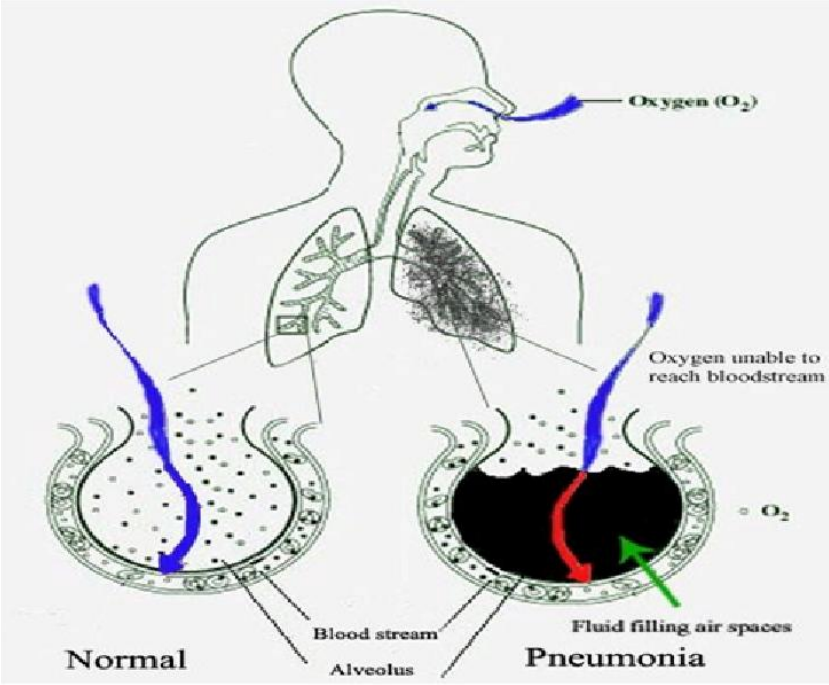
Nursing care plan based on priority nursing diagnosis

Nursing Diagnosis	Objective	Nursing Interventions	Evaluation
1. Ineffective airway clearance related to copious sputum production.	Client maintains patent airway clearance as manifested by adequate coughing reflex, clearing secretions and clear lung sounds.	1. Monitor sputum production, noting color, consistency, amount, and odor. 2. Provide adequate humidification and hydration to loosen secretions. 3. Stress the importance of activity and exercise. 4. Teach the patient to turn, cough, and deep breathe. 5. Provide chest physical therapy and postural drainage, if indicated. 6. Administer nasotracheal suction, if indicated. 7. Administer bronchodilators, if indicated. 8. Administer antibiotics, if indicated.[6]	Client maintain patent airway clearance
2. Ineffective breathing pattern related to chest pain, tachypnea and hypoxia.	Client maintains normal breathing pattern as manifested by lack of dyspnea, respiratory rate of 12 to 20 breaths per minute, lung sounds equal bilaterally and bilaterally equal chest expansion.	1. Monitor ABGs as indicated. 2. Monitor respiratory rate, rhythm, and depth and use of accessory muscles. 3. Position for comfort with head of bed elevated to facilitate efficient use of diaphragm. 4. Administer pain medication as needed. 5. Administer oxygen as indicated.[6]	Client maintain normal breathing pattern
3. Impaired gas exchange related to ventilation perfusion mismatch.	Client attains balanced gas exchange as manifested by reduced cyanosis, dyspnea, improved ABGs gradually leading to normal findings.	1. Observe for cyanosis, dyspnea, hypoxia, and confusion, indicating worsening condition. 2. Follow ABGs / SaO_2 to determine oxygen need and response to oxygen therapy. 3. Administer oxygen at concentration to maintain PaO_2 at acceptable level. Hypoxemia may be encountered because of abnormal ventilation- perfusion ratios in affected lung segments. 4. Avoid high concentrations of oxygen in patients with COPD, particularly with evidence of CO_2 retention; use of high oxygen concentrations may worsen alveolar ventilation by removing the patients only remaining ventilatory drive 5. Place patient in an upright position to obtain greater lung expansion and improve aeration. Frequent turning and increased activity (up in chair, ambulate as tolerated) should be employed. [7]	Client attain balanced gas exchange
4. Pain related to effects of inflammation of the parietal pleura and frequent coughing.	Client verbalizes maximum reduction of pain as manifested by appears comfortable.	1. Place in a comfortable position (Semi-Fowler's) for resting and breathing; encourage frequent change of position to prevent pooling of secretions in lungs. 2. Demonstrate how to splint the chest while coughing. 3. Avoid suppressing a productive cough. 4. Administer prescribed analgesic agent to relive pain. Avoid narcotics in patients with a history of COPD and use very cautiously in elderly. 5. Apply heat and / or cold to chest as prescribed. 6. Assist with intercostal nerve block for pain relief. 7. Encourage modified bed rest during febrile period. 8. Watch for abdominal distention or ileus, which may be due to swallowing of air during intervals of severe dyspnea. Insert a nasogastric or rectal tube as directed.[7]	Client verbalize maximum reduction of pain.

Prevention (CDC) recommends yearly vaccination for every person 6 months and older. Immunizing health care workers decreases the risk of viral pneumonia among their patients. When influenza outbreaks occur, medications such as amantadine or rimantadine may help prevent the condition.[2]

The best way to prevent pneumococcal disease is by getting vaccinated. The pneumococcal vaccine is a shot that helps protect against some of the more

Figure 2: Pneumonia fills the lung's alveoli with fluid, hindering oxygenation. The alveolus on the left is normal, whereas the one on the right is full of fluid from pneumonia



Reference: Pneumonia. Wikipedia: The free encyclopedia. [online] 2013 Aug 28 [cited 2013 Sep 2]; Available from URL: http://en.wikipedia.org/wiki/File:Symptoms_of_pneumonia.svg

than 90 types of pneumococcal bacteria. Following are the Vaccines for available against Pneumococcal infections:

1. *Pneumococcal Conjugate Vaccine (PCV13 or Prevnar 13®):* For Children protects against the 13 types of pneumococcal bacteria. PCV13 is also recommended to help prevent pneumococcal disease in adults with certain medical conditions.
2. *Pneumococcal Polysaccharide Vaccine (PPSV23 or Pneumovax 23®):* Protects against 23 types of pneumococcal bacteria. It is recommended for all adults 65 years and older and for anyone who is 2 years and older at high risk for disease.[12]

Conclusion

Prevention is best rather than treatment as pneumonia is considered comparatively to other disease as such. The patient needs to be assured that complete recovery from pneumonia is possible. It is extremely important to emphasize the need to take all of the prescribed medication and to return for follow – up medical care and evaluation. Adequate rest is needed to maintain progress and to prevent relapse. The patient considered to be at high risk to pneumonia should be told about available vaccines and should discuss with the health care provider.

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[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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