Strengthening the Profession of Nursing

Enhancing Transformation

Proceedings of the National Conference

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Editors

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"A balanced intellect presupposes a harmonious growth of body, mind and soul"

Mahatma Gandhi

Preface

"Let us never consider ourselves finished nurses. We must be learning all of our lives." This quote, attributed to Florence Nightingale in the 1800s, foreshadows the need for nurses to constantly learn and adapt to be key contributors in healthcare. This mandate has never been more important than it is today as nurses strive to meet the constantly changing demands of today's complex healthcare system. In fact, healthcare delivery system in India is transforming on a rapid pace, with advancement in medical sciences, technology and patient expectations. The dramatic changes in the healthcare system require competent nurses to perform assigned duties independently applying complex knowledge, expertise and critical thinking.

The primary goals of nursing education remain the same: nurses must be prepared to meet diverse patients' needs; function as leaders; and advance science that benefits patients and the capacity of health professionals to deliver safe, quality patient care. Considering the opportunities, emerging challenges and strategies, imperative to strengthen the nursing education, practice and research, a National Conference on "Strengthening the Profession of Nursing: Enhancing Transformation" was successfully conducted on 24-25 January 2019 by MGM New Bombay College of Nursing, at MGM Educational Campus, MGM Institute of Health Sciences, (Deemed to be University), Navi Mumbai, India.

One hundred and seventy participants across the country-participated in the conference. Majority of the participants were from Maharashtra, Gujarat and Jharkhand State. 27 resource persons were invited from renowned institutions/ universities of India like; NITTE University Mangalore, Post Graduate Institute of Medical Education & Research, Chandigarh, Bharati Vidyapeeth (Deemed to be University), Sangli, Symbiosis International (Deemed to be University), Pune, Pravara Institute of Medical Sciences, Loni, College of Nursing, CMC Vellore, Maharashtra University of Health Sciences, Nashik, and from our own MGM Institute of Health Sciences (Deemed to be University), Navi Mumbai were invited. The speakers were invited from Intellectual Property Consultancy and Legal Advisory Firm, Higher Education Forum, Suasth Healthcare India Limited, South Asia and Middle East, Arjohuntleigh Healthcare Private Limited, Mumbai.

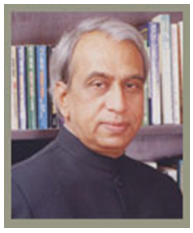
The conference covered several aspects of emerging trends in the area of nursing for providing a momentum to deliberate on current challenges and opportunities, strategies for robust nursing innovation, research and progress towards advanced practice. 18 peer-reviewed scientific papers and 16 posters were presented.

I am exceedingly thankful to the management of MGM for extending invaluable help and guidance in the organization of conference. I owe my sincere thanks to Dr. Shashank D. Dalvi, Hon. Vice Chancellor, possessed with creative prowess to conceptualize the theme for the conference. I am indebted to all resource and chairpersons for their precious inputs. I acknowledge all the authors for their invaluable contributions. I thank teaching and nonteaching staff for their creativity, hard work and team spirits which has made the conference a grand success. A special word of appreciation shall go to all heads of conference committee and members for their efforts in refining the minutes. I am extremely fortunate to have support of students for carrying out all the tasks successfully as and when assigned to them.

I am happy and convinced that the conference has provided a platform to participants for interacting with each other as well as with resource persons which lead to the fruitful deliberations. I hope that this conference volume will become a knowledge repository for the researchers and nurse practitioners.

Prabha K Dasila

Message



MGM Institute of Health Sciences (MGMIHS) which was founded in August 2006 is today an innovation driven premier Health Science University in our country. The accomplishments of the University are a reflection of the vision, commitment, hard work and dedication of the faculty, staff and students of the constitute colleges and University departments.

I congratulate MGM New Bombay College of Nursing for being recognized among top ten promising Nursing Colleges in India, 2018. I appreciate the efforts of nursing faculty for providing quality education and preparing highly competent nurses for the country.

It is a moment of great pleasure that the college of nursing is organizing a conference on theme "Strengthening the Profession of Nursing: Enhancing Transformation." I wish the organizers and all the delegates a great success.

There is a dramatic change in the progress of nursing profession beginning from bedside nurse to a clinical practitioner. This conference is apt for the current need of hour and will be a right forum for strengthening nursing profession.

I hope this conference will enlighten the participants to take a lead for innovations and advanced Nursing Practice in India.

Shri Kamalkishor N Kadam
Chairman
MGM Trust & Chancellor MGMIHS

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Welcome Address

Ms. R. Ponchitra
Organizing Secretary &
Vice Principal,
MGM New Bombay College of Nursing
MGM Institute of Health Sciences (MGMIHS)
(Deemed to be University)
Navi Mumbai - 410209, India

Distinguished guests, delegates, ladies and gentlemen**.** It is an honor and privilege for me to welcome all on behalf of MGM New Bombay College of Nursing (MGMNBCON) for 2-day National Conference from 24-25 January 2019.

At the outset, I wish to brief you all in short about the Mahatma Gandhi Mission Trust, popularly known as MGM, which was established on 20 December 1982 at Nanded, Maharashtra, with the vision to provide quality education by applying innovative and dynamic pedagogical techniques. Since its inception, the Trust has focused on providing healthcare services, school education and higher education with dedication and commitment. The MGM Trust, which is the parent body of the MGM Institute of Health Sciences (MGMIHS), recognized the need for promoting medical education in the country so as to improve the quality of life for individuals and the community by promoting health, preventing and curing diseases, advancing biomedical and clinical research and imparting educational programs for budding physicians and scientists. To accomplish its vision, two medical colleges were established in Maharashtra, one in Navi Mumbai in August 1989 and the other in Aurangabad in January 1990. In 2006, the University Grants Commission (UGC) of the Government of India accorded the status of Deemed University to MGMIHS with two of its constituent medical colleges. Since then, a number of institutions have emerged under the umbrella of MGM in various disciplines of health and allied sciences affiliated to the university.

The MGM Institute of Health Sciences is among the preeminent universities of the country. It strives to provide and sustain high quality in teaching, research and patient care. The university is committed to creativity, innovation and excellence in every sphere of its working. The education system, including the curriculum and practical training, is so designed that tomorrow's doctors and medical scientists possess well-developed clinical skills and attitudes necessary to provide the best evidence-based patient care to each and every individual and particularly to those from a lower socioeconomic status, following ethical practices. Today, the

University offers professional degree courses in MBBS, MD, MS, M.Sc. and Ph.D., which are recognized by respective councils and follow the UGC guidelines. Clinical training is imparted in the University's own hospitals including rural hospitals. It has over 1800 medical and non-medical faculty and consultants who are involved in teaching as well as research programs of national relevance. Approximately 400–500 students graduate from the university each year.

The university is known today for the excellence in its teaching, research, patient care and community outreach programs serving people from various strata of life with focus especially on rural communities. The university is accredited grade 'A' by National Assessment and Accreditation Council (NAAC) and accreditation of teaching hospital with Mahatma Jyotiba Jan Arogya Yojana, National Accreditation Board for Hospitals and Healthcare Providers (NABH) grade 'A' and National Accreditation Board for Testing and Calibration Laboratories (NABL) for diagnostic laboratories.

The MGM New Bombay College of Nursing a constituent unit of MGMIHS had its inception in 2008. During the last ten years, the institute has grown profoundly from undergraduate to postgraduate and PhD program. It is one among the pioneering colleges in India for offering the Nurse Practitioner in Critical Care (NPCC) postgraduate program commenced from 2017. I feel proud to share with you all that our college has been recognized as one among the Top 10 promising nursing colleges in India according to Higher Education Review Magazine Survey; November 2018.

The aim of nursing college is to prepare professional nurses who will be capable to render comprehensive healthcare at different levels to public with commitment and compassion. It is our endeavor to enhance the professional growth of nursing through persistent ongoing research programs. Continuous efforts are made to mold student as an individual citizen and as a perspective member of nursing profession in order to uphold the dignity and maintain the standard of the nursing profession.

I hope the deliberations of conference will provide an opportunity to all of you to interact with each other in order to exchange the views and experiences which would ultimately enhance innovative ideas for development of nursing profession.

Unfolding the Theme

Dr Prabha K Dasila
Director
MGM New Bombay College of Nursing
MGM Institute of Health Sciences (MGMIHS)
(Deemed to be University)
Navi Mumbai - 410209, India

Ladies and gentlemen,

At the opening of the conference, I wish to express my most profound gratitude to our management for their valuable involvement for planning of this conference. We owe our special thanks to Honourable. Vice Chancellor for sowing seeds in framing the title of this event. I have the privilege of having Dr. Punitha Ezhilarasu, former Dean, College of Nursing CMC Vellore and currently a Senior Consultant at Indian Nursing Council, New Delhi as a Chief Guest. It was very kind of her to have accepted our invitation to agree to be the Chief Guest and also delivering the keynote address.

I am delighted to acknowledge the presence of all the resource persons from various renowned institutes and Universities of India like NITTE University Mangalore, PGI Chandigarh, Bharati Vidyapeeth Deemed University Sangali, Symbiosis International Deemed University, Pune, Pravara Institute of Medical Sciences Loni, Maharashtra University of Health Sciences Nashik, Swasth Health Care India Ltd. and from our own MGM Institute of Health Sciences Navi Mumbai. (Total 27 resource Persons = 21+6)

The senior esteemed speakers from Intellectual Property Consultancy and Legal Advisory Firm, Higher Education Forum and South Asia & Middle East Arjo Huntleigh Healthcare India Private Limited have come over here to grace the occasion. The conference activities will revolve around three major categories: (i) Nursing Education; (ii) Nursing Practice; and (iii) Nursing Research based on the theme and subthemes. These activities include plenary sessions, panel discussion, symposia, paper and poster presentation. At the end of day, variety entertainment program will be presented by the students of MGM NBCON, Navi Mumbai, India.

Theme-Strengthening the Profession of Nursing: Enhancing Transformation

Transformation implies to the process of marked change in the form, nature, or character in order to improve it with little or no resemblance to the past. It is a well known fact that the healthcare industry is advancing and reshaping to greater heights, both in growth and dimensions for optimizing the quality of care, and in the healthcare delivery system nurses are the custodians and coordinators of patient care. If we look back, over the years, profound changes in the society, advanced technology and healthcare environment has transformed, the field of health care. The roles and responsibilities of nurses have been transforming with developments in medical sciences, policy regulations, accreditation norms, healthcare priorities and emerging advances. The current health care environment is greatly different from the past. It demands highly competent nurses who are authorized to function independently and collaboratively for an extended clinical role.

Recognizing the advances in medicine and technology, it is crucial to reform the existing under graduate and postgraduate nursing curriculum, to make it relevant to the requirements of current health-care scenario. The existing UG and PG syllabus contains massive theoretical content which requires to be revisited, to make it compatible to meet the requirements of current healthcare system globally. The National Health Policy, 2017 emphasized on shaping healthcare system in India in all its dimensions. In light of these recommendations the Indian Nursing council introduced path breaking competency-based Nurse Practitioner Programmes and prepared curriculum for Nurse Practitioners in Critical Care (NPCC) and Nurse Practitioners in Primary HealthCare. The competency based NPCC programme emphasizes a strong clinical component with only 20% of theoretical instruction and 80% of clinical experience. Looking forward for many more such competency based programmes.

The beneficiaries of all these actions are the students of today and tomorrow; who are born in a totally digital world. “In the past, teachers were the only reliable source of information and content provider, who deliver instructions, set the learning outcomes and assess the progress and success of students. The scenario is changing day by day.” The students of today have opportunity to access each and every information at their fingertips. They are competent and capable to use the newer emerging information technology in order to accomplish the assigned tasks. To teach these Millennial and Generation Z (born between 1980 and 2000) nursing students, the teachers should focus on fostering innovation, by putting curiosity, critical thinking, and deep understanding of the rules and tools of inquiry at the centre of the curriculum.

To deliberate on all these areas we have

Session 1 (Day 1) Nursing Education: Past, Present and Future includes historical development of nursing education, academic leadership and envisioning a new paradigm of nursing education. We will be enriched by the deliberations from our experts on the topic.

The Panel Discussion (Day 1) Need for Curricular Reform will highlight on the current status of nursing curriculum, content saturation, a paradigm shift to concept based curriculum, factors influencing curricular reforms and benchmark indicators. The discussions during the panel discussions will definitely bring out fruitful suggestions for curricular reforms.

Session 2 (Day 1) includes **Challenges and Strategies for Teaching Generation Z**. This conference will elucidate the nurse academicians to strategize various methods of teaching to overcome the challenges of teaching students of current generation.

Session 5 (Day 2) Progress Towards Advanced Practice in Nursing will provide deliberations on reflections on progress of advanced practice on Nursing and what are the competencies required. Exploring advanced roles for nurses in health care system for quality patient care. The expert will share their own experiences to enlighten the participants.

Nurses, at workplace face several daunting challenges such as shortage of staff, health hazards, long working hours with low salaries, disharmony, lack of teamwork, lack of recognition and performing the non-nursing roles. Such challenges make them less efficient in rendering quality care to patients thereby hoisting an unhealthy reputation to that particular healthcare setting and resulting in the nurse leaving the profession, less students opting for nursing contributing to staff shortage. Success of every health care delivery system rests on harmonious relationship amongst the healthcare professionals. A healthy work environment is considered as safe, empowering and satisfying. Creating a positive workplace environment is crucial.

Symposia (Day 2) Interprofessional and Collaborative Clinical Practice will include deliberations on significance of interprofessional and collaborative clinical practice in healthcare today, inter-professional competencies, boundaries and barriers, strategies to promote interprofessional and collaborative practice.

Session 6 (Day 2) Building Positive Work Place Culture facilitating promote building positive work place culture will highlight the importance of harmonious relationship amongst the healthcare professionals for the success of every healthcare delivery system.

The scope of nursing practice has expanded and extended to different settings other than hospital. There are numerous careers opportunities available in nursing and healthcare field one of which is nursing entrepreneurship. In India the concept of entrepreneurship is yet to receive its popularity, while in western countries nurse entrepreneurs are well-established with their innovations to support healthcare industry. Innovation is not a new concept to the nursing profession. Nurses worldwide are engaged in innovative activities on a daily basis. One of the earliest examples of innovations is Nightingale’s landmark study of maternal morbidity following childbirth. Her study proved that the death rate was higher among women who gave birth in the hospitals. Her innovation resulted in changes to the services and saving of women’s lives.

According to a report by ICN, innovation in nursing applications is extremely important for improving health, preventing diseases, avoiding risk factors, developing healthy life standards, qualifying the care and treatment methods. However, the contribution of nurses to healthcare innovation is seldom recognized, publicized or shared amongst nursing and the wider public. PhD and PG students carry-out extensive scientific work, preparing the tools, information booklets and other materials for their research work. Most of the time the students stop working on the work they have done, after finishing their viva voce. The tools, information booklets, etc. remain nicely stacked in the shelves of library.

Session 3 (Day 1) Entrepreneurship and Creativity in Nursing: The experts will elaborate discussion on Entrepreneurship and career alternatives for nurses with sharing of their own experiences in the field.

Session 4 (Day 1) Innovation and Intellectual Property Right: To discuss on this topic we have very senior professional and expert amongst us who will enlighten nursing participants on developing a new idea, putting it into practice and protecting the intellectual property by proceeding for patent and other means.

I hope the deliberations from distinguished speakers will tremendously benefit the delegates, students, researchers and faculty members to update their knowledge. I am sure this conference will provide, the participants a platform to network with each and make this event a memorable. Total 170 participants form different parts of the country have registered for the conference. There are 19 scientific papers selected, which will be presented by the participants in two days. We have also received 16 conceptual posters based on various subthemes of the conference which are displayed outside the auditorium and will remain displayed on both the days. I request all of you to go through these posters.

I thank all teaching and non-teaching staff for their creativity, hard work and team efforts to make this programme a great success. I appreciate the all the conference committee heads and other members for conducting several meetings to refine the minute details of each and every element of this conference. Of course, the students for their support in carrying out all the tasks assigned to them.

Once again, I thank each and everyone for attending the inaugural session and boosting our enthusiasm to make this conference a great success.

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Address by Dignitaries

Dr Sudhir N Kadam
Medical Director
MGM Institute of Health Sciences (MGMIHS)
(Deemed to be University)
Navi Mumbai 410209, India

A very good morning to all distinguished faculty, stakeholders and delegates.

At the outset, I wish to congratulate all especially Dr Prabha K Dasila who has been pioneering source for organizing first time 2-day National Conference on *Strengthening the Profession of Nursing: Enhancing Transformation*. The scenario of Nursing is changing very fast. In 1992, there was not a single nurse, not even an Auxiliary Nurse Midwifery (ANM) to start with a hospital in Navi Mumbai, India, which is just 20 km away from Mumbai. She argued that it is unethical to train Secondary School Certificate (SSC) pass students and ask them to perform the duties of nurse. I have been able to convince her that when no one to assist doctors, care the patient, it is not unethical to train someone for a good cause. Dr Prabha trained a few students from vernacular medium for one year to help the doctors and carry-out basic functions of nursing. There are still 10 such nurses working in the hospital. Dr Mary Mathew also joined. We started General Nursing & Midwifery (GNM), BSc Nursing, MSc Nursing and went up to PhD Nursing. Maximum students registered for PhD are from Nursing Field.

The nurse practitioners' work has been found remarkable in western countries for last couple of years. It has been found that 60–70% workload in the area of critical care practice in a big hospital has been taken over by nurse practitioners independently. Thus, the role of nurse is changing from compassionate care of patient along with assisting to medical practitioner to taking place next to doctors or sometimes taking a place of doctors when they are not available. Hence, there is a need to change the nursing educational policy and curriculum as well.

In medical college, all professors, lecturers are teaching the graduates and simultaneously they work in the hospital. The time has come for nursing college to play the similar role. There may be compressive shortcomings. You need to change the curriculum, may be Indian Nursing Council (INC) regulation need to be changed for the same, and you have to make up yourself for this change.

The Professor of Obstetrics and Gynecology (OBG) in medical college and nursing college both should teach their students in clinical area. What we preach that there is need to be practiced by teachers in the clinical area. Now students as well as faculty need 50% theory and 50% practical. It will take some time. Whatsoever I am saying it is not from my mind but it is from Chief Guest of today's Session, Dr Punitha. In her college they practice similar things. Of course, they have sufficient staff. If there is a will, you will be able to do it. It may not happen in 5 units of all Departments of medicine and surgery, but at least start with one unit. I think rest will follow you. Think all staff nurses are your tutor. Definitely you will be able to transform whole teaching and rest will take your model as a guide.

Nurses are very meticulous about time. They gave me 4 minutes to talk and I talked up to 5 minutes. So thank you very much. I wish all the best for the conference.

*****

Dr Shashank D Dalvi
Vice Chancellor
MGM Institute of Health Sciences (MGMIHS)
(Deemed to be University)
Navi Mumbai 410209, India

On the auspicious occasion of 2-day National Conference on *Strengthening the Profession of Nursing: Enhancing Transformation,* the ideas and views expressed by Chief Guest, Dr Punitha before the gathering has been found very much impressive, expressive and apt today's context required for the development of nursing profession.

I congratulate organizers who have taken a lead in formulating large number of relevant topics. I understand it is going to be very much useful. Many problems and challenges were described in the address of Chief Guest. The deliberations will go long way to improving the status nursing profession in India. It is a right time to stretch and expand fullest potentials.

Medical Council of India (MCI) is going to implement competency-based curriculum from 2019 onwards whereas in nursing it is since many years. Government of India is taking congruence of nursing profession, thinking of allowing them to practice.

The Chief Guest has very rightly said *God helps those who help themselves*. In fact, nurse's unity has helped a lot to the nursing profession. I am sure others will join to help them. MGMIHS has been promoting MGM New Bombay College of Nursing (MGMNBCON) in various activities. For example, we started Nurse Practitioner Program in Critical Care and going to complete second year as well. The higher education survey figured MGMNBCON as one of the top ten ranks under most promising Nursing Institutes in India.

Whenever the question of women empowerment occurs, nursing profession comes in my mind. In my 39 years of experience, I met a number of unemployed qualified doctors, dentists, and physiotherapists, etc. but I have never met till date even a single unemployed qualified nurse. Though nurses have rendered various types of services for the welfare of human beings, but unfortunately their profession, services have not been recognized many of the times. In the key note address as Dr Punitha said I agree with triple impact of nurses lead to better health, greater gender equality and stronger economies. Influence of politics is necessary at higher level, e.g. to receive awards. Nursing profession needs to be taken at congruence. Nursing profession is growing higher and higher. No-doubt, on request of Indian Nursing Council (INC), Dr Punitha, consultant has nicely designed the curriculum for Nurse Practitioner in Critical Care; but in my opinion, the autonomy should be given to Nursing Colleges for its implementation in right way when, what and how to taught. There should not be fixed duty hours.

I think I have taken much time. I wish all the success for the conference.

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Key Note Address

Dr. Punitha Ezhilarasu
Chief Guest
Senior Consultant
Indian Nursing Council, New Delhi

Good morning to all.

- Nurses and midwives contribute 50% of health work force in most countries.
- In India two-thirds of health workforce are nurses.
- WHO estimates world needs 9 million nurses by 2030.
- India requires 2.4 million nurses.
- India ranks 75th rank among 133 developing countries with respect to number of nurses
- 2016 Triple impact of nursing has been recognized by WHO in terms of Better Health, greater gender equality and Stronger economies.

Challenges faced by nursing profession globally are:

- Staffing and material resources, working conditions/remuneration, quality of education/training and support resulting in poor quality of care
- Frequently nurses are not allowed to practice to the fullest extent of their competence
- Unable to share their learning
- Few opportunities to develop leadership occupy leadership roles and influence wider policy.

Global initiatives are taken to face the challenges, namely

- UN's Sustainable Development Goals (17 goals) Well-trained nurses are vital in achieving quality, safe, competent and cost-effective healthcare to meet SDGs (2015-30)
- WHO Global strategic directions for nursing & midwifery (2016-20) Strengthening nursing and midwifery is key to improve the health of the population (Four themes)
- 'Nursing Now' Global campaign (empower and support nurses, UHC will not be achieved unless nursing is strengthened).

Initiatives by Indian Government and Indian Nursing Council (INC)

Government of India has mentioned in 12th Five year plan that well-trained nurses to contribute towards UHC. Similarly, NHP 2017 due recognition is given to nursing workforce. The policy highlighted following steps to strengthen the nurses for same by:

- Strengthening nursing education, clinical training and regulation
- Establishment of NP and specialist cadres, centres of excellence for nursing
- Renewal of license, CNE
- National licentiate examination.

INC has also taken concrete steps by introducing following activities:

- Nurse practitioner programs (NPCC, NPPHC, Midwifery NP)
- Advanced practice roles/specialist training
- Revision of curriculum-strengthening PHC component
- NRTS (Nurse Registration Tracking System) Live register
- Capacity building of faculty
- Nurse Practice Act
- Integration model.

Transformation enhancement is required among various strata of people and systems. They are:

- Faculty, students, nurses, nursing supervisors/leaders
- Healthcare professionals
- Politicians
- Patients and community.

Following points are key to enhance transformation of nursing profession:

- Educational system
- Faculty development programme
- Clinical training and nurses' competencies
- Motivated students and faculty
- Dissemination of innovative and effective practices
- Support of nurses, healthcare professionals and politicians to nurses
- Involvement of nurses in policy development
- Leadership and governance.

The unique contributions of nurses to healthcare are nurses with professional knowledge, hands on care, person centered and humanitarian values.

WAY FORWARD

- Advancing the role of nursing in healthcare, education, policy and leadership—through advocacy, training, collaboration, engagement, research and visibility
- Emphasis in nurses' unique role
- Transformation in and amongst nurses first and rest will follow.

CONCLUSION

- We need to create empowered clinical nurses, nurse educators/leaders/managers/researchers who can contribute to healthcare, collaborate, and influence at multiple levels (local, national and global) to strengthen nursing and health outcomes
- Experience nurses need to support upcoming nurses
- Nurse leaders should be placed at key positions and involved in decision-making contributing to nursing and healthcare.

Together we can achieve it. Thank you.

****

CHAIRPERSON: DR PRABHA K DASILA

SESSION 1 TITLE: NURSING EDUCATION: PAST, PRESENT AND FUTURE

Speaker: Dr Fatima D'Silva, Dean of Faculty of Nursing sciences, NITTE University, Manglore, Karnataka,
Email: ftds_1970@rediffmail.com

Subtitle 1.1: Historical Development of Nursing Education

Address by Chairperson: We have a session on how nursing education has evolved from past till to-date, which will reiterate that which will reiterate that it is a continuous process of Improvement. So I will request Dr Fatima to deliberate on this topic.

Session by Dr Fatima D'Silva

Thank you madam for giving me this opportunity.

History provides a valuable insight to the contributions of eminent personalities in the field of nursing and the development of it as a profession. Though nursing in the pre-historic times was regarded undervalued, it has turned out to be a noble and valued profession today with nurses performing complex roles as nurse practitioners, certified nurse midwives, and nurse anesthetist in varied health settings.

Nursing Education-Global Contest

1860: Florence Nightingale the pioneer of modern nursing played an immense role in establishing the first formal training school of nursing in London in the year 1860. Her book 'Notes on nursing' was the first instructionmanual for the formal training of nurses.

1872: The first nursing school **New England Hospital for Women**, emerged in the United States under the Florence Nightingale model

1873: **Linda Richards** became the **first nurse trainee** to graduate.

Browns report recommended **two levels of nurses**: Practical and professional. Thus Hospital based education shifted to institutions of higher learning

Mildred Montag put forth a 2-year curriculum (associate degree) to overcome shortage of nurses during World War II-offered at community college

1893: The American Society of Superintendents of Training Schools for Nurses (renamed the **National League for Nursing Education in 1912**) became the first professional nursing organization. Its purpose was to establish and maintain a universal standard of training for nursing.

1903: North Carolina passed the **first permissive licensure legislation,** provided the nurse the modern legal title "registered nurse"

1911: Martha Jenks. Chase Co. sent the first healthcare manikin to Hartford Hospital.

1917: The National League for Nursing Education released the first Standard Curriculum for Schools of Nursing.

1909: First BSc(N) program at University of Minnesota. Strongly supported by ICN founder (Ethel Gordon Bedford Fenwick)

1923: The Gold mark Report recommended nursing schools have separate governing boards and university educated faculty. Yale School of Nursing was the first autonomous school of nursing with its own dean, faculty, budget and degree. **For the first time, education took precedence over service to a hospital, with training based on an educational plan rather than on service needs.**

1952: National League for Nursing—accreditation body of nursing schools in the United States.

1964: The Nurse Training Act phased out hospital schools and increased the baccalaureate programs emphasizing the need for nursing education in institutions of higher education. Graduate studies and advanced practice programs were also initiated.

1970–1980: A new generation of high-fidelity simulators with specialized features started to replace Mrs. Chase dolls and became a mainstay in nursing classrooms.

2004: The Society for Simulation in Healthcare formed to become a leader in the professional advancement of the application of medical simulation in healthcare.

Today—Nursing education continues to evolve with new technology and standards to create the best possible patient care and further the advancement of nursing as a profession.

Nursing Education in India

Military nursing was the earliest form of nursing in India and St. Stephens Hospital, Delhi was the first training institute of the Indian women as nurses in 1867. First school of nursing started at Government General Hospital, Madras with a six-month diploma midwives programme with four students in 1871. There was no uniform standards of education. Full fledged school in J.J. hospital, Bombay. Bai Kashibai Ganpat first Indian nurse in 1886. By 1900 nursing schools started in various parts of India under the missionaries or government 1897: Dr. B.C. Roy did great work in raising the standards of nursing. In 1946 The first bachelor's degree program at Delhi (RAK) and the Christian Medical College and Hospital (CMCH) in Vellore. 1948-50 -four nurses were sent to the U.K. by Govt. of India for mental health nursing diploma. 1951: Two-year ANM course was established in St. Mary's Hospital at Punjab. 1952: a post-certificate Public Health Nursing programme was instituted at the college of Nursing, New Delhi and later transferred to All India Institute of Hygiene and Public Health, Calcutta. Community health nursing was integrated in the curriculum of GNM and BSc Nursing courses.1959-The first master's degree course at the RajkumariAmrit Kaur College of Nursing, Delhi.1962 - Diploma in pediatric nursing was established at J.J. Group of Hospitals, Bombay. 1963: School of Nursing in Trivandrum, instituted the first two-year post certificate bachelor's degree programme. 1964: Psychiatry was included in the curriculum 1992: PhD at RAK CON, Delhi. 2003: The College of Nursing PGI, Chandigarh and College of Nursing, CMC Vellore were designated as WHO collaborating centers for nursing and midwifery development. The development of Nursing in India was greatly influenced by the Christian missionaries, World War, British rule and by the International agencies such as the World Health Organization UNICEF, the Red Cross, UNSAID, etc.

Development of Bombay Presidency Nursing Association

1890: First state association: Bombay presidency nursing association was formed
1908: TNAI was established. There were no Indians in the role of secretary or President until 1948 (Nair & Healey 2006).
1910: North United board of examination for nurses was organized. Thus formal evaluation of nurses began
1913: South India board was organized
1926: Madras State: first registration council and act was passed to set basic standards in education and training.
1935: State wise councils developed
1947: INC ordinance was passed to set up uniform standards of education in nursing. These bodies set forth legal parameters and guidelines for the practice of nurses as clinicians, educators, administrators, or researchers.

Committees—upheld the standards of nursing education

Recommendations of various national health committees appointed timely also influenced the nursing curriculum. High Power Committee (1987) alongside five year plans have brought about a transition in the status of nursing and midwifery. National Health Policy 2002 and 2017 also greatly recommend the need for enhancing the skill of nurses, increasing the number of graduate nurses, training nurses for superspecialty courses, set minimum requirements for admission, continuing education and staff development of nurses.

Present Scenario of Nursing Education is Very challenging as

- Health needs are complex—apart from chronic diseases, violence, disasters
- Scientific and technological advancements
- Cultural diversity
- Nurses roles are evolving

Way Forward

A paradigm shift has been seen in the teaching learning process. Emphasis is placed more on outcomes rather than the process. There is a shift from *an* instruction paradigm to a learning paradigm. Focus is on interprofessional education and collaborative practice rather than isolated, independent learning and practice. Nursing education in the present times has also highlighted the importance of advanced technology in preparing high tech nurses in promoting safe and quality care based on evidence-based nursing practice. Innovative evaluation strategies have also been encouraged such as OSPE, mini clinical examination, direct observation of procedural skills, etc. placing more emphasis on competencies. Several regulatory bodies, professional associations and committees such as the INC, TNAI in collaboration with global professional associations such as ICN, JPHEIGO, have played a vital role in uplifting the standards of nursing education in India.

Conclusion

There is a shift from hospital-based education to university/collegiate education. Several innovative career ladder options are presently available to nurses other than diploma, baccalaureate, master's and doctoral programs.

Speaker: Dr. Sandhya Ghai, Principal, National Institute of Nursing Education PGIMER, Chandigarh.
Email: principal.nine@gmail.com

Subtitle 1.2: Envisioning a New Paradigm of Nursing Education

Dr. Sandhya Ghai: Thank you Dr. Prabha

"Learn the past, watch the present, and create the future."

Envisioning of new paradigm in nursing education is the process of imagination of the future possibilities and represents how nurses will be prepared to provide care for the population in future, i.e. 2030 or 2050. Future of nursing is based on the future of nursing education and vice versa. Strengthening the commitment of nurses with nursing knowledge and skill is important for them to better address the global changes and their implications for public health. The rapidly changing healthcare system requires nurses to possess increasing knowledge, clinical competency, greater independence, and autonomy in clinical judgment. Nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by healthcare reforms and to advance improvements in increasingly complex healthcare system. Sophisticated technologies and society's orientation to health and self care are rapidly causing educational needs of nurses to grow. Better educational preparation of student nurses will lead to better performance with respect to safe, cost-effective quality care and is good for the profession as well as for the healthcare of the society.

We need to look into the future perspective of nursing before developing the strategies to prepare our profession for the future. Various factors may influence the future of nursing profession. Global warming may increase the population migration. Hence, Nurses will need to develop a universal ethos care, which is compatible with all cultures. Ongoing urbanization has caused lifestyle problems with the increasing prevalence of chronic diseases and non-communicable diseases like hypertension, cardiovascular diseases, diabetes and asthma demands extended nursing role at primary and tertiary level. Improved healthcare system has lead to increased expectancy thereby rapidly increasing aging of the world population and will require more nurses to meet their health needs. Increasing stress and psychosocial factors also affect the health of the population. Emerging trend of new diseases and advancements in technology also remind the nurses on updating their competency.

To meet the global needs and overcome existing and emerging challenges, we need to frame the future of the nursing profession. In future, our profession need to further mature with enough number of competent nurses with the right skills. The profession must continue to accumulate strength and responsibility in the field of healthcare, and nurses with advanced practice will have to continue to expand their scope of practice, so that they continue to contribute to culturally congruent care practices that promote health, healing, quality of life, and even world peace. Nurses will achieve higher levels of education and training through an improved education system that promotes seamless academic progression. Nurses will practice to the full extent of their education, training and potential. The society will receive specialized nursing care at primary, secondary and tertiary preventive level. Evidence-based practice in patient care, nursing education and management and research approaches will further expand the practice scope of nursing. In future, nurse robots are also likely to reduce human suffering by advanced monitoring, care and decreasing assistance waiting time. Interactive video communication will continue to be used to monitor basic health without the need of transportation to the hospital. Nurses will be full partners with physicians and other health care professionals in redesigning healthcare system.

To build the future of nursing, we need to envision a new paradigm in nursing education. The various strategies that can be adapted to empower nursing education include need-based curriculum change, faculty development program, interprofessional education, strengthening of educational institution by government, innovations in teaching-learning processes, education quality assurance, evidence-based practice in education, utilization of technological advancements, emphasis on high tech-high touch approach, uniformity and standardization of nursing program, preparation of global nurses, transcultural nursing education, enhancement of career opportunity, higher education opportunities, short courses on specialized nursing, specialization in graduate level and dual role of nursing educators by collaborating with nursing care providers.

Nurse educators must continuously stay abreast of nursing issues and trends to keep up with the ever-changing nature of the specialized field. Research is necessary to demonstrate the effectiveness of teaching approaches and strategies. Nurse educators need to develop the science of nursing education through qualitative and quantitative research to add to the knowledge underpinning nursing education strategies. Evidence-based nursing education will enhance the development of science of nursing education through rigorous research. Collaborative strategic partnerships, innovative strategies, advocating for the advancement for both the profession of nursing and safe cost-effective quality patients care will help us to meet the critical issues faced by nursing today as well as in the future. Hence, as 21st century progresses to meet the new challenges, nursing education needs a paradigm shift. As per demand of multidisciplinary teams in clinical practice to provide holistic/comprehensive safe cost-effective patient care requires interprofessional education.

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Speaker :Dr. Siddharth Dubhashi, Director (Academic), and IQAC coordinator, MGMIHS, Navi Mumbai.
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Subtitle 1.3: Academic Leadership

Address by Chair person, Dr. Prabha K. Dasila: May I call upon next speaker the most vibrant and dynamic personality in MGMIHS. His presence today tells his involvement in Nursing Education.

He is none other than Dr. Siddharth Dubhashi, Director (Academic), and IQAC coordinator, MGMIHS, Navi Mumbai, who will deliver a session on Academic Leadership.

***Dr. Dubhashi**: Thank you madam for kind introduction and accommodating me in your programme. All presentations from morning were regarding challenges faced by nursing profession which requires leadership to overcome it.*

There was lot of bonding between nurse, incharges and doctors during my time. OT nurse is the one who taught me suturing. She hit me on my hand when I did mistake. She taught me with authority, love and caring attitude, perhaps if she has not taken that academic leadership, I would not have become a good surgeon today. There was no such conference but she was actually leading. Nowadays this type of bonding is missing and generating the need for discussing leadership.

Is leader and manager same? No. Manager cope-up with complex situation whereas leader will be involved in the whole process of coping. They rise from grass root level and indulge in coping with change, with situation related to research, practice or academic ventures.

What is the need for academic leader?

Academic leadership is required for retention and development of faculty, improvement of outcome, and sustain nursing programme.

Academic leader need to identify various zones of people with whom they are working. First zone, is the dead zone—people who develops curriculum sclerosis, they do not want to change. Second zone comfort zone—people in this zone feel they have been successful, no one can threaten us. They will be doing repetitive things. They do not want to come out of their comfort zone, but still they can be motivated if they attend conferences, workshops, etc. Another zone is panic zone—this people always try to do something new but they repetitively fail. They will often feel burned out, frustrated. People in this zone are dangerous they will complain nobody is allowing them to do something. The fourth zone is the stretch zone in which people stretch self to commit themselves for lifelong learning, adapting to change. They inspire and encourage others. They are with positive attitude and allow others to stretch.

Team stands for together everyone achieves more. To work in a team, first the teams should be developed at University level, institutional level and departmental level.

Follow team process—formulate the team-like minded people. Bosses are not required all the time. Team requires peers for constructive criticism. Do not involve people who will take you back. Develop the idea, work on it and good next step in process transformation—make a concrete plan and implement it.

What are the leadership traits required?

Knowledgeable, confident, respectable, role model, capable of making mistakes and correcting them, compassionate, problem solver, who influence and works well with others, goal oriented, good observer, communicator and listener and above all a motivator.

We all delegate the responsibilities. Give it with accountability and check for response. Whether they are able to do it or not. Managers must remember novice has not done mastery. Novice cannot jump from one step of studentship to mastery. So, they need to be under observation and need to be helped to develop competence. Otherwise it may result into stress instead of satisfaction. Novice has unconscious incompetence, Beginners have conscious incompetence, competent person has conscious competent and masters have unconscious competence.

Higher education leadership framework: Model the way, inspire a shared vision, challenge the process (take criticism healthy way), foster collaboration and encourage the heart of others. So that you will not go into panic zone.

There is a need to find mentors to boost the morale: Mentors are someone you respect, someone you can approach repeatedly in crisis, who has consented to be a mentor. Recognize the efforts of mentor and later you be the mentor for others. This transformation need to be seen when you want to be an academic leader.

There are different models to achieve this, e.g. SOCCSS Model: Situation analysis, concise the options, be aware of the consequences, make proper choices, adapt strategies, simulate in the particular environment. SOLVE Model: Seek, observe, listen, vocalize and educate.

Role modelling is required in academic, social and cultural behaviour. An integral part of curriculum is to be an academic leader, yet it is hidden. Leader has to practice professionalism by demonstrating respects for others, honour integrity, excellence in performing duty, sense of accountability with patient, society and profession, altruism and good communication. Have mutual understanding between teacher-student, nurse patient, which is missing nowadays.

What are the sins of a leader?

- Truth, if it becomes a weapon against persons
- Loyalty, if it becomes blind
- Tolerance, if it becomes indifference
- Self-confidence, if it becomes arrogance
- Faith, if it becomes self-righteous.

There are ten commandments to be effective leader.

1. Know yourself.
2. Demonstrate a sense of direction and mission, with clear achievable goals.
3. Make the hard decision, take responsibility for the decision.
4. Avoid the use of authority.
5. Innovate.
6. Build commitment, optimism, trust and cooperation.
7. Have patience.
8. Have a good sense of humor.
9. Do a periodic SWOC analysis.
10. Nurture a culture of leadership.

Remember respect need command and not the demand. Above all you must salute your work so everybody will salute you.

There is always need for:

1. A combination of leadership and management competencies
2. Be a student and a teacher
3. Enthuse and Engage those who follow
4. Be a role model.

Manager will always say Go but leader will say let's go..
Be the change you want to see in the world …

Comments by Chairperson: The session had been found motivating. It had generated great interest and enthusiasm among the participants. I wish to thank Dr. Fatima for elaborating about the historical development of nursing education succinctly. Dr. Sandhya Ghai took us to present scenario and future challenges in nursing education. With this remarks, I conclude that the future of the nursing profession is bright, therefore nursing institutes and educators have to shoulder a great responsibility and accountability for creating smart nurses who will meet demands of the society effectively and efficiently.

PANEL DISCUSSION

Moderator: Dr. Mary Mathews and Ms. Preethi Mathew

TOPIC: NEED FOR CURRICULAR REFORM

Panelist:
Current Status of Nursing Curriculum: **Dr. Mary Mathews**
Factors Influencing Curricular Reform: **Dr. Nilima Bhore**
Content Saturation in Nursing Curriculum: **Dr. Sharadha Ramesh**
A paradigm Shift to Concept-Based: **Dr. Fatima D'Silva**
Curriculum Benchmark Indicators in Nursing Curriculum: **Dr. Sivabalan**

Address by Ms. Preethi Mathew: Its my great pleasure to introduce the panelist from various university for the hot topic: Need for curricular reform. Today we are going to discuss about various aspects of curriculum and curriculum reforms. So I have panelist cum Moderator **Dr. Mary Mathew**, *Prof &Principal, MGM College of Nursing, Vashi, Navi Mumbai, MH* from MUHS University, Nashik. **Dr. Nilima Bhore** *Dean, College of Nursing, Bharati Vidyapeeth Deemed University, Sangali, MH.* **Dr. Sharadha Ramesh**, *Prof & Principal, Symbiosis College of Nursing, Symbiosis International Deemed University, Pune, MH.* **Dr. Fatima D'Silva,** *Professor & Principal, NITTE Usha Institute of Nursing, NITTE University (Deemed to be University), Mangalore* **and Dr. Sivabalan** *Prof & Dean, College of Nursing, Pravara Institute of Medical Sciences, Loni, MH.*

Current Status of Nursing Curriculum: Dr Mary Mathew

As I am a moderator come one of the panelist before I start I threw few questions to myself to discuss about topic given to me, i.e. current status of nursing curriculum.

Is curriculum dynamic, effective and appropriate in present scenario? Where pass out graduates are going to work, where there is a cost contentment, complex treatment, standards and guideline, patients voice for high acuity, decrease length of stay and exercise new role?

Curriculum is a tool in the hands of the teacher to mould his pupils according to aim and objectives in his "school" said by Cunningham. Though the curriculum is the ultimate evidence-based approach to nursing education in which students learn to provide skilled and compassionate nursing care in fluid and uncertain health-care environments" as stated by National League for Nursing 2003 it is influenced by changing health care priorities influenced by political, economic, social, technological, legal and environmental factors.

Current curriculum of nursing education is mean to "Enter to learn and Depart to serve." It is continuously evolving and it is a product of long-term efforts. It is based on the needs of the people. Though it provides logical sequence to subject matter, it still provides flexibility at administrative level. It includes stuff for teacher as well as student, from whole to part and part to whole, treatment of illness vs its prevention, information gathering versus problem-based learning. Currently, the nursing curriculums need to focus on individual as well as mass population, community. Medical model as well as socioecological model to have long-term harmony with the environment. Need to focus on existing as well as futuristic needs. If one compares it with global curriculum, we have only compulsory core subjects in the curriculum unlike elective courses like arts/crafts or cookery in western curriculum of nursing.

Factors Influencing Curricular Reform: Dr. Nilima Bhore

1. What are the trends influencing curricular reforms?
   Answer by Dr. Nilima: Recognition of nurses potentials, value in healthcare system and as they are in huge number already in contact with community and patient. This causes necessity to develop competency so that they can develop their fullest potential and work as middle level manager in community as well as share the responsibility with medical professionals.
2. What are the student factors that influence curricular reform?
   Answer by Dr. Nilima: Today's student are born in the environment of technology, with lots of information. So to engage them for learning is a difficult task in traditional classroom setting.

3. What are the faculty factors that influence curricular reform?
   Answer by Dr. Nilima: Faculties are also overloaded with pool of information and make them difficult to focus on core aspects of learning depending on the type of nursing education programme and level of student.
4. What are the healthcare factors that influence curricular reform?
   Answer by Dr. Nilima: Emerging diseases, advances in science and technology in diagnostic and treatment sector and health and hospital information technology are the major factor which requires addition of knowledge in the curriculum.

   Increasing demand of basic services in underserved community as well as advance services in urban areas has changed the mode of delivery of health services and demands various skills to be developed in the students.
5. What are the faculty perception influencing curricular reforms?
   Answer by Dr. NIlima: The activity of curriculum evaluation helps the teacher to know its usage from its stakeholders. This gives insight to the changes require in curriculum. This will make the faculty to feel satisfied that they are able to meet the demands of society. Faculty will also able to provide focused or concept-based learning. But some teachers may be anxious about loss of their identity and respect.
6. What are the benefits of students due to curricular reform?
   Answer by Dr. Nilima: Definitely, there will be the benefit to the student in terms of approach to learning, maintaining the interest in nursing, developing the concepts which can be applied in various appropriate contexts that is critical thinking skills. It can foster innovation too.

Content Saturation in Nursing Curriculum—Dr. Sharadha Ramesh

Address by Ms. Preethi: Madam rightly said the need of focused learning. We always hear from teachers, students as well as wards of students that there is overload of content. Madam Sharadha can you throw a light on content saturation in nursing curriculum.

1. What are the causes of content saturation ?
   Answer by Dr. Sharadha: As made Nilima Bhore said causes of content saturation are inevitable shift from industrial age to information age, dynamic changes in health care delivery. The conventional method of teaching, i.e. teacher—centered pedagogy, content repetition, the broad academic and practice gap and lack of concept-based Curriculum and approach are also some more factors precipitating to content saturation.
2. What are the solutions/strategies to overcome content saturation? How to rescue nursing education from content saturation?
   Answer by Dr. Sharadha: Aware of the need for a paradigm shift in curricular content
   - Avoid brooding over the ever increasing syllabi
   - Actively involve in faculty development programmes
   - Develop newer concepts based on the curricula
   - Accept and initiate changes
   - Actively consider alternatives
   - Dramatic reform and innovation in nursing education
   - Must partner with other healthcare providers and policy makers to bring a change
   - Avoid saturating with redundant teaching—learning concepts
   - Concept-based curriculum with a conceptual learning approach
   - Preparation is needed for nursing graduate.

   Just to conclude, it is an era of rapid changing healthcare environment so be prepared.

Preethi: Thank you Dr. Sharadha

A Paradigm Shift to Concept-Based curriculum: Dr. Fatima D'Silva

Q. Address by Ms. Preethi

1. Is there a need for paradigm shift in NE?
   Answer by Dr. Fatima: Being prepared for a change is an attribute to an enlighten and educated person. Today change is the necessity. As we know nurses are the backbone of the healthcare system work for 24 hours, with lots of technological advances in the system and lots of expectations from the patient, nurses need to be updated with lots of technological inputs. So navigating move from contact-based model to content-based model to concept-based model is required.
2. What is the role of teacher in concept-based curriculum?
   Answer by Dr. Fatima: The role of a teacher is more of facilitator. They direct their students and seek experience to concept learning of students. So here students is in the center while facilitating teaching-learning process unlike in traditional method—teacher centered.
3. In India can we implement concept based learning?
   Answer by Dr. Fatima: Yes we can implement as it is not a very new concept. In 1960-70s this was very much therein western countries tried in Kinder garten and especially elementary schools. It is a dream came true.
4. What are the challenges?
   Answer by Dr. Fatima: Like faculty who has curriculum sclerosis, resistant to change, then it can hinder to move forward with concept-based curriculum. Faculty has fear that they may loose identity as a teacher. This must go out of their mind. Motivating the students to have concept-based learning. Students will not be provided with the notes. Students will be asked to make their own notes under the guidance of trained faculty.

Comments

Dr. Nilima Gore: I think commitment or dedicated teachers and consistent leadership is very much important to overcome the challenges.

Dr. Sharadha: Our nursing curriculum is nicely written. We should appreciate the garland of various teaching learning activities which no other professional course has. Everybody is copying nursing curriculum. Yet we have not started with plagiarism of curriculum. Of course there is a gap of not more than ten percent. So like minded teachers and mind blowing curriculum. One can forget the efforts of teachers who formulated the curriculum.

Thank you Dr. Fatima, Dr. Sharadha, and Dr. Nilima you all have really enlighten us to take a challenge of use of concept-based curriculum.

Curriculum Benchmark Indicators in Nursing Curriculum—Dr. Sivabalan

Dr. Mary: We always talk about quality and standards in nursing practice, patient safety indicators for nurses, etc. I will like to know from Dr. Sivabalan about indicators applicable to nursing education institutes.

1. What is benchmarking in nursing education?
   Answer by Dr. Sivabalan: It is a rule or guideline by which organization/product/service/education/ others can be measured or judged. The process involves observing at standards, best practices, and evidence-based education and then identifying potential areas of improvement.

   In nursing benchmarking indicator is a quality assurance tool used to maintain high standards in nursing curriculum as well as supports open communication to all stakeholders for the continuous improvement and development. It can be an internal or competitive benchmarking and the principles are maintaining quality, improving customer satisfaction, improving patient safety and continuous improvement.

   Benchmarking indicators: The curriculum is flexible and reflects current societal and healthcare trends and issues, research findings and innovative practices incorporating the local and global perspectives. A well-designed curriculum is implemented throughout the country uniformly as per Indian Nursing Council regulations with support of State Nursing Councils, Universities and Accreditation agencies. The core curriculum is a base for the professional identity and evolution of eligible nursing professionals. It is imperative

that the nursing curriculum is evaluated while considering the benchmarking indicators. The answers for following questions will make everyone to understand how better the nursing curriculum is.

a. Is the curriculum regularly refined to incorporate current societal and healthcare trends and issues, research findings, innovative practices, and local and global perspectives?
b. Do all students have an extended, relatively intense learning experience with individuals from cultures other than their own?
c. How much class time is devoted to self reflection, values clarification, analysis of what it means to be a nurse in the 21st century?
d. What learning experiences give students the opportunity to develop confidence in their ability to advocate and teach patients/families, serve as a member or leader of a multidisciplinary team?
e. To what extent does each clinical experience help students develop their ability to provide culturally competent, evidence-based care to patients/families/communities experiencing a wide range of health problems?
f. What research has been used to determine how the curriculum is designed?
g. The teaching and learning strategies varied to meet the needs of diverse student populations?
h. What are evaluation methods has been employed to evaluate the effective implementation of curriculum as well as grading of students?

2. What are the academic performance indicators in nursing education?

Answer by Dr. Sivabalan: The common benchmarking indicators of nursing curriculum are:

a. Course retention and course completions.
b. Course design and development and its evaluation-periodically at least every 3 years for PG and every 5 years for UG curriculum. INC has not revised the curriculum since 2006 but under the political and societal influence everytime suggested necessary things to add into the syllabus, e.g. regrading environmental health, HIV-INC instructed to add necessary things at the college level but do not delete anything from INC syllabus.
c. Student progression rates—number of students passing and % of passed outs going for higher studies or continuing education. It is seen that after bachelor course once they gets government job they wait for deputation and by the time priorities changes.
d. 100% employability and placement. We are fortunate enough none of the graduates remains unemployed.
f. Competency-based indicators that need to be checked before final year students passed out from the college other than routine theory and practical exam.

This benchmarking aimed at producing high competent nurses with high English proficiency to work in the community with excellent output for social development and ready to enter the global markets with international competency for global competitiveness.

3. What are the bench mark indicators of nursing curriculum of India with International Curriculum?

International curriculum is based on presence of credit system. They also have choice-based curriculum and online education courses for nurses. So Indian nursing curriculum can have international benchmark indicators such as credit system, choice- based curriculum. At present when we approach INC, INC refused to start credit-based system in existing nursing curriculum. About choice-based system we have only for medical surgical nursing specialty of PG curriculum. We can at least start with online short-term courses for nurses which are lacking in India. We have distance learning programme. So these can be the international bench mark indicators for nursing curriculum in India.

In short the regulatory bodies like Indian Nursing Council, State Nursing Councils, Universities and other accreditation bodies will contribute to the establishment of efficient processes for benchmarking and peer review of assessment of nursing curriculum. Similarly, it is everyone's responsibility for protecting the health and safety of people by ensuring a high standard of nursing and midwifery education.

Concluding remarks By **Dr. Mary Mathew**

Thank you Dr. Sivabalan. I will like to conclude that present nursing curriculum is not too bad. We have nursing process and writing of assignments following the same. We formulate nursing diagnosis with related to factor, is an example of developing competency of critical thinking. It means it is therein the curriculum and need to be implemented by the students, teachers and by staff. It is there as one of the important activities under nursing domain during NABH accreditation. So do not write it just for sake of writing, thinking that no body is reading or bothered. Of course, we can go for new evaluation methods which will measure the competency-based learning.

Thank you very much to all the panelist. Questions can be discussed on a lunch table due to shortage of time.

CHAIRPERSON: DR. SANDHYA GHAI AND MS SUSAN JACOB

SESSION 2: CHALLENGES AND STRATEGIES FOR TEACHING GENERATION Z

Speaker: Dr. T Sivabalan, Professor and Dean, Faculty of Nursing, Pravara Institute of Medical Sciences (DU) College of Nursing, Loni (BK), Maharashtra Email Id;sivavimal.guru@gmail.com

Subtitle 2.1: Challenges for Teaching Generation Z

Address by Chairperson Dr. Sandhya **Ghai**: We just had a panel discussion on 'Need for curriculum Reform'. But to meet the need's of current generation students, Generation Z students is a real challenge. So I will request Dr. T. Sivabalan to cautious us with characteristics of and challenges for teaching Generation Z students.

Introduction

Generation Z students are the first to be born in a totally digital world and most electronically connected. Internet has enabled them to always be connected, has access to large amounts of information (do not know world without internet). Uses smartphones for 16 hours per week and come to class with a cell phone, laptop, I pad or other tablet device. They are the newest member of nursing cohort, also known as 'iGens', 'Zeds' and 'Zees', and they are age 21 or younger, who were born in 1995 or after.

Characteristics: Gen Z students are more realistic, career minded and loyal; compassionate, thoughtful, determined and responsible; do not want to let others down, they will advocate for what they believe in, and they want to make a difference in other people's lives; spend lot of time online and likes to communicate in short bursts of information (text message) instead of lengthy message (email); prefer 'learning from the internet' over learning from print material (books); prefer learning by observation, visual experience and practice instead of reading and listening to classroom presentation; has average attention span of 8 seconds; and expect prompt feedback and answer.

What Gen Z wants?
They want to teach things they can not Google it. Education need to be social, participatory, just in time learning, visually driven, most up to date information, and instructors need to be as facilitators.

Challenges:
1. Prefers nontraditional teaching methods
2. Favours interpersonal and independent learning
3. Wants practical value and active learning
4. Require personal communication and use of technology.

Way forward: It is important to understand the Gen Z. Instructors must be prepared to teach using technological and social media, use creative classroom setups, explore the internet as a communication tool, replace PPT with open discussion, lively debate and structured group work, move away from traditional teaching to more learner based learning and lecturers needs professional development support.

Comments by Dr. Sandhya Ghai, Chairperson: Rightly said we need to be cautious and conscious while teaching Generation Z students. Teachers need to be updated with demands of students and how to make nursing education more interesting and fulfilling the aspirations of students.

Speaker: Dr. Nilima Rajan Bhore, Dean, Faculty of Nursing & Principal, BVDU, College of Nursing, Sangali.
Email:nilima@yahoo.co.in

Subtitle 2.2: Strategies for Teaching Generation Z

Address by Chairperson, Ms. Susan Jacob: So we understood what are the challenges of teaching generation Z, but its time to come up with solution and strategies instead of weeping over it. So I welcome Dr. Nilima Bhore to throw the light on various strategies to overcome the challenges.

Dr. Nilima Bhore: Thank you Susan.

The biggest challenge for any teacher is capturing each student's attention, and conveying ideas effectively enough to create a lasting impression. As a teacher, to tackle this challenge effectively, you should implement various strategies. One can divide the strategies into two—classroom management strategy and teaching learning strategy.

Classroom Management Strategies

Effective classroom management strategies involve organization, fostering good working relationships, as well as a disciplined yet personable attitude. Deciding which techniques to use can nonetheless be difficult, as every student and class is unique. Pairing the students for problem-solving and concept mapping, use of field trips or virtual tour, use of filmstrips/videos, inquiry-based instructions for simulation, placement of knowledge and problem triggers in the classroom, giving one minute break, equal opportunity to student to respond and valuing of ideas of students with respect followed by discussion will be the few strategies to manage the boredom and maintain learning environment in the classroom.

Teaching Strategies for Effective Nursing Education

Nursing is a field demanding clinical knowledge and skills to care for the patients and his family. The learning process in nursing is very unique because nursing student should be able to perform the activities of the profession in live situations. Critical thinking is crucial in providing safe, competent and skillful nursing practice. Nurse educators are obligated to create learning environments that support critical thinking. Teaching strategies that involve experience by "doing" and dialogue with "others" will promote more significant learning. Innovative strategies must be adopted to enhance experience and facilitate dialogue.

Following are the emerging trends in teaching learning methodology based on this concept.

Case base learning

The investigative case-based learning approach is a method of learning and teaching that gives students opportunities to direct their own learning as they explore the science underlying realistically complex situations followed by discussion with the facilitator.

Problem-based learning

Problem-based learning (PBL) is a teaching method in which complex real-world problems are used as the vehicle to promote student learning of concepts and principles as opposed to direct presentation of facts and concepts. In addition to course content, PBL can promote the development of critical thinking skills, problem-solving abilities, and communication skills. It can also provide opportunities for working in groups, finding and evaluating research materials, and lifelong learning.

Use of multimedia in the classroom: Multimedia technology as an innovative teaching and learning strategy in a problem-based learning environment. Educational classrooms use multimedia formats from various media. Text and graphics include slideshows, presentations, diagrams and info graphics. Audio includes podcasts, audio books, audio clips and recordings. Screen captures, lecture captures, animation, are examples of video components of multimedia. Other multimedia components include blogs, webinars and other interactive content. Instructors must remember to show the multimedia to students in a face to face classroom setting and only for educational purposes.

Active learning classroom: Active learning classrooms are designed to promote the concept of "active learning" into in-person classroom environments of any size, for virtually any type of course. Active learning involves

the engagement of students and educators in the learning process through collaborative classroom activities and reflection.

Web-based learning: It is one-way to learn, using web-based technologies or tools in a learning process. In other words, learner uses mainly computers with videocamera, microphone and speaker mounted on computer to interact with the teacher, other students and learning material. **Web-based learning consists of technology that supports traditional classroom training and online learning environments. Videoconferencing, E-learning, tele teaching, blackboard learn are the forms of web-based learning.**

Videoconferencing

Videoconferencing (or videoconference) means to conduct a conference between two or more students and instructor at different sites by using computer networks to transmit audio and video data. As the two students speak to one another, their voices are carried over the network and delivered to the other's speakers, and whatever images appear in front of the video camera appear in a window on the other participant's monitor. Students can present the cases, conduct seminar, show live demonstration and ask queries and feedback. Videoconferencing helps in connecting diverse student groups from different places.

E-learning: This method helps students in adaptation of different distance learning technologies for self-directed, active learning and refocusing from educator to the subject through internet.

Tele teaching: Online model of education where learner directly interacts with tutor. This is learner oriented learning which promotes discovery learning at their office or home.

Blackboard learn: Blackboard learn is a course management system for instructors to put class materials on the Internet. It provides a variety of tools to facilitate teaching and learning. All online courses use Blackboard learn course management system. Blackboard learn can be used as a supplemental tool to enhance face-to-face teaching. The basic tools used in a blackboard learn course includes a syllabus, learning module, discussions, calendar, email, announcements, grade book, exams, and assignments.

Conclusion

A combination of technologies and social media plays a critical role in this by promoting the integration of technologies, humanization of virtual interactions, and personalization of learning. New technologies continue to emerge and bring with them the promise to reform and revitalize today's higher education system. Globally, there has been a call for a paradigm shift, from a teacher to a learner centered approach in nursing education. After discussing these innovative and emerging technologies, very few are supported by research that the effectiveness of several of these technologies in improving student learning and achievement (e.g. active learning classrooms, simulation technology), and most of them have not been fully evaluated and likely will need to be refined iteratively as weaknesses are identified and new challenges arise. Furthermore, educators must be fully trained and incentivized to use new technologies. Nonetheless, these technologies and/or others not yet conceptualized will surely be incorporated into healthcare education as it evolves to meet the many challenges of 21st-century learning.

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CHAIRPERSON: DR. PRABHA K. DASILA AND MS. R. PONCHITRA

SESSION 3: ENTREPRENEURSHIP AND CREATIVITY IN NURSING

Speaker: Dr. A.K. Sengupta, Founder and Convener, Higher Education Forum (HEF) MH.

Subtitle 3.1: Entrepreneurship—Concept and Process, Setting up and Sustaining the Business.

Address by Chairperson Dr. Prabha Dasila: In plenary session 1 we have discussed about present and future of nursing profession. Even WHO has recognized the potentials of nurses which is already proved in developed countries. Many nurses aspire to do something different. In order to support all those who aspire to be entrepreneur here we have a eminent speaker Dr. Sengupta. Sir will speak not only about entrepreneurship but he will equip us with various traits one should have to be an entrepreneur and what are the challenges to sustain any business.

Dr. A.K. Sengupta: Thank you Madam.

The starting point of entrepreneurship is **innovation** that leads to an idea: To undertake an activity, whether product or service. The objective is to do something **totally new** or doing an **existing thing in a different way**. End goal is to satisfy an **unmet demand** or **create a demand.** However, idea alone is not adequate. To bring the idea to the stage of commercialization is a tedious process that includes legal structure formation, writing a project report, getting funding from different sources (angel investor, banks, PE funding), implementation of the project by being with human talent to support and most importantly making breakthrough in terms of **customer acquisition**.

We have often seen that many entrepreneurs are not in aposition to convert the idea into a business proposition because of break in linkage in some aspect of the value chain. To sustain the business particularly at the beginning stage, achieve break event and finally to make profit is a long drawn process. **Perseverance** and **shock absorption capacity** are the two most important traits that each entrepreneur should have at least in the preliminary stage.

It has often been a matter of academic debate whether **prior work experience** after the basic qualification is a requirement to become a successful entrepreneur particularly for a **first generation entrepreneur**. There are success stories on either side. However, prior work experience in a business venture may expose the person to intricacies of a business enterprise and thus may equip him/her to take business decisions better and faster. Running an entrepreneurial business involves all aspects of business functioning including **production, logistics, sales and marketing, human resource management, technology and innovation**. Thus an entrepreneur has to develop **core competencies** into the basics of all the functional areas as stated above to run the business successfully and it is in this context, prior work experience might help.

Other major challenge before an entrepreneur is to **scale up**. We often see that many Indian first generation entrepreneurs are not in a position to scale up owing to various reasons and thus either stagnate or take an easy option of exit. While exit may not be a bad idea, the purpose of creating an entrepreneurial venture is to create and expand the enterprise into a big entity that has strong **competitive advantage**. Thus, the strategy of an entrepreneur should be to create a sustainable **globally competitive entity**. This, however, is not easy to achieve for all.

The **eco system** for entrepreneurship in India today is conducive and ease of doing business is also becoming favourable. Funding options are also easily available. This is the right time that the Indian entrepreneurs should take advantage of the system and try to create what silicon valley did in USA about 3 decades ago. The future history of Indian economy will be written through success stories of Indian entrepreneurs.

All professional students should, therefore, seriously explore entrepreneurship as a **career option**.

Remarks by Chairperson: As Dr Sengupta said perseverance of idea is very important in sustaining the entrepreneurship in any field. Thank you sir we have one more speaker with us who will be sharing her experiences on same line.

Speaker :Ms. Sushila Samuel, Director, South Asia and Middle East, Arjo Email Id: sushila.samuel@arjo.com

Subtitle 3.2: Career Alternatives for Nurses Sharing of Own Experience

Address by Chairperson Ms. Ponchitra R: Today nurses are not only seen at bedside but also seen in various settings in the health industry. We have Ms. Sushila with us who will highlight various career in nursing and how was her path in this direction.

Ms. Sushila: The millennium has become the metaphor for the extraordinary challenges and opportunities available to the nursing profession and to those academic institutions responsible for preparing the next generation of nurses. Transformations taking place in nursing and nursing education have been driven by major socioeconomic factors, as well as by developments in healthcare delivery and professional issues unique to nursing.

Some of the trends to watch, which can impact the future of nursing

- Changing demographics and increasing diversity
- The technological explosion
- Globalization of the World's economy and society
- The era of the educated consumer
- The growing need for interdisciplinary education for collaborative practice
- The cost of health care and the challenge of managed care
- Flow of resources
- Supply of manpower and competition
- Role delineation and role confusion
- Public opinion
- Nursing practice and theory, etc.

Career Pathways and Opportunities

- Bedside nursing
- Clinical nurse manager
- Team leaders
- Unit managers
- Senior management/director nursing
- Clinical nurse specialist
- Nurse practitioners/advanced nurse practitioners
- Nursing education: Lecturer, professor, dean, etc.
- Nurse researcher
- Nurse midwives
- Nursing professor
- Nurse anesthetist
- Clinical specialist in healthcare companies
- Military nursing
- Cruise ships/helicopters/air ambulance, etc.
- Patient safety nurse/officer
- COO/GM's, etc. in hospitals and healthcare industries
- CEO of hospitals.

The opportunities are endless

Some of the Emerging roles in nursing

- Patient nurse navigator
- Informatics nurse
- Nurse entrepreneur

- Nurse intrapreneur
- Nurse leader
- Transitional care nurse
- Electronic intensive care unit nurse.

Nursing Today

It is not just that nursing is becoming a broader field; it is becoming deeper, too. The opportunity to pursue medical specializations is blooming, but the real opportunity is in mastering complex, multifaceted issues that impact our healthcare system and our nation. It is more than knowing how to perform tasks and procedures; it is about being a more effective member of the healthcare team and navigating clinical systems. Today's nurses are not just caring for the sick; they are changing our very notion of modern medicine and healthcare delivery.

Nurses are giving TED talks, publishing scientific research, developing mobile medical applications, helping design medical equipment, actively addressing healthcare policies, etc. They are collaborating with their colleagues, from various fields like social work, physical therapy, medical fraternity, etc. to hospital administrators, public safety personnel, policy makers, etc. The field is growing, and so are the opportunities.

Nursing has become more complex in ways that could not have been imagined a generation ago. Now there is an imperative to be not just a great caregiver but a great innovator too. The demands of health care are calling for a new generation of thinkers who want to be agents of care innovation.

As the largest group of healthcare professionals, nurses are leaders and change agents from the bedside to the boardroom.

It is a profession for the intellectually curious, lifelong learner.

Comments by Ms. Ponchitra R., Chairperson: Today we see, nurses are doing career in informatics, forensic, pain management, research, supply chain manager, hospital administrative head (CEO, HR, purchase, maintenance, patient feedback), nurse practitioners, industrial nurses. So the sky is only the limit. As Dr. Sengupta said if you have trigger, perseverance and as Madam Sushila said updated with required knowledge and skills, nurses are going to be a major talented work. So one must work for a dream career.

CHAIRPERSON: DR. RAMAN YADAV AND MRS. JYOTI CHAUDHARI

SESSION 4: INNOVATION AND INTELLECTUAL PROPERTY RIGHTS

Speaker: Dr. Gopakumar G. Nair, CEO, GNAs, Principal Patent Attorney
Email: gopanair@gnaipr.net

Subtitle 4.1: Innovation and Intellectual Property Rights

Address by Dr. Raman Yadav, Chairperson: People spend money to gain knowledge but through intellectual property rights you can generate money through your knowledge. Sounds interesting and falsifying. So we will call Dr. Gopakumar to talk about intellectual property and how to preserve the rights of intellectual property. And also how to generate money.

Dr. Gopakumar: Thank you Dr. Raman.
Innovation is the key as well as bridge on the highway to successful growth and progress in nursing as well as hospital industry. Securing of inventions through intellectual property protection, more particularly, through 'Patents' is essential not only for healthy asset creation but also as a form of defense against costly litigations. Even incremental innovations can help improve ease of serving the patient more efficiently and can be protected through efficient and smart drafting of patent specifications/applications. After filing a patent application, the same can also be published in the form of an article thereafter. Major revamping of the Indian Patent Office in infrastructure, manpower, automation and digitalization has helped inventors to get the grant of patents expeditiously in recent times. Better patient handling in hospitals by nursing staff through stress—free creativity and by employing new ideas to solve problems and bridging the gaps is possible through innovative approach. Patenting of such inventions leads to value addition, value creation and intellectual asset generation and management with value addition and wealth creation. A few of the titles of the granted patents/patent applications relating to patient-care are reproduced below:

- Personal viewing device with system for providing identification information to a connected system (US6735328)
- Steering mechanisms for hospital beds (US8327479B2)
- Intelligent nurse robot (US20050154265A1)
- Nursing cover (20110023209, 10010119, 8990968, 20140338096, 8661565, 20120240306, 8196222, 8191173, 20120102617, 8091145)
- Pull up nursing garment (7878881)
- Nursing garment (7878880, 20130232661)
- Nursing apparel (20110191934)
- Post-surgical drain facilitator gown (7942856)
- Child carrier cover (7913321)
- Nursing apron (7895668)
- Convertible garment for carrying and feeding infants (9986775)
- Hands-free pumping garment (9538795, 20150143605)
- Fashion garment and method of using same (9101169)
- Fashion scarf with hidden nursing cover (9003565)
- Breastfeeding garment (20140259277)
- Patient gown for a medical treatment facility (8821461)
- Caregiver cover (8707467)
- Garment for accommodating intravenous catheters and gastronomy tube (8690835)
- Heat-resistant and/or liquid-resistant covering (20140075644)
- Nursing canopy (8671465, 20110296581)
- Magnetic securing device assembly and method for securing a garment while nursing (8640266)
- Privacy cover (20140007315)

- Nursing garment, nursing jacket or top (20130269082)
- Nursing cover and method for converting cover to a purse (20130198929)
- Nursing cape (20130152271)
- Privacy blanket (20130025022)
- Pumping/nursing bra (8323070, 8192247)
- Hands-free pumping and nursing bra or tank (8307463, 20110314587)
- Pull up nursing undergarment (8226452)
- Garment (8221186)
- Configurable supportive protection system and methods (8209773)
- Nursing cover-up (20120151657)
- Patient gown (8196223, 8028346)
- Fashion and nursing scarf/shawl (20120131723)
- Breastfeeding cover (8151372)
- Detachable and removable camisole panel (8096851)
- Infant wrap and method for use (8020217)
- Nursing pad (8012138).

Comments by Dr. Raman, Chairperson: Sir, has explained well about the concept of copyright and patent and at a time how both can be possible in one case. So it is the skill to prepare the draft for patent or copyright and there are government and non-government agencies are there who help in this matter.

Speaker: Sharadha Ramesh PhD, Director, Symbiosis College of Nursing, Symbiosis International University, Pune, Maharashtra
Email:director@scon.edu.in

Subtitle 4.2:Innovation and Intellectual Property Right in Nursing

Address by Ms. Jyoti Chaudhari, Chairperson: After Gopakuamar's interesting session now we will see relevance and scope of intellectual property rights in Nursing. I invite Dr. Sharadha Ramesh to focus on various innovations done by nurses and how to go for protecting the rights of such intellectual property of nurses.

Introduction: Business strategies have been redesigned in the global competition. Focus has shifted from how to use reposition in the world to how to create wealth. Today wealth creation is changing from resource based knowledge to brain process and an ability to create, to sell, to explain and to solve problems. This has resulted in wealth creation through the brains. Unlike a car or a house which we secure through lock, knowledge is an abstract substance of the human. This makes the knowledge transformation a debate whether it is correct or it should be a secret.

How to convert knowledge as property? More than the material we own knowledge has to be protected. Knowledge will not reduce the availability to others. But how to substantiate that it is the individual property. There are predominantly two ways to turn knowledge into property.

1. Secrecy which is used to protect three types of information trade secrets, know-how and rituals. But this kind of secrecy will not help the health world.
2. Intellectual property laws including copyright, patent, registered industrial design and trademark, legislation and conventions will be helpful for health field.

Intellectual Property Components has 2 components

1. Industrial properties include inventions, process, products and approaches, industrial design and marks and trade names to distinguish goods.
2. Copyrights: Include literacy work, numerical works including any accompanying words, dramatic works, promotions and graphic works, pictorial, graphic works, and other creative works, sound, architectural works.

Before moving to IPR one should understand the difference between creativity and innovation. Creativity is thinking up new things. Innovation is doing new things. Innovation is the act of constructive thinking, grouping knowledge, skills. Attitude into new original and rationalizes. Why we need innovation? Global demand on healthcare services, work force, time and money shortage, quality of life. What is the advantage? The idea is combined supervision to the old one.

It is compatible, less complex, trial ability, observability, it is both conceptual and perceptual, it is simple and focused. What is an invention?Any new or useful process or method, machine or apparatus, article of manufacture, improvements of any of the above. A patent is an exclusive monopoly grant by the government of an inventor over his invention for limited period of time. Some other types of intellectual property rights are also called patents in some jurisdictions: Industrial design rights are called design patents in the US, plant breeders' rights are sometimes called plant patents. In modern usage, the term patent usually refers to the right granted to anyone who invents any new, useful, and non-obvious process, machine, article of manufacture, or composition of matter. The four patent offices are located at Kolkata, Mumbai, Delhi, and Chennai.

Intellectual Property Rights (IPR)

IPR is the body of law developed to protect the creative people who have disclosed their invention for the benefit of mankind. This protects their invention from being copied or imitated without their consent.

Purpose of getting a patent: To enjoy the exclusive rights over the invention. The patent is to ensure commercial returns to the inventor for the time and money spent in generating a new product. What can be patented? An invention must pass four tests: 1. The invention must fall into one of the five "statutory classes": Processes, machines, manufactures, compositions of matter, and new uses of any of the above. 2. The invention must be "useful". 3. The invention must be "novel". 4. The invention must be "nonobvious".

Procedure for patent registration in India

Step 1: Write down the invention (idea or concept) with as much details as possible.
Step 2: Include drawings, diagrams or sketches explaining working of invention.
Step 3: Check whether the invention is patentable subject matter.
Step 4a: Patentability search.
Step 4b: Decide whether to go ahead with patent.
Step 5: Draft (write) patent application.
Step 6: Publication of the application.
Step 7: Request for examination.
Step 8: Respond to objections.
Step 9: Clearing all objections.
Step 10: Grant of patent.

Advantages of owning patent would be: You own the invention for given time (20 years). You can use it to build a business. Rent it (in this case license it) to existing businesses. Exclude all others for using, selling, offering for sale and importing your invention in your country. You can completely sell the patent to other company.

Conclusion: Any innovation in the nursing care, where less time is used for the process and is non-obvious should be applied for IPR. Though the patent making is in very rudimentary stage in the nursing fraternity, to survive in the world nurses has to give a try.

Comments by Chairperson, Ms. Jyoti Chaudhari: In fact, while developing a device or making ideas into reality is not a cup of tea for the nurses. This can be achieved by penning down the ideas for achieving the desired results with the help of professional/technical experts. Nurses have been innovating health practices from the era of Florence Nightingale till to-date such as; sanitary reforms, Ryles tube, gloves. Thus, it is an appeal to all students and staff to keep themselves open and prepared for accepting the challenges in reality for the betterment of the health of human beings.

CHAIRPERSON: MS. R. PONCHITRA AND MS. MARIA PREETHI MATHEW

SESSION 5: PROGRESS TOWARDS ADVANCED PRACTICE IN NURSING

Speaker: Mrs. Ida Nirmal, Professor, Medical Surgical Nursing And Clinical Nurse Specialist in Stoma Care, CMC, Vellore.
Email id :idanirmal@gmail.com

Subtitle 5.1: Reflections on Advanced Practice in Nursing: Competencies for Advanced Practice Nurses

Address by Chairperson Ms. Maria Preethi Mathew: Today in day 2 morning sessions of conference we are blessed with Mrs. Idea. Since yesterday lot of deliberations were done on nurse entrepreneurship, nurse practitioner. And you are the right person to talk about advances in nursing practice with challenges.
Dr. Ida Nirmal: Thank you Madam.

The increasing demand for healthcare services on all levels is placing great strain on healthcare systems throughout the world. Escalating demands combined with a shortage of General Practitioners (GPs) have forced politicians in many countries to reevaluate the distribution of work tasks and areas of responsibility between different healthcare personnel. Registered nurses' (RN) roles and scope of practice have been expanded and the quality and cost-effectiveness of healthcare systems have improved. Advanced Practice Nursing (APN) is an umbrella term for various nursing types and includes nurses acting in diverse advanced roles. The conception and education of Nurse Practitioners (NPs), or Advanced Practice Nurses (APNs) as they are later known, emanates from America in 1960s. APN today encompasses clinical nurse specialists, NPs, midwives and nurse anesthetists. During the past two decades, APNs have become a well-established professional group in many developed countries.

In an increasingly complex health care industry, APNs are playing a vital role. They are offering new ways of delivering cost-effective care and increasing access to qualified practitioners for many patients and their families. They are often providing health care to under-served populations. APNs are often primary care providers and are at the forefront of providing preventive care services to the public. According to the International Council of Nursing, APNs are defined as: ***"A registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which she/he is credentialed to practice."***

Advanced practice nurses must be grounded in theory and research as guides to their clinical practice. While they work in collegial capacities with physicians, they must be prepared to diagnose and treat patients with acute and chronic illnesses and to prescribe medications. These responsibilities require nursing professionals who are as smart and savvy as they are caring and compassionate.

Advanced practice nursing requires a higher level of education, a Master of Science in Nursing (MSN) at the minimum. Through extended education, one can expect to gain a larger skill set, increased assessment abilities, the ability to plan for and implement care, and the competency to offer diagnoses. MSN programs also allow nurses to become an expert in a nursing specialty, so that they can go onto treat specific populations or diseases.

APNs possess the competency to assess, diagnose and treat normal and/or acute health problems and situations and to provide follow-up care and treatment for chronic conditions. Furthermore, APNs are capable of assessing a patient's health situation and history, evaluating and identifying a patient's need for care, ordering diagnostic or laboratory tests and prescribing medications (rights vary from country to country) as well as referring patients for further care and/or admitting or discharging patients from hospital. In essence APNs offer holistic care. The eight core competencies of APNs are direct clinical practice, ethical decision-making, coaching and guidance, consultation, cooperation, case management, research and development and leadership.

Address by Chairperson Ms. Maria Preethi Mathew: Thank you Ms. Ida your session was really motivating and bringing lots of hope to our participants to go for advanced care nurse practitioner.

Subtitle 5.2: Exploring Advanced Roles for Nurses in Healthcare System for Quality Patient Care

Speaker: Kawaljeet Oberoi, Vice-President Nursing, Suasth Health Care, Navi Mumbai.
Email: kawaljeet_oberoi@yahoo.com

Address by Ms. Ponchitra R., Chairperson: Today, we have Ms. Kawaljeet Oberoi, Nurse administrator. She will throw light on advanced role of nurses for quality patient care.
Ms. Kawaljeet Oberai: Thank you Ms. Ponchitra.

Nurses have key roles to play as hospitals continue their quest for higher quality and better patient safety.

India has 2 nurses and 0.725 physicians per 1000, with a globally typical concentration in urban areas leading to limited healthcare access in rural settings. India prepares a significant number of physicians and nurses and in that context the shortage of healthcare providers is interesting to consider. "Nurse practitioner programmes and licentiate examination for nurses are among the key initiatives under the National Health Policy 2017 of the government of India. The ministry of health & family welfare has entrusted the Indian Nursing Council with their implementation in a time-bound manner," The Indian Nursing Council has initiated a Post Graduate Nurse Practitioner Critical Care Programme, the first postgraduate nursing residency program in India. Nurse-led clinics, shall increase the scope for nurses to practice more autonomously and to develop and apply advanced practice.

Many countries around the world have integrated various types of Advanced Practice Providers (APPs) into their healthcare systems. The main motivating factors for recognizing and developing APPs worldwide include physician shortages and the need for improved access or delivery. APPs are recognized in dozens of countries, and have similar scopes of practice, graduate level education requirements and clinical training. At the same time, there is wide variability among countries in the actual function and independence of the advanced practice nurse (APN), particularly the nurse practitioner (NP). Nurses are allowed to practice independently in some middle- and low-income countries such as Thailand and Nigeria, as well as in high-income countries, such as the USA, Australia, Canada, Ireland, the UK, Finland and the Netherlands. Israel has begun to introduce APPs, specifically NPs, in a variety of fields, including geriatrics, palliative care and diabetic care.

Advanced practice registered nurse is a term used to encompass Certified Nurse-Midwife (CNM), Certified Registered Nurse Anaesthetist (CRNA), Clinical Nurse Specialist (CNS), and nurse practitioner (NP). In 2004, the number of registered nurses (RNs) prepared to practice in at least one advanced practice role was estimated to be 240,461, or 8.3% of the total RN population. The APN movement has been growing exponentially with APNs employed in every healthcare sector.

The American Association of Colleges of Nursing had envisioned that all APN master's-level programs will evolve to a Doctorate of Nursing Practice (DNP) by 2015. This evolution to the doctoral level for APN education stems from the three Institute of Medicine (IOM) reports, *Too Err is Human*, *Crossing the Quality Chasm & Health Professions Education: A Bridge to Quality*, which emphasized widespread problems related to patient safety and called for dramatic restructuring of traditional health professions education. These reports recommended all health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidenced-based practice, quality improvement, and informatics. It was emphasized that the best-prepared senior-level nurses should be in key leadership positions and participating in executive decisions.

Comments by Ms. Ponchitra R., Chairperson: Thank you Madam Kawaljeet, for your experience sharing session. I am sure our nurses will definitely take this opportunity to develop advanced skills.

CHAIRPERSON: MS. SAVIA FERNANDEZ AND MS. PADMAJA DHAWALE

SYMPOSIUM TITLE: INTERPROFESSIONAL AND COLLABORATIVE CLINICAL PRACTICE (IPCCP)

Speaker: Mrs. Meenal Rane, Professor and Principal ITM College of Nursing, MUHS, Nashik
Email Id:meenalrane59@gmail.com

Symposium Subtitle 1: Significance of Interprofessional and Collaborative practice in Healthcare Today

Address by Chairperson, Ms. Padmaja Dhawale: : The improvement in patient outcomes is not only depends upon doctors line of treatment but entire healthcare team. So I will invite Mrs. Meenal to elaborate on significance of interprofessional and collaborative practice in healthcare.

Mrs. Meenal Rane:

"Greetings in business are never done by one person. They are done by a team of people."

- Healthcare is also a business, like any other business, the healthcare industry stands to benefits from that drive innovation and growth a unique service, but that fact alone does not guarantee their success.
- Healthcare industry is growing and specializing and that leaves lots of opportunities for start up.
- In view of this a vision for collaborative practice has emerged. Today patients have complex health needs and typically require more than one discipline to address issue regarding their health status.
- Interprofessional collaboration is healthcare is a challenge and innovative approach towards success.
- Interprofessional collaboration is defined as "When multiple health works from different professional backgrounds work together with patients, families, caregivers and communities to deliver the highest quality of care."
- To implement this new approach health professional leaders must critically evaluate the culture, systems and infrastructure of currently in place.
- Collaboration is more than just working together and working well with others outside the traditional care circle.
- It will need innovative tools, resources and technology that can stand up to and promote the demands of team based care delivery today.
- Hence collaboration mean healthcare professional assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making-decision to formulate and carry-out plans forpatient care.
- The importance collaboration occurs when multiple health professional from different speciality work collaboratively with patient their family and caregiver to deliver high quality care.

Benefits interprofessional and collaborative practice in healthcare:

- It empowers team members
- It closes communication gaps
- It enables comprehensive patient care
- It minimizes the hospital stay
- It minimizes readmission rates
- It promote patient centered care.
- It enhance the recovery of the patient.

Elements of interprofessional collaboration: Responsibility, accountability, coordination,

Communication, cooperation, assertiveness, autonomy, mutual trust and respect.

We have all participated in teams, but the culture of healthcare has long emphasized solo acts. The nurse act a part from the physical, who is unaware of the physical therapists role. Meanwhile, the pharmacist fails to communicate with member of the medical office staff, who are preoccupied by a now reality show.

This present services will emphasize why interprofessional collaboration is important and it will provide concrete examples of how make IPC work across multiple setting.

IPC is important in healthcare setting. The triple aim of improving patient experience and satisfaction, improving health of the population and reducing costs is not attainable without IPC.

However, currently IPC is the exception, not the rule. Each of the health professional must shift its focus toward. Collaboration, partnerships and sharing rather than operate in silos.

The quality and safety of care and the need to contain costs, require all profession to work together in an environment of respect with a protected shortage of healthcare provides including physicians and nurse, it is imperative to work collaboratively and more efficiently.

If the team professionals do not communicate and collaborate, their performance suffers. In the healthcare field, poor communication is often cited as a root cause of medical errors. Effective teamwork and good workingrelationships can reduce errors and improve outcomes. IPC optimizes patients outcome by improving communication and teamwork.

Another reason IPC important is that it promotes coordination of care across the continuum of healthcare in all setting. Working as a team the patients care is coordinated throughout the healthcare continuum.

This promote sharing of knowledge and working toward a common goal where each professional learns about each other's roles and responsibilities from each other. IPC helps ensure better communication with less chance of error, whether a patient is being transferred from surgery to the intensive care unit or from an acute care setting to a long-term facility for examples. IPC replaces the traditional physician centered system with one that revolves around the patient. Such a system works well with the team-based approach of IPC with IPC team members focus on the

Symposium Subtitle 2: Inter-professional Competencies, Boundaries and Barriers.

Speaker: Dr Gayatri Bhonsale-Kadam, Associate Professor, Ophthalmology MGMIHS, Navi Mumbai
Emailid: gayatri.bhonsale@googlemail.com

Address by Chairperson Ms. Savia Fernandez: Now I welcome Dr. Gayatri to share her experiences regrading interprofessional collaborations in Indian context, its boundaries and barriers.

Dr. Gayatri: WHO defines IPCP as a system wherein multiple health workers of different professional backgrounds work together with patients, families, caregivers and communities to deliver the highest quality of care (WHO 2010)

The western countries have adopted the idea of IPCP in research and clinical practice over the past decade. It is, however, a relatively new concept in our part of the world but one that definitely needs to be emphasized and implemented. So, what is IPCP? In simple terms, it is a team with multiple healthcare professionals (nurses, physicians, paramedical health workers) working together in order to improve patient care, safety and outcomes.

Various studies have shown that IPCP improves access to care, appropriate use of specialty services, chronic disease outcome and safety.

IPCP also improves indicators of safety like complication/error rate, length of hospital stay, mortality, sta turnover and response to emergencies.

WHO has linked IPCP with better outcomes in family health, non-communicable / infectious diseases, humanitarian efforts, and response to emergencies.

For any team to function effectively the members must exhibit some core competencies, IPCP is no dffierent.

Obviously, in a team of multiple health professionals some competencies will be specific to individual professions but some common core competencies must be common to all members.

Competencies of IPCP, laid out by the American Association of Colleges of Nursing are divided into four domains:

1. Values/ethics for interprofessional practice.
2. Defined role's and responsibilities.
3. Transparent and effective interprofessional communication.
4. Teams and teamwork.

Successful IPCP requires the continuous development of these interprofessional competencies by not only health professionals in clinical practice but also students as part of their early learning process.

The development of interprofessional collaborative competencies (interprofessional education, IPE) requires institutional efforts to engage students of dffierent professions in interactive learning from and with each other.

Being able to work effectively as members of multi-professional clinical teams while students must be a fundamental part of their learning so that they enter the workforce ready to practice effective teamwork and team-based care.

However, there exist multifactorial barriers in the implementation of IPCP. Accreditation and specific professional culture seem to hinder the IPE.

Accreditation bodies dictate curriculum content in most healthcare courses and have been slow to integrate IPCP in requirements and regulation of various curriculums.

Accreditation boards need to mandate IPE and IPCP concepts in nursing, medical and paramedical curriculums.

Most healthcare students start their curriculum with preformed notions about their professional identity, which get entrenched with time making it vital to address these assumptions earlier on. Changing attitudes

and beliefs of all individual professional is an inherent barrier to the introduction and integration of IPCP in the current scenario.

Tradition, professional culture and concerns about IPCP boundaries continue to hinder the further development of IPCP.

These factors will need to be addressed at an individual and institutional level.

Understanding these barriers will help nurses, paramedical health workers and physicians, in clinical practice, to implement IPCP and improve patient care.

Symposium Subtitle 3: Strategies to promote Inter-professional and Collaborative Clinical Practice

Speaker: Dr. Sagar Sinha, Head, Critical Care Unit & Assistant Professor, Emergency Medicine
MGM Medical College & Hospital, Navi Mumbai
Email: drsagarsinha@gmail.com

Address by Chairperson: Ms. Padmaja Dhawale: To have early recovery of patients with shortage of multidisciplinary staff, there is a need for multitasking among existing staff. I welcome Dr. Sagar Sinha to discuss various strategies to promote inter-professional and collaborative practice.

Dr. Sagar Sinha: With evolution of healthcare in all spheres especially technology, modern medicine is a stark contrast to that of a few decades earlier. However this era has also been marked by greater risk of lawsuits and a contentious patient–doctor relationship especially in India. With greater dependence on evidence-based medicine and increased regulatory requirements in form of documentation to assure quality processes (like NABH), physicians are finding it increasingly difficult to focus on patient-care alone. The focus may have well shifted from actual care to perception of care.

This does not hold true for paramedical personnel who are routinely used to and better at handling paperwork besides providing care to the patient which often goes beyond their job description. Nurses are able to handle patient emotions well and are more closely connected to the patient, perhaps maybe even more vested in the outcome. With modern regulation set to expand their role, it is crucial to develop a symbiotic relationship at a higher level and with deeper meaning.

The west recognized these phenomenon decades back and has already formalized protocols and regulation for increasing participation. The changes are already well incorporated into the system and it works like a well-oiled machine with minimal friction.

Certain strategies at unit level work like

1. Nurse-Led Protocols—especially with sedation, ambulation, nutrition and end-of-life care
2. Interdisciplinary Reviews-involving nursing personnel by active participation
3. Clinical Audits—active team roles with recommendations for action will foster leadership qualities
4. Administrative Roles—additional responsibilities help promote confidence and build character
5. Trust-Escalation Matrix—building upon successive situations and skills, staff could start gaining more independence in decision-making.
6. Compassion—basic courtesies, forgoing ego and showing compassion as an equal is the strength of the unit.

The fundamental drive in this area boils down to three things:

1. Intent—individual motivation and desire to put in the extra mile to get a positive outcome.
2. Skills—baseline operational requirements with individual capabilities are a key determinant in medicine.
3. Faith—trust develops overtime in these situations and requires faith, which goes both-ways.

Besides these, legislation, regulation and administrative framework are the structural changes in the system which is a top-down approach. Although lengthy, sometimes messy and difficult to implement, it is essential.

For successful interprofessional and collaborative clinical practice, a complete amalgamation of horizontal and vertical integration is required. Success in this area could completely revolutionize the dynamics of healthcare in our country and provide immense professional satisfaction to all healthcare providers.

Comments from Chairperson, Ms. Savia Fenandez: Even though nurses are being trained to diagnose and prescribe treatment, the nurses and health personnel need cooperation and collaboration. One of the strategies could be sharing of expertise for delivering the speech for other professionals and orientation to the curriculum. Thank you Ms. Meenal, Dr. Gayatri and Dr. Sagar Sinha.

CHAIR PERSON: Ms. Aleykutty John and Ms. Vandana Kumbhar

SESSION 6: BUILDING POSITIVE WORK PLACE CULTURE

Speaker: Dr. Sripriya Gopalkrishnan, Professor cum Principal, Sadhu Vaswani College of Nursing, Pune.
Email: sripriyagalkrishanan@gmail.com

Subtitle 6.1: Work Culture in Nursing

Address by Ms. Aleykutty John, Chairperson: Any change to occur whether its curriculum or nursing practice in hospital one requires healthy work culture at workplace. Here I will call Dr. Sripriya deliberate on the same.

Dr. Sripriya: "Workplace culture is the new black"
Culture is the way you thick act and interact. It is the character and personality of the organisation.Workplace culture has been defined by employees and employers as "The way we do things around here" (Bower 1996). Wren Hall says *"A positive workplace culture is where staff are engaged within the organisation. They feel involved and emotionally connected; they invest in their role and the organisation to support the goals and values of the organisation. They enjoy coming to work!"*

What is work culture ?

Work culture is the study of:

- Beliefs, assumptions, thought processes and attitudes of the employees and employers
- Mission, vision, values, ideologies and principles of the organization.

The core values of workplace culture are teamwork, innovation, trust, people, quality and responsibility.

Workplace culture helps to determine:

1. What people think of your organization?
2. What motivates our employees?
3. What behaviours do they think will be rewarded or punished?
4. What are the unspoken rules that everyone knows?

A healthy workplace culture is characterised by:

- **Satisfied employees and increased productivity.**
- **Good Employee relationships:** Respect for fellow workers, professional behaviour are its features.
- **Equal treatment to all employees:** Impartial treatment and no favouritism.
- **Appreciation of top performers.**
- **Positive discussions among employees—**Team members interact with each other. Transparency is existing at all levels among employees.
- **Employee friendly policies and practical guidelines in the organisation:** Decorum and discipline of the workplace is maintained.
- **Promotes team building activities to bind the employees together.** Training programs, workshops, seminars and presentations to upgrade the existing skills of the employees.

What do employees look for in a great place to work: Purpose, opportunity, success, appreciation, well-being, and leadership.

1. **Purpose** means connecting with organization's reason for being or the difference you make in the world.
2. **Opportunity** means providing employees the ability to learn new skills, develop, and contribute.
3. **Success** means giving employees the opportunity to innovate, do meaningful work, and succeed.
4. **Appreciation** means acknowledging and recognizing employees' outstanding work and unique contributions.
5. **Well-being** means paying attention to improve employees' physical, social, emotional, and financial health.
6. **Leadership** means connecting employees to purpose, empowering them to do great work, and creating a sense of camaraderie.

In nursing, workplace culture also determines the quality and quantity of nursing services rendered including staff and patient satisfaction.

In addition, a positive workplace enhances the psychological and physical well-being of the nurse, and is a safe workplace. To provide a safe the workplace culture:

- Minimising workplace hazards
- Train nurses to develop ability to handle job related risks and life issues
- Using best practices to improve workplace culture
- Rebooting workplace culture to include a healthy lifestyle menu, and fitness.
- Rewards to steps taken towards health prevention and wellness.

Examples of providing workplace safety are sexual harassment committee with stringent rules for offenders, infection control committee to provide infection safety. A strong workplace culture is essential to improve patient outcomes in practice and student outcomes in nursing education.

A positive workplace culture

- Has managers and leaders who are dedicated to delivering high quality care, support, and act upon feedback
- Encourages managers and leaders to be open, approachable and empowering
- Encourages a person-centered culture of fairness, support and transparency
- Managers and leaders encourage and support a strong focus on inclusion, equality, diversity and human rights
- Meets the needs of people who need care and support, staff and other stakeholders
- Ensure problems and concerns are always a priority and are committed to resolving them.

The leader's behaviour creates, or tolerates or influences the culture. The leader has a primary responsibility for setting or adjusting the culture. A workplace culture of fear slows organizations down, causes hesitation and leads to negative stress. A workplace culture that respects work life balance increases employee well-being and leads to increase productivity. In conclusion one must remember Mahatma Gandhi's quote "you must be the change you expect to see in others".

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Comments by Chairperson Ms. Aleykutty John: Thank you madam Sripriya for this wonderful session. The work culture is very important not only for the organizational growth but also professional growth of the individual.

SUBTITLE 6.2: FACILITATING POSITIVE WORKPLACE CULTURE

Speaker: Dr. Rakesh Ghildiyal, Prof./HOD, Dept. of Psychiatry MGM Medical College, Kamothe, Navi Mumbai.
Email: rakghil@gmail.com

Address by Chairperson Ms. Vandana Kumbhar: In today's stressful life where more than one-third of the time emplyees are spending at workplace how to maintain the positive work culture for smooth functioning and mental balance is really challenge. We have Dr. Gildiyal among us who will be elaborating on ways and means to elaborate on positive workplace culture.

Dr. Ghildiyal: An increasing number of people at work are reporting psychological distress at work place, due to actions initiated or condoned, wittingly or unwittingly, by colleagues' or seniors/managers. These situations result in staff finding themselves being disciplined, referred by their manager to occupational/ psychological health services, and being marginalized by others because of some kind of apparent 'wrongdoing' that is never clearly expressed or exposed.

The people most affected are professionals, providing legal, **medical, nursing, psychological, teaching, social work**, banking and other services to the community. For them, there is no satisfactory outcome. The best that can happen is a change of job. The worst is a change of life. All suffer degrees of psychological distress arising from the events.

Managers, wittingly or unwittingly, contribute to psychological distress at work, whilst occupational health and other services seldom address the real causes of distress, which include the managers.

The high incidence of absenteeism, reporting sick or sickness, and staff attrition/turnover continues to cause concern for legal, insurance, business and service costs, and personal reasons. The impact is all around us. The decline in standards, quality and effectiveness of the public services is manifest.

People who **feel well perform better** than people who do not. Well-being is a highly personal interpretation of how we feel, and differs from people to people. Different people feel stressed at different levels of hardships and obstacles.

Hence having a positive, enhancing, enriching work culture paves the way for greater achievements by Organizations, eventually leading to greater output, creativity, quality of life, and lesser sickness—psychological or physical.

Building a positive work culture requires attention to be paid to the principal cultural foundations of the organization the purpose, the structure, the processes and the behaviours of the controllers. If these are built to a specification of **virtuous intent, values, psychological contract, trust and commitment**, then employee engagement is almost assured. These results in high levels of well-being and performance of staff and the organization.

SIX ASPECTS OF GOOD WORK CULTURE

1. Purpose means connecting employees to your organization's reason for being or the difference you make in the world.
2. Opportunity means providing employees the ability to learn new skills, develop, and contribute.
3. Success means giving employees the opportunity to innovate, do meaningful work, and be on winning teams.
4. Appreciation means acknowledging and recognizing employees' outstanding work and unique contributions.
5. Well-being means paying attention to and constantly working to improve employees' physical, social, emotional, and financial health.
6. Leadership means connecting employees to purpose, empowering them to do great work, and creating a sense of camaraderie.

Organizations that marginally improve in each of these six areas see dramatic improvements in recruiting, engagement, tenure, satisfaction, and other business metrics such as revenue growth and expansion.

Comments by Chairperson Ms. Aleykutty John and Ms. Vandana

Thank you Dr. Sripriya and Dr. Ghildiyal for giving new insights related to workplace culture and its importance. Definitely this will help all as everybody is a part of work culture. This will also help in reducing high turnover of staff, burnout among students, teachers, employed nurses in the hospital. Indirectly lead to productivity and quality patient care.

To Assess the Cardiac Disease Knowledge Among 18–45 Years Patients Admitted with Myocardial Infarction in Selected Teaching Hospitals of Mumbai

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ABSTRACT

Aim of the study was to assess the cardiac disease knowledge among 18–45 years patients in selected teaching hospitals of Mumbai and to identify association of knowledge levels with demographic variables. **Methods and materials:** Descriptive cross-sectional case control study was carried out using convenient sample. (cases = 100, controls = 200). Patients aged 18–45 years admitted with first episode of myocardial infarction and 200 healthy controls without any history of cardiac diseases in selected teaching hospitals of Mumbai. Pre-validated free access Heart Disease Fact Questionnaire was used to assess the coronary risk factors with test-retest reliability (r = 0.89). Interviewer administered the questionnaires to the study participants and responses recorded. Scores were calculated by summing correct answers for each question. (range 0–30). Inadequate knowledge score was indicated by mean score of <70%. **Results:** Mean age of the cases was (37.96 ± 5.86) and controls (37.76 ± 5.56) (p> 0.779), male to female ration is 9 : 1 among cases and among controls 8 : 1.4. The score of knowledge on cardiac disease was found <50% among 1% vs 9%, 50–69% among 6% vs 25.5%, >70% among 93% vs 65.5% in cases and controls respectively and is statistically significant (p<0.05) and chi square 26.83. Surprisingly more knowledge score was frequently observed among cases as compared to their counterpart. There is significant association between age and knowledge, as the age advances knowledge too at p>0.05. Males have more knowledge among cases (p<0.05) (chi sq.9.498). More educated and cases with lower occupation, Lower- middle class strata have more knowledge among cases and upper and lower middle class has good knowledge among controls. **Conclusion:** Good knowledge levels were observed among cases as compared to controls. These findings support that only good knowledge does not mean but its application in day to day life need to be focused.

Keywords: Cardiovascular disease, knowledge, myocardial infarction, cardiac disease knowledge.

INTRODUCTION

Some people are at greater risk of cardiovascular disease (CVD) than others. Factors linked to an increased risk of CVD are family history, age, sex, cigarette smoking, excessive alcohol consumption, abnormal lipid and lipoproteins, high blood pressure, high blood glucose, physical inactivity, overweight and obesity. It is estimated that 23.3 million people will die by 2030, because of cardiovascular disease.[1]

Coronary heart disease is the most common type of heart disease, killing more than 3.85 lakh people annually. Knowledge of heart disease risk factors is extremely low among young adults. There is threshold level of heart disease knowledge which must be attained to influence behaviour and risk factor level.[2] 17.7 million people die every year from cardiovascular diseases that is 31% of all global deaths.[3]

Myocardial infarction (MI) is a disease of heart and blood vessels. It is predicted that India will host half of cases of heart disease in the world. In western countries last few years lots of information campaigns were launched focused primarily on disseminating information about prevention of heart disease risk factors such as high fat diet, dyslipidemia, smoking, hypertension (HT), *diabetes mellitus* (DM), sedentary lifestyle.[4]Adherence to healthy nutritional and lifestyle recommendations can play an essential role in the prevention of heart disease and MI.[5]

Heart disease knowledge is integral to promote healthy lifestyle and prevent disease. Low education level, low health literacy and low socioeconomic status may cause barriers to acquire good health knowledge. One of the study found that increased cardiovascular risk was associated with less knowledge of heart attack symptoms.[6]

In 2016, there were an estimated 62.5 million and 12.7 million years of life lost prematurely due to heart disease in India and United States, respectively. World Health Organization (WHO) has set the goal of reducing the risk of premature mortality due to non-communicable disease including heart diseases by 25% by 2025.[7]

Objectives

- To assess the cardiac disease knowledge among 18–45 years patients admitted in selected teaching hospitals of Mumbai
- To find out association between cardiac disease knowledge and demographic variables.

MATERIALS AND METHODS

Descriptive cross-sectional case control study was carried out using convenient sampling technique. (cases = 100, controls = 200). Patients aged 18–45 years admitted with first episode of myocardial infarction and 200 healthy controls without any history of cardiac diseases in selected teaching hospitals of Mumbai. Pre-validated free access Cardiovascular Disease Risk Factor- Knowledge Level (CARRF-KL) scale with 30 items was used to assess the coronary risk factors with test-retest reliability (Chron Bach Alpha, r = 0.89). Interviewer administered the questionnaires to the study participants and responses recorded. Total scores were calculated by summing the total number of correct answers, and converting it into percentage with higher scores indicating more knowledge. Participants with score of <50% were classified as low level of knowledge while score between 50 and 69% were considered as moderate level and CARRF-KLscores >70% as good level of knowledge.

Inclusion criteria: Cases

- 18–45 years patients diagnosed and admitted with first episode of MI
- Residing in Mumbai
- Willing to participate by consent
- Can comprehend English/Hindi/ Marathi.

Inclusion criteria for Controls

Patients 18–45 years admitted with non-cardiac conditions with age and residence matched.

Exclusion criteria

- 18–45 years patients admitted with myocardial infarction who are critically ill.
- Myocardial infarction due to congenital coronary abnormality.
- Controls: Patients without history of cardiac illnesses.

Ethical consideration

Study was approved by Institutional Ethics Committee for human subjects from both selected teaching hospitals. Administrative approval was obtained. Informed, written consent was obtained prior to study.

Data collection

Permission obtained from authorities of the selected teaching hospitals. Ethical clearance and administrative approval obtained from both the teaching hospitals. The purpose of the study was explained to study participants and written informed consent obtained from them. Data was collected from July 2016 to July 2017.

RESULTS

Section I: Demographic Characteristics of the Participants

***Table 1*. Distribution of sample in relation to their demographic variables**

	Cases (n = 100)		Controls (n = 200)	
Age (years)	**f**	**%**	f	%
18–30	10	10	16	8
31–35	17	17	52	26
36–40	39	39	61	30.5
41–45	34	34	71	35.5
Gender				
Male	90	90	170	85
Female	10	10	30	15
Marital status				
Unmarried	14	14	43	21.5
Married	86	86	157	78.5
Number of children				
1	15	15	23	11.5
2	42	42	69	34.5
>3	26	26	48	24
No children	17	17	60	30
Type of house				
Slum	19	19	35	17.5
Chawl	40	40	126	63
Apartment	41	41	39	19.5
Use of lift				
Yes	16	16	5	2.5
No	84	84	195	97.5
Education				
Illiterate	9	9	39	19.5
Primary school	9	9	7	3.5
Middle school	47	47	86	43
High school	20	20	43	21.5
Intermediate/post high school diploma	1	1	0	0
Graduate/postgraduate	13	13	25	12.5
Professional honors	1	1	0	0
Family income				
d″2164	1	1	13	6.5
2165–6430	13	13	55	27.5
6431–10718	28	28	78	39
10719–16077	25	25	23	11.5
16078–21437	14	14	10	5
21438–42875	15	15	12	6
d″42876	4	4	9	4.5
Occupation				
Unemployed	0	0	31	15.5
Unskilled worker	25	25	44	22
Semiskilled	21	21	39	19.5
Skilled	32	32	57	28.5

Contd...

Clerical/shop owner/farmer	10	10	23	11.5
Semiprofessional	7	7	6	3
Professional	5	5	0	0
Socio-economic status				
Upper class	1	1	0	0
Upper middle	23	23	19	9.5
Lower middle	20	20	44	22
Upper lower	56	56	135	67.5
Lower class	0	0	2	1

Table 1 depicts that maximum number of cases versus controls were in the age group of 36–40 years (39%, 30.5%), followed by 41–45 years (34%, 35.5%). Almost 2/3rd of cases were in the age group of 36–45 years. Males were 9 fold than females. Male to female ratio of cases 9 : 1 vs control was 8 : 1.4.

MI was frequently observed among married patients with their counterparts. Majority of the cases and control were educated up to middle school level. Majority of sample has family income between ₹6,431–10,718 per month (28%, 39%).

1/3rd of the cases and control belongs to skilled worker category (32%, 28.5%), whereas 1/4th of the sample were unskilled workers (25%, 22%). Followed by 1/5th were semi-skilled (21%, 19.5%).

Majority of the participants (56% and 67.5%) constitute upper lower socioeconomic class among cases and controls.

Section II: Cardiac Disease Knowledge

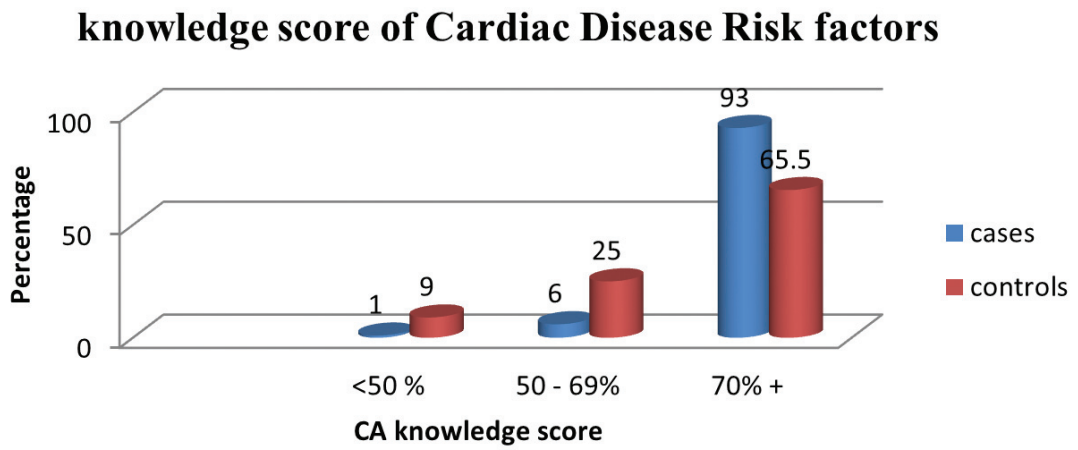

Fig.1: Distribution of sample in relation to their knowledge regarding CARRF_KL

Figure 1 illustrate that more than 70% knowledge was observed among 93% and 65.5% in cases and controls respectively.

Table 2 Item-wise analysis of Cardiac Disease Fact Questionnaire (CDFQ) n = 300 (cases 100. Controls 200)

	Cases	Controls			p-value (chi-sq.)
Knowledge Q. NO	f	%	f	%	
Person realizes of having CHD	81	81	151	76	0.177 (1.150)
Family history increases your risk	81	81	149	75	0.133 (1.575)
Elderly are at risk of heart disease	83	83	145	73	0.029 (4.030)
CHD can be prevented	78	78	146	73	0.213 (0.881)

Contd...

Smoking is a preventable cause	87	87	153	77	0.021 (4.594)
Smoking is a risk factor	82	82	153	77	0.174 (0.276)
Risk is reduced when smoking stopped	80	80	143	72	0.072 (2.525)
2–3 portion fruits and 2 vegetables daily	82	82	145	73	0.046 (3.268)
Red meat harmful if >3 times/week	79	79	148	74	0.210 (0.905)
Eating salty increases BP	79	79	145	73	0.140 (1.489)
Fatty meals do not increase cholesterol	78	78	143	72	0.143 (1.452)
Solid fats at room temperature are beneficial for health	76	76	131	66	0.041 (3.436)
Low carbohydrate and fat are beneficial for health	76	76	149	75	0.447 (0.080)
Overweight is a higher risk for CHD	84	84	144	72	0.014 (5.263)
Regular exercises reduces risk of CHD	82	82	149	65	0.094 (2.117)
Risk can be reduced by exercising only in gym	81	81	145	73	0.070 (2.592)
Slow walking and wandering are also exercises	81	81	153	77	0.231 (0.787)
Stress, sorrow and burden increases risk of CHD	80	80	143	72	0.072 (2.525)
BP increases under stressful conditions	81	81	144	72	0.058 (2.880)
High BP is a risk for CHD	82	82	149	75	0.094 (2.117)
BP control reduces the risk	82	82	145	73	0.029 (4.030)
HT medication should be used for lifetime	82	82	143	72	0.031 (3.920)
High cholesterol is a risk factor for CHD	83	83	145	73	0.029 (4.030)
There is a risk if HDL is high	90	90	148	74	0.001 (10.409)
There is a risk if LDL is high	81	81	150	75	0.154 (1.355)
High cholesterol then medicine is given	82	82	141	71	0.021 (4.321)
Diabetes is a risk factor for CHD	81	81	137	69	0.01 (5.244)
Risk can be reduced by controlling glucose	87	87	148	74	0.006 (6.638)
Junk food increases risk of increased cholesterol	77	77	144	72	0.216 (0.859)
Moderate alcohol is not harmful in view of CHD	80	80	148	74	0.158 (1.316)

Mean knowledge score among cases was 81.3 which was higher than the mean knowledge score of control (73). That shows the knowledge level of cardiac disease risk factors among general population is lower, making them vulnerable to continue with risk factors and acquire the cardiovascular disease.

Section III : Association of Cardiac Disease Knowledge with Selected Demographic Variables

Table 3: Association of Cardiovascular Disease Risk Factor Knowledge Level (CARRF-KL) with age and gender

n = 300 (cases 100. Controls 200)

Variable	Group	Category	<50%	50–69%	>70%	p-value	Chi-square
Age	Case	≤35 yrs	0 (0%)	0 (.0%)	27 (100.0%)	0.249	2.784*
		>35 yrs	1 (1.4%)	6 (8.2%)	66 (90.4%)		
	Control	≤35 yrs	6 (8.8%)	15 (22.1%)	47 (69.1%)	0.709	0.688
		>35 yrs	12 (9.1%)	36 (27.3%)	84 (63.6%)		
Gender	Case	Male	0 (0%)	5 (5.6%)	85 (94.4%)	0.009	9.498*
		Female	1 (10%)	1 (10%)	8 (80%)		
	Control	Male	15 (8.8)	43 (25.3%)	112 (65.9%)	0.959	0.083
		Female	3 (10%)	8 (26.7%)	19 (63.3%)		

(Note : * suggest significant)

Table 3 suggests that there is association between age and cardiovascular disease risk factor knowledge and it is statistically significant. ($p>0.05$) and also depicts that Male have more knowledge than females among cases ($p<0.05$)

DISCUSSION

Mean age of study population in among cases is (37.96 ± 5.86) and control (37.76 ± 5.56) and male to female ratio is 9 : 1 among cases and among control 8 : 1.4. In similar study done in Ghaziabad, India, the mean age of the sample was 36.24 ± 4 and male to female ratio is 5.25 : 1.[8] One of the most consistently observed risk factor for MI is male gender. The skewed gender distribution among males (90%) vs females (10%) is supported by the similar study done in Japan the males were 95% and females were 5%.[9]Dang A et al[10] also found similar male preponderance with a ratio of 7.8 : 1 among young adults with MI in Goa, India. These findings signify MI being predominantly a disease of male gender. Marital status and low education level was associated with myocardial infarction but the results are different in contrast to a study done by Hu Bet al[11] suggested that being single education among women was associated with MI and low level of education was highly associated with MI among both men and women.

In the present study 93% of participants showed above 70% CARRF-KL score among cases.

Mean knowledge score among control was only 72.9% in comparison to mean knowledge score of cases (81.3%). That shows the knowledge level of cardiac disease risk factors among general population is lower, making them vulnerable to continue with risk factors and acquire the cardiovascular disease. While a study carried by Adeseye A et al the mean score was 48.6%. and Only 19.9% assessed to have a good knowledge, 49% had poor knowledge and 31.2% had fair knowledge of heart disease risk factors.[12] Also the study done by Ali A Ammouri et al shows 60.5% had inadequate mean knowledge scores of cardiac risk factors.[13] Also in another study done by Chinju G et al shows that the percentage of participants who were aware about risk factors were 48% and 52% were unaware.[14]

CONCLUSION

Although knowledge alone is not sufficient, it is thought to be a prerequisite for making sound health decision. Monitoring population's knowledge of heart disease risk factors can help guide public health program. Identifying risk factors and interventions to reduce these risk factors, is of absolute importance to prevent and reduce MI among the young population . There is urgent need for targeted patient education and public health intervention such as mass awareness and screening camp based on level of awareness of various risk factors of cardiac disease.

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INFERTILITY RELATED STRESS AMONG COUPLES UNDERGOING ART: A MIXED METHODS STUDY

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ABSTRACT

The prevalence of infertility among Indian population is around 14%[1] and treatments are complex, prolonged with uncertain outcomes, which results increase of physical burden and psychological distress among couples. **Objective**: To explore the stress among infertile couples. **Methodology**: Sequential explanatory mixed methods[2] was adopted. Thirty infertile couples attending a fertility clinic at tertiary hospital were selected through purposive sampling with maximal variation. Validated Infertility related stress questionnaire (reliability 0.81) was incorporated for quantitative data collection. Qualitative data was collected by in-depth interview of five couples and thematic analysis was done. Ethical compliance was maintained throughout the study. **Analysis:** Sociodemographic data revealed that the mean age of the wives and husbands 32.6 ± 5.2 and 36.2 ± 5.4 years respectively. BMI was higher in 53.3% of women and 66.7% of men. Stress was measured in terms of four domains, stress related to sexual domain (55.8%) was found high, followed by social domain (52.2%) among women, whereas men had higher stress related to spouse support related domain (48.3%). Emotional domain related stress was similar among both. The overall stress comparison among wives and husbands was found to be statistically non-significant (ë2 = 3.784, P = 0.286). Content analysis of the in-depth interviews revealed two major themes: Stress related to family members and social life, impact on their personal relationship.

Conclusion: It is the need of the hour to develop Nurse-led interprofessional, collaborative interventions to enhance the partnership among the couple and reduce the experience of stress.

Keywords: India, infertility, sociodemographic factors

INTRODUCTION

The clinical definition for infertility as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse." This is keeping with WHO definition of male and female infertility in the International Classification of Diseases (ICD 10).[1]

The prevalence of infertility among Indian population is around 14%.[2-3] There has been a steady up surge in treatment seeking behaviour among the infertile couples. Assisted reproductive technology has advanced tremendously in past few decades. With advancements it has been noticed that the treatments are complex, prolonged with uncertain outcomes, tend to increase physical burden and psychological distress among couples.[3] It is a well-known fact that increasing stress levels significantly alters the HPO axis of the woman. This alters the woman's reproductive hormonal milieu and can contribute to ovulatory dysfunction and subfertility. Men with stress issues often have erectile and coital dysfunction again contributing to subfertility.

Several studies have been done on whether or not anxiety or depression contributes to infertility as the major factor. A European study found that anxious women took longer to conceive and were more likely to miscarry, than women who have lower levels of anxiety.[4] Another study has shown that women with a history of depression are twice as likely to subsequently experience infertility when compared to women with no such history. Yet another study showed a higher level of luteinizing hormone in depressed woman that can render them sub fertile. Present study was conceptualized to explore exhaustively the stress experienced among infertile couples.

MATERIALS AND METHODS

Sequential explanatory mixed methods[5] was adopted for the present study. The research question framed to structure the study was: What is the impact of stress among couples undergoing infertility treatment? Following were the objectives of the study:

- To measure the level of stress among infertile couples and compare it between respective partners.
- To explore in-depth experiences of infertile couples.

- Stress was operationally defined in the study as "altered scores in terms of social, sexual, emotional and spouse support related domains as measured by the infertility related stress questionnaire".
- The null hypothesis H_{01} framed for the study was "there will be no significant difference in stresslevels of infertile male and female partners as measured by infertility related stress tool at 0.05 level of significance".

Setting

Study was conducted at a 1500 bedded tertiary hospital and research centre, with fertility clinic at Navi Mumbai. The fertility centre offers ART namely Intrauterine Insemination (IUI), In Vitro Fertilisation-Embryo Transfer (IVF-ET), Intra Cytoplasmic Sperm Injection (ICSI), Assisted Hatching (AH), etc. The study was conducted in the month of December 2018.

Participants

Target population comprised of all the infertile couples attending the fertility centre. Couples who were willing to participate, women aged above 18 years and below 50 years, men aged above 21 years and below 55 years and who can read, write, speak and understand English, Hindi and Marathi were included in the study. Couples with secondary infertility, known and severe psychiatric disorders, with sexual dysfunction, having undergone previous ART were excluded from the study. 30 couples were selected through purposive sampling technique for phase one of the quantitative study. Later five couples were randomly selected for in-depth interview for qualitative data collection.

The researcher interviewed each infertile couple fulfilling inclusion criteria, using couple-based dyadic approach; it was incorporated with the view to establish a better interaction. All participants were interviewed in one or two sessions lasting approximately 30 to 60 minutes. Thirty couples were selected by purposive sampling technique with maximum variations, including different causes of infertility, wide range of age, different infertility duration, religion, etc. A semi structured questionnaire was developed for gauging, section 1: Sociodemographic variables like age, religion, education,occupation, family types, number of members and family income. Section 2: Anthropometric data. Section 3: Details about Habits. Section 4: Reproductive health: Age of marriage, trial for pregnancy, sexual orientation. Section 5: Psychological domain. Section 6: Financial domain.

In order to elicit the outcome variable of the study, infertility related stress questionnaire was developed. It was a 5-point Likert scale (strongly disagree, disagree, somewhat agree, agree, strongly disagree) with four domains namely social domain, sexual domain, emotional domain and spouse support related domain, comprising of 30 questions in total. The tool was validated for content and construct by experts. Reliability of the tool was established using test retest method. The reliability of the instrument by Cronbach's alpha internal consistency was 0.81. Qualitative data was collected by in-depth interview of five couples and thematic analysis was done. Ethical compliance was maintained throughout the study.

Ethical Considerations

This study was part of a larger research approved by Ethics Committee for Research on Human Subjects at MGM Institute of Health Sciences. Written permissions were procured from administrators before commencement of the study. Prior to the interviews, participants were made acquainted of the objectives of the research and an informed consent was obtained. Confidentiality of the information collected was maintained throughout the study and they could withdraw from the research anytime they desired.

ANALYSIS

Quantitative Data Analysis

Data was analysed in two parts. SPSS software was used for quantitative data analysis. Sociodemographic data sheet consisted of six sections namely basic demographics, anthropometric data, habits, reproductive health domain, psychological domain and lastly economical domain.

Sociodemographic data revealed that the mean age of the wives and husbands 32.6 ± 5.2 and 36.2 ± 5.4 years respectively. Majority of the couples were Hindus (83.3%) followed by Buddhist (10%). As per educational

status majority of the wives (33.3%) were graduates and working, whereas majority of husbands (33.3%) completed higher secondary education. Revised Kuppuswamy scale[6] was incorporated to determine the socio-economic status of the couples, it was seen that the majority (60%) couples belonged to upper middle class. Majority of the couples (63.3%) resided in the joint family.

Body Mass Index was calculated by measuring the height and weight of the individuals. BMI was higher in 53.3% of women and 66.7% of men.

The third section comprised of details related to habits, women were non-smokers and non-alcoholics. Among men 23.3% were smokers and 43.3% alcoholics (occasional indulgence).

The fourth section comprised of reproductive health, average age at marriage of women was 25.5 ± 4.55 years, men was 29.5 ± 5.17 years. Duration of marriage was from 2 years to 19 years, and for trial for pregnancy was from 1 year to 15 years. All the couples reported to be heterosexual as sexual orientation. Majority, i.e. 80% of the couples were staying together, remaining 20% of them stayed separately due to different location of job of spouse. Trial for pregnancy was delayed due to the infertility diagnosis and treatment. Frequency of physical relationship was reported to be occasional per week among 60% of the couples. 66.7% of the couples stated that they were unaware in relating pregnancy trial with ovulation.

The fifth section elaborated about psychological aspects. Majority of wives, i.e. 46.3% were stressed, 23.4% had painful experience and only 23.3% were relaxed while in physical relationship with the partner, where as 56.1% of husbands were relaxed and 36.7% were stressed. While stating about reaction of partner towards inability to have child, majority of women (43.3%) reported that their partners were supportive, only 6% of them were anxious. Whereas majority of men, i.e. 33.3% reported that their partners were anxious, 23.3% were tensed and frustrated.

The last section consists of economical domain. Majority (56.7%) of the couples expressed that they would meet the financial expenses towards infertility treatment by their salaries, 20 % of them would take loans.

Majority of the women, i.e. 30% had blocked fallopian tubes, 23.3% had polycystic ovarian syndrome. Whereas among men, 30% were diagnosed with oligospermia, 10% had azoospermia. Majority of the couples had visited two or three infertility specialists before registering with fertility clinic for study.

The outcome variable stress among infertile couples was explored through infertility related stress questionnaire. Stress was measured in terms of four domains, namely stress related to social domain, sexual domain, emotional domain, and spouse support related domain. Among women, 52.5% were stressed related to social domain. Whereas very less 39.4% men reported stress related to social domain.

In the sexual domain, 55.8% women mentioned stressed whereas only 45% men reported the same. Emotional domain related stress was more or less similar among both women (47%) as well as men (48.3%). The last domain, i.e. spouse support related stress was high among men (48.3%) than women (47%).

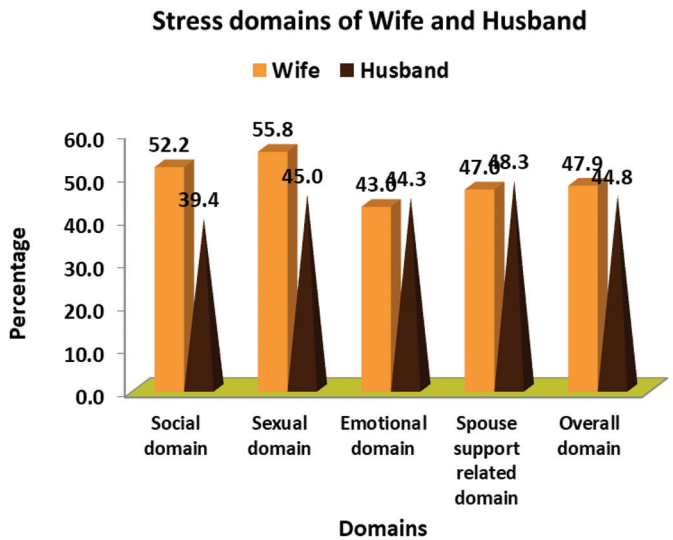

Fig.1: Comparison of stress among infertile couples

The overall stress compared among women and men was found to be statistically non-significant (ë2 = 3.784, P = 0.286), the null hypothesis, i.e. there will be no significant difference in stress levels of infertile male and female partners as measured by infertility related stress tool at 0.05 level of significance was accepted. This statement helped to conclude that both the partners as couples require nurse-led interventions in order to reduce their stress levels while undergoing infertility treatment.

Qualitative Data Analysis

Content analysis of the in-depth interviews was undertaken for five couples who expressed more stress; the taped interviews were transcribed by the help of a software. The basic purpose of content analysis is to extract concepts and relations that would explain the collected data. Content analysis of the in-depth interviews revealed two major themes: Stress related to family members and social life, impact of stress on their personal relationship.

Mostly all participants reported feeling social pressure in response to their infertility and were quite uneasy when asked questions about having children. A couple reported that our stress is primarily because of responses from our joint family members. Whenever we are at social gatherings, they ask questions like, "Do not you have a child?" We are exhausted answering them.

A woman 38 of years, married for 11 years reported tearfully that her source of stress is her mother-in-law. She has told her at various occasions to leave her son, as she does not give a child to the family and she does not deserve him.

The second most important theme identified was stressful personal relationship with the spouse. A couple reported that "when the doctor says the important alternative nights to have sex, then my mind is preoccupied with the thoughts of having a child and related failures, disappointments. This makes me frustrated and unhappy. One does not get the same as earlier. I feel we are drifting away, with our stress and frequent arguments".

The analysis of the study highlights on the prevailing stress among the infertile couples and there seems to be enormous necessity to support such couples.

DISCUSSION

There remains a constant threat and pressure to conceive, programmed approach to conception, loss of privacy to interventionists and the treatment itself negatively impacts the marital adjustment and sexual functioning among infertile couples as evidenced in the current study. The couples undergoing the extensive treatment experience distress pertaining to social domain, sexual domain, emotional and spouse support related domain. Similar results have been evidenced in a study conducted in India, 80% of women, 72% of men experienced stress related to infertility and treatment.[7]

LIMITATION

Data was obtained solely on verbal response and the response of the subjects were taken on a 'as is' basis. Being a hospital-based study, sample subjects were couples who were attending infertility centres for treatment causing a potential bias.

CONCLUSION

Most of the couples suffering from infertility describe it to be the most stressful and depressing event of their lives. Stress can be a contributor to infertility and can adversely affect the treatment success. Recent scientific evidence suggests that psychological therapy, especially mind body therapy to counter stress can significantly improve pregnancy rates among couple undergoing ART.

Thus, stress reducing strategies and low-cost infertility treatment facility offer to be the ideal combination to fulfil the dreams of parenthood for the suffering subfertile couples in India. It is the need of the hour to develop nurse-led interprofessional, collaborative interventions to enhance the partnership among the couple and reduce the experience of stress.

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BRIDGING THE GAP BETWEEN THE GENERATION Y AND Z

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ABSTRACT

Statement: Expectations of generation Z nursing students from their generation Y teachers. **Objectives:** To find out the expectations of students related to interpersonal, conceptual and technical skills. **Research Methodology:** Web based survey was conducted on 52 nursing students in selected colleges of Mumbai by using nonprobability convenient sampling technique. Data was collected online by using five-point Likert scale. **Analysis: Interpersonal skills:** The teacher should increase motivation, should deal topic with simplicity, allow for distractions, and should use understandable way of communication. **Conceptual skills**: Students opined that teacher should act as a mentor. They should be flexible in dealing with the students, and refer to recent information while teaching. The teacher should allow for self-study and autonomy, teacher should offer straight solutions to the problems. **Technical skills:** The teachers should use videos, photos to introduce the topic, the teachers should be updated to recent apps and technology, should use media and should be available for online communication.**CONCLUSION:** In order to tackletech savvy, smart and dependent Generation Z student's we teachers also need to be digital immigrants to stay with these Digital natives. The teachers need to update themselves, if they want to keep the students from their class engaged instead of walking out of the class.

Keywords: Generation Y, Generation Z**,** technical skills**,** conceptual skills**,** interpersonal skills.

INTRODUCTION

A study conducted by Barnes and Noble College, New Jersey USA, shows that today's students refuse to be passive learners. They are not interested in simply showing up for class, sitting through a lecture, and taking notes that they will memorize for an exam later on. Instead, they expect to be fully engaged and to be a part of the learning process themselves.

As the generations are undergoing changes, similarly student generation is also expecting changes. Old traditional methods of teaching-learning cannot keep the students engaged in the same classroom. On the basis of this, the researcher thought of exploring the views of Generation Z students from their Generation X teachers.[1]

LITERATURE REVIEW

The Generation Z students are keen to discover, make themselves self-educated. They can process the data or any information quickly. The new students, who seek admission in the colleges, are more smart in comparison to previous generation students. In fact, this has forced for updating the education system. Teachers are required to improve their own skills in order to be at par with this generation.[2]

The students of the Generation Z prefer to use all their senses in learning instead of just teacher using chalk and board method for teaching. Videos are the most preferred method by the new generation students as shown by the newer researches. The Generation Z students in the age group of 14 – 23 expect their education to be molded with the help of technology in all different possible ways as quoted by Pearson and the Harris Poll.[3.]

YouTube is the second largest preferred method than the teacher by the Generation Z students. YouTube is ahead than the lectures given by the teachers, than even the books. One thing to be still kept in mind is that even if the Generation Z likes technology, they have yet not stopped going physically to the colleges for the educational experience. Only 26% of the students rank taking online courses preference than the rest.[4] Generation Z and M*illennials* still give the teachers and their professors as the highest rank in helping influence for their personal and professional development which is highest than their friends and higher than their parents.

Nowadays going to the tuitions is like a fad but only 25% of Generation Z students than compared to 40% Millennials have confidence to say that they can still achieve good career without attending regular college which is not the big number to be considered. When asked about the value of college highest number that is 80% of Generation Z students and 74% of the Millennials agreed that the college has excellent, good and fair value. 20% indicated that college is of no value or has little value. It reveals that college is still considered important by the Generation Z and Millennials as well.

Generation Z students want to reach to the top of their profession on day versus Millennials. 60% of Generation Z students wish to help to those people who are not that lucky as they are, however, it was agreed by only 48% of Millennials. Diversity is another important value–more than 6 in 10 Generation Z respondents agree that having diverse friends makes them a better person, while slightly more than half of Millennials agree with that statement.[5]

The next generation of students, i.e. the **Generation Z, or I Gen** will enter the higher education very soon. Millennials are fond of technology, but compared to them Generation Z are far further. Generation Z are technology savvy who will be technology natives spending their whole lives completely driven by technology which will be very important for learning to happen and also to lead life.

To educate these students of Generation Z the teachers must adapt the changing pedagogical approaches by adding more audio video aids to their content in the curricula. The teachers have to be very streamlined in their preparations. Teachers say that students may be able to deal with the twitter or face book but they still they have to learn about technology based educational applications.

Today's world is drowned in technology. Smart phones, tablets, are the favourite toys of these Generation Z. The continuous touch of the Generation Z students with the technology has changed the way the Generation Z students think, understands and also applies the data or the information. Gen Z are very expert in the place of finding information rather than the type of information to be found. They are aware that the answers to all their questions lies in the digital world where they can easily get the information using their fingertips. Technology has molded their grey matter in a different directional thinker and therefore we as educators need to change our way and our outlook of accessing and processing the information along with displaying it in front of the students in a novel manner.[5]

Generation Z students are preparing themselves to face any further challenges and to keep themselves in par with the outside world. Therefore, the teachers also have to keep themselves updated and fast learned with technology. If the teachers are aware about the expectations of the Generation Z students from their teachers, the teachers can take efforts to meet these expectations about technology and be in highest priority of Generation Z students.

Assumption: Student's expectations about their teachers may vary from individual to individual.

RESEARCH METHODOLOGY

Research Approach: Quantitative approach. **Research Design:** An exploratory descriptive survey design was undertaken to find out the expectations of Generation Z students from generation X teachers. **Setting:** Selected colleges of Nursing in Mumbai. **Population:** UG Nursing students. **Sample:** Students of Generation Z who were able to access the survey form via internet. **Sample Size**: 52 **Sampling Technique:** Non-probability convenience sampling. **Data collection tool and technique:** Web based survey with self-prepared pretested five point Likert scale (strongly disagree to strongly agree) with 20 items describing the opinion of characteristics of interpersonal skills (5 items), conceptual (7 items) and technical skills (6 items). Participants consent was approved through emails and what's app and accordingly the link of the tool was forwarded to them.

Result of the Study

1. *Interpretation on Interpersonal Skills*

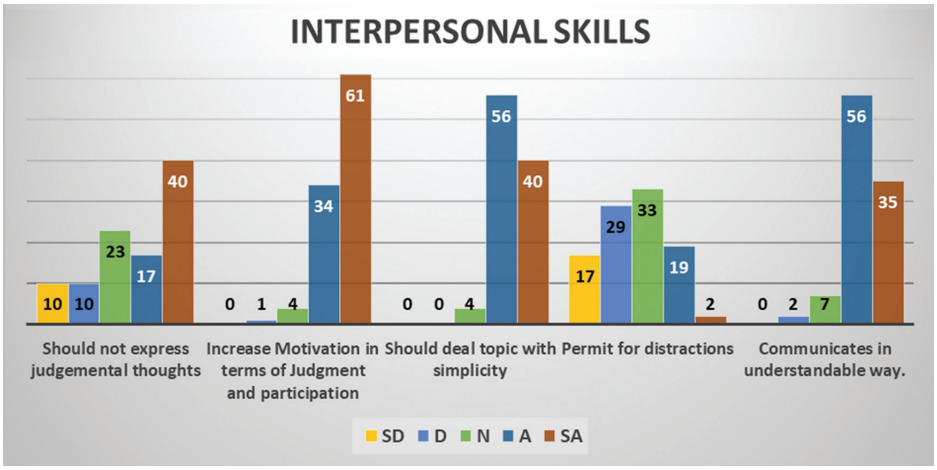

Fig. 1: Distribution of samples with regard to interpersonal skills

Based on Figure 1

Fig 1 shows that regarding interpersonal skills of teachers, maximum % of samples agree (61% strongly agree and 34% agree) that teacher need to motivate students by increasing their involvement in learning. The 40% of samples strongly agree that teachers should not express judgmental thoughts and should deal the topic with simplicity. The statement 'communication should be in understandable language during the teaching learning process' were strongly agreed by 35% and supported by 56% of samples. There was a mixed response for the statement saying teacher should permit distraction as some students agreed and some disagreed but majority, i.e. 33% remain neutral in answering this statement.

2. *Interpretation of Conceptual Skills*

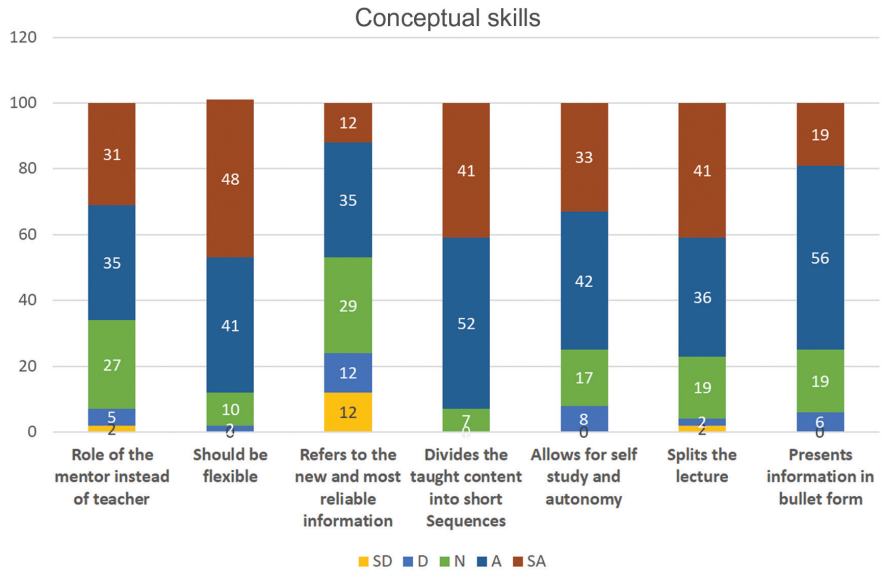

Fig. 2: Distribution of data with regard to conceptual skills

Figure 2 depicts among seven opinions of students regarding requirement of conceptual skills among teachers, opinion stating that teacher should be able to divide the content of teaching into short sequences has highly agreed by the students (41% SA and 52% A), followed by the opinion on ability of the teacher to be flexible while dealing with the students (48% SA and 41% A). None of the sample strongly disagreed that teacher should allow the student for self study and use autonomy and present information in the bullet form.

3. *Interpretation of Technical skills*

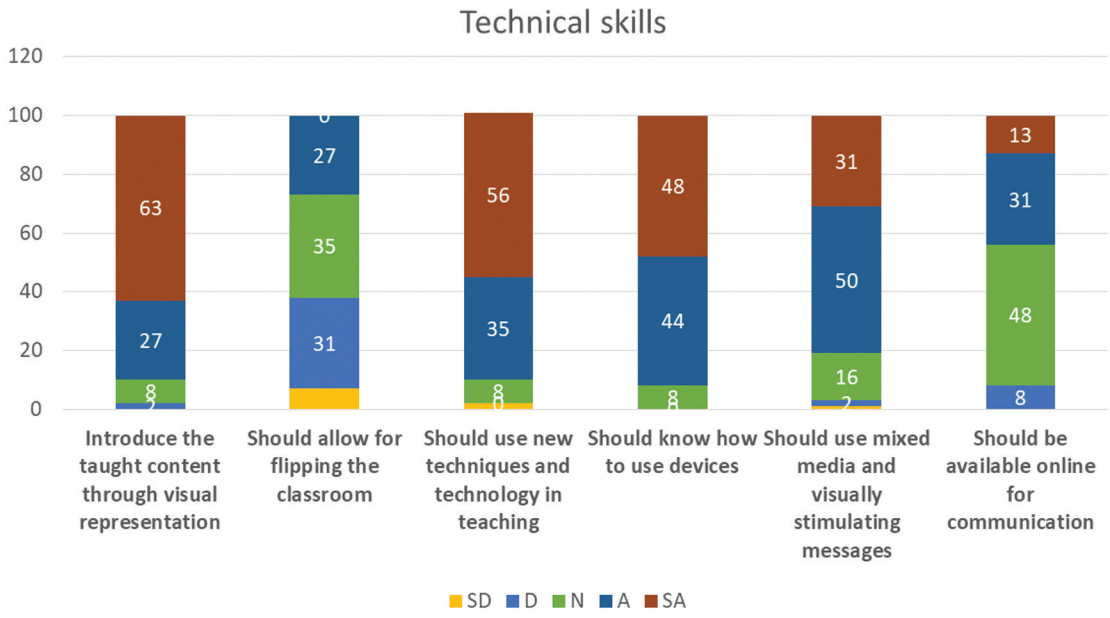

Fig. 3: Distribution of data with regard to technical skills

Figure 3 exhibits the student's opinion about statements regarding requirement of technical skills among teachers. Among all technical skills majority of the students (63%) strongly agree that teacher should introduce the content to be taught through visual representation (drawings, charts maps, etc.) or dynamic (movies, videos, etc.) than just theoretical content, followed by 56% of students strongly stating that teacher should use new techniques and technology in teaching and 48% of students strongly agreeing that teacher should know to use devices for teaching learning process.

DISCUSSION

Web based survey clears that students expect their generation X teachers to be par with the Generation Z students. Students desire their teachers to be updated with recent technology needed for improving the teaching-learning process. Students do not want to be just passive listeners. They want to have all sensory stimulation while learning not the traditional methods.

From the above data teachers need to update themselves, if they wish to keep the students from their class engaged instead of walking out of the class.

CONCLUSION

In order to tackletech savvy, smart and dependent Generation Z students, we teachers need to be digital immigrants to stay with these digital natives.

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PREDISCHARGE INFORMATION NEEDS OF FAMILY MEMBERS OF PATIENTS SUFFERING FROM ACUTE CORONARY SYNDROME FROM SELECTED HOSPITAL OF NAVI MUMBAI

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ABSTRACT

Background: The success of treatment depends on the continuity of the care extended back home after the discharge from the hospital. There exists a gap between what information is provided to the patients and their family to that information which they expect at the time of discharge. The information needs assessment will help to improve the patient and family education and it will aid in enhancing the care at home.

Objective: This study was conducted to explore the predischarge information needs of family members of the patients suffering from acute coronary syndrome (ACS).

Methods: A descriptive study was conducted in a tertiary care hospital in Navi Mumbai. 100 family members of patients suffering from the first event of Acute Coronary Syndrome were included in the study by using purposive sampling method. The data was collected by the use of the Cardiac Patient Learning Needs Inventory (CPLNI) and data was analyzed using SPSS version 20.0.

The results: A total of 100 family members caring for patients suffering from first event of ACS were interviewed to rate the predischarge information needs. The majority of the family members were from 20–30 years of age group and 73% were female. 37% of them educated up to high school. The analysis of the predischarge information needs revealed that the need for symptom management was rated as the most important need ($\tilde{x}$ = 21.3), followed by medication information ($\tilde{x}$ = 20.94) as well as etiology and risk factors ($\tilde{x}$ = 20.81).

Conclusion: *It can be concluded that nurses must assess the information needs of the family members prior to giving discharge and provide a need based health education not only to the patients but also to the ones who are actual caregivers.*
Keywords: Predischarge, information needs, ACS, family members

INTRODUCTION

Theburden of cardiovascular diseases is rising day by day in India.[1] As per the prospective analysis of Create Registry data, it is seen that India is bearing the highest burden of acute coronary syndromes across the world.[2] Acute coronary syndrome (ACS) is an umbrella term for acute event resulting from myocardial infarction or unstable angina.

In the current era, family centered care is a trending concept in health care. Best practices are being followed all over; let it be in oncology care, pain management, child care or critical care areas.[3] Institute of Patient and Family Centered Care (IPCC) believes in working with the patients and families in the planning, delivering and evaluating the healthcare. Families take active part in direct care of patients and health decision-making. Patient and family centered care improves the care experience better in the family. There is an improvement in the satisfactions of not only the clinicians but also the staff. This helps in making a wise use of the available resources.

However, it is observed that a protocol for structured discharge planning does not exist in most of the healthcare settings. Also there is shortage of staff and time, due to which the prioritization of the discharge instructions is not done for the patients as well as family members. The instructions thus received are not according to their individual needs and preferences. Due to these circumstances, patients often may feel fearful and not prepared for the discharge. Studies suggest that the willingness and the ability of the care providers to accommodate the needs and preferences determine the involvement of patients as well as families in the preparations for discharge.[4] Thus, this study was carried out with an objective to explore the predischarge information needs of family members of the patients suffering from acute coronary syndrome (ACS).

MATERIAL AND METHODS

A Quantitative research approach and a descriptive survey design were used. The study was conducted in a tertiary care hospital in Navi Mumbai. 100 family members of patients suffering from the first event of Acute Coronary Syndrome (AWMI, IWMI, STEMI, NSTEMI) and unstable angina were interviewed. They were selected by a purposive sampling method. The immediate family members or extended family members directly involved in the care of the patient who were willing to participate were included in the study. The tool was a structured questionnaire which comprised of two sections, viz. the demographic data of the family members and the Modified Cardiac Patients' Learning Needs Inventory (CPLNI). The reliability of the Cronbach's alpha for the total questionnaire was found to be 0.891. The items Rated in Modified CPLNI included 34 items such as basic understanding about ACS (7 statements), etiological and risk factors (5 statements), lifestyle factors (2 statements), medication information (4 statements), dietary information (4 statements), physical activity (4 statements), symptom management (5 statements) and miscellaneous (3 statements). An ethical approval and permission obtained from hospital authorities. Then, family members ranked the information needs on the CPLNI prior to a day or two of the discharge of the patients after the consent of participation.

RESULTS

The demographic data of the patients whose family members were included in the study is depicted in the Table 1. 48% patients were diagnosed as unstable angina and 52% as myocardial infarction (AWMI/IWMI/STEMI/NSTEMI). They were managed either by Percutaneous Transluminal Coronary Angioplasty (PTCA) [59%], Coronary Artery Bypass Graft (CABG) [9%] or by medications [32%].

Table 1: Distribution of the characteristics of patients

Variable	*Categories*	*Frequency*	*Percentage (%)*
Diagnosis of the patient	Unstable angina	48	48
	MI (AWMI, IWMI, STEMI, NSTEMI)	52 (17/8/10/17)	52
Management	PTCA	59	59
	CABG	9	9
	Medication	32	32

The demographic characteristics of the family members as shown in Table 2 shows that the maximum family members, i.e. 56% belonged to 20–30 years age group and 73% were females and majority being home makers. 37% had completed high school education.

Table 2: Demographic characteristics of the family members

Demographic variables	*Family members (n = 100)*	
	F	*Percentage*
Age (in years)		
20–30	56	**56.0**
31–40	27	27.0
41–50	13	13.0
51–60	4	4.0
Gender		
Male	27	27.0
Female	73	**73.0**
Marital status		
Unmarried	35	35.0
Married	65	**65.0**
Education		
Primary school	14	14.0
Middle school	17	17.0
High school	37	**37.0**
Post high school diploma	16	16.0

Contd...

Grad/postgrad	16	16.0
Occupation		
Home maker	58	**58.0**
Unskilled worker	8	8.0
Semi-skilled worker	13	13.0
Skilled worker	1	1.0
Clerical, shop owner	8	8.0
Professional	1	1.0
Unemployed	11	11.0
Total Family Income		
more than 30001	10	10.0
20001 – 30000	22	22.0
10001 – 20000	64	**64.0**
5001 – 10000	3	3.0
Less than 5000	1	1.0

Table 3: The information needs listed as VERY IMPORTANT by the family members of the patients suffering from ACS: (n=100)

MCPLNI subscales	*Mean*	*S.D*
Basic understanding about ACS (4 items)	16.25	1.839
Etiology & Risk factors (5 items)	**20.81**	1.947
Lifestyle factors (2 items)	8.56	0.77
Medication information (5 items)	**20.94**	1.922
Dietary information (4 items)	16.7	1.494
Physical activity (5 items)	19.34	2.45
Symptom management (5 items)	**21.3**	2.047
Miscellaneous information (3 items)	12.86	1.101

The Table 3 have listed down the means of the items in the modified cardiac patients learning needs inventory (MCPLNI) that were ranked as very important by the family members. The items of symptom management, medication information and aetiology and risk factors were the ranked highest by them.

The first top ten ranked information needs have been noted in the Table 4.

Table 4: The very important information needs as ranked by the family members of the patients suffering from ACS (n=100)

Rank order	Information needs identified by the family members before getting discharged from hospital
1	What can be done to reduce the chances of having another heart attack?
2	How to recognize that the chest pain is due to ACS?
3	What are the signs and symptoms of a heart attack?
4	What to do if he/she gets chest pain?
5	Why is he/she taking each of the medications that he/she is on?
6	What causes heart attack?
7	What is angioplasty/bypass surgery?
8	What tests and investigations may be needed in the future?
9	When to call the doctor (family physician) or an ambulance?
10	When should he/she take each of the medications that he/she is on?

DISCUSSION

Majority studies have focused only on patients' information needs before discharge.[5] The patients have to prioritize information that is pertinent to survival, such as symptom management, rather than broader lifestyle issues such as exercise and diet.[6] Very few studies have highlighted the needs of the family members. This study highlights the information needs of family members which are similar to information needs of patients

documented in other studies. They are such as symptom identification; for prevention and /or early identification of further events.

RECOMMENDATION

The recommendations emerged from the study were as follows:
1) Better communication should be facilitated among care providers, patients and families. 2) Patient centered care will be more effective if family members are involved. 3) More qualitative studies would help in gaining insight about the ways the families tackle the issues back home, especially when it is unsupervised by nurses.

CONCLUSION

Family members are pillars in the care of the patients. Identification of their needs would definitely allow the nurses to focus on the priority areas. Such an educational process could lead to more favourable outcomes for the patients. Thus, there is a need for intensive rehabilitative educational programme to be taken up by the nurses that will help in the prevention of complications of MI, early and timely recognition of complications, if any. The patients would have a better adherence to medications, thus, reducing the chances of earlier readmissions with a positive change in the lifestyles.

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EFFECTIVENESS OF RELAXATION TECHNIQUES ON SELECTED PARAMETERS AMONG POSTOPERATIVE OPEN HEART SURGERY PATIENTS

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ABSTRACT

Background: Pain and anxiety are common phenomenon after open heart surgery. Inadequate pain and anxiety management after open heart surgery predisposes patients to many complications. **Objectives:** To assess the selected parameters among postoperative open heart surgery patients before and after implementing relaxation techniques. To assess the effect of relaxation techniques on selected parameters among postoperative open heart surgery patients. **Method:** Research approach used in this study was descriptive evaluatory approach. The sample size was 30 postoperative open heart surgery patients. Sampling technique used was purposive sampling. The investigator used two scales to assess pain (Numerical Pain Rating Scale) and anxiety (Modified State Anxiety Inventory) among postoperative open heart surgery patients. **Results:** Maximum subjects i.e., 23 (76.67%) were male of total subjects. Majority of subjects, i.e. 18 (60%) belonged to the age group of 40–64 years. In regards to the type of open heart surgery, 10 (33.33%) subjects were operated for Coronary Artery Bypass Grafting (CABG) on pump, 08 (26.67%) had undergone mitral valve replacement, 07 (23.33%) had undergone CABG beating heart surgery (off pump) and 05 (16.67%) were operated for aortic valve replacement. On the application of 't' test it was found that there was significant difference in the pain score and anxiety score before and after the intervention at $p<0.05$. The heart rate and BP has also decreased after implementation of relaxation techniques.

Conclusion: The relaxation techniques was found to be effective in reducing pain, anxiety, heart rate and blood pressure among postoperative open heart surgery patients.

Keywords: Relaxation technique, pain, anxiety, postoperative open heart surgery patients

INTRODUCTION

In India, the focus for long has been on the control of acute and chronic infections and communicable diseases. Mortality data from global burden of diseases studies have revealed that cardiovascular disease especially coronary heart diseases are important causes of death in India. Worldwide, of the 17.5 million deaths from cardiovascular diseases, 20% deaths occurred in high income countries, 8% in upper middle income countries, 37% in lower-middle income countries and 35% in low income countries including India. There is epidemiological evidence that health transition is occurring rapidly in low and middle income countries. In many regions of these countries, cardiovascular diseases, especially coronary heart disease, are more prevalent among the illiterate and low socioeconomic subjects.[1]

Cardiac surgery is known to be accompanied by postoperative anxiety. Patients experience anxiety and depression months after Coronary Artery Bypass Graft surgery (CABG). Increased anxiety is correlated with poorer quality of life and worse long-term psychological outcomes. Psychological intervention reduces pain, severe anxiety, hostility, and depression in these patients and thus improves quality of life (QOL). Relaxation therapy is a well-established psychological therapy for alleviating psychological distress in patients with cardiac surgeries.[2-5]

The researcher has reviewed various journal articles[6-14] and found that teaching these simple and cost-effective methods of relaxation will really help to improve the outcome of the patients. The findings of the study might help in providing holistic nursing care to open heart surgery patients.

METHODS

In this study descriptive evaluatory approach was used. The research design selected was pre-experimental one group pre-test post-test design. The researcher chose two hospitals for the study which has well-established cardiovascular thoracic surgical department.

Samples of 30 postoperative open heart surgery patients (2nd, 3rd and 4th postoperative days) were selected using purposive sampling technique. Modified State Anxiety Inventory tool was administered to the client and the prescore was recorded as baseline. The client was further asked to rate the intensity of pain on the Numerical Pain Rating Scale and then the investigator measured the heart rate, respiratory rate and blood pressure before the intervention. The heart rate and respiratory rate was measured manually by investigator and blood pressure was measured by observing readings on standard cardiac monitor. Once the score was obtained, relaxation technique (deep breathing and meditation) was given using the language best understood by the client. Deep breathing was performed 10-12 times for 2 mins followed by meditation for 28 minutes. The selected parameters (pain, heart rate, respiratory rate, blood pressure and anxiety) were checked after administering relaxation technique. As the patients were on analgesics the relaxation technique was given after the half-life of drug.

The analysis of demographic data was done by calculating the frequency and percentage. The analysis of heart rate, respiratory rate, blood pressure, pain score and anxiety inventory score was done by calculating 't' value.

RESULTS

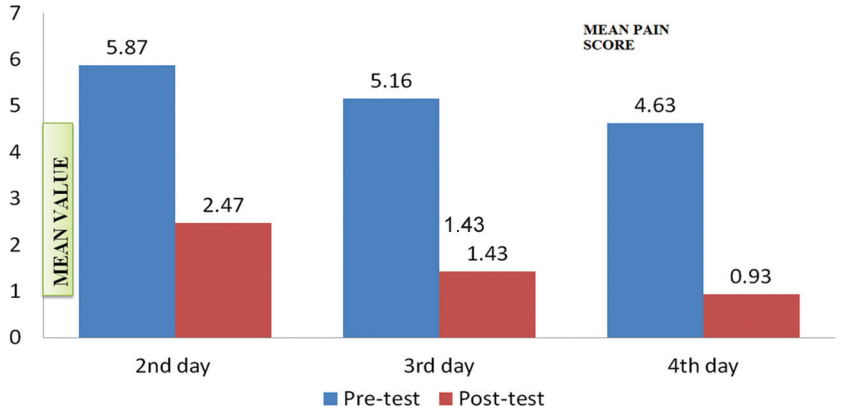
Maximum subjects, i.e. 23 (76.67%) were male of total subjects. Majority of subjects, i.e. 18 (60%) belonged to the age group of 40–64 years and 14 (46.67%) subjects did graduation. With regards to the type of open heart surgery, 10 (33.33%) subjects were operated for Coronary Artery Bypass Grafting (CABG) on pump, 08 (26.67%) had undergone mitral valve replacement, 07 (23.33%) had undergone CABG beating heart surgery (off pump) and 05 (16.67%) were operated for aortic valve replacement.

Table 1: Comparison of anxiety before and after administration of relaxation technique

N = 30

Baseline Pre-test 2nd day	Post-test 2nd day	Post-test 3rd day	Post-test 4th day	MD	SED	Calculated Value t test	Table value	Signi-fican-ce
Mean SD	Mean SD	Mean SD	Mean SD					
31.4 ±4.13	15.3 ±2.8			16.2	0.99	16.2	2.04	S
31.4 ±4.13		13.5 ± 1.9		17.9	0.91	19.6	2.04	S
31.4 ± 4.13			12.4 ±1.19	19	0.86	22.2	2.04	S

S = Significance at 95% level of confidence



Graph 1: Comparison of pain score before and after administration of relaxation technique.

The figure no.1 and table no.1 supports the significance of relaxation technique in relieving the pain and anxiety respectively.

Table 2: Comparison of heart rate before and after administration of relaxation technique

N=30

Post-operative days	Pre-test		Post-test		MD	SE_D	Calculated t value	Table value	Significance
	Mean	S.D.	Mean	S.D.					
2nd	94.76	8.19	91.66	7.44	3.1	0.30	10.18	2.04	S
3rd	88.63	3.92	86.16	3.95	2.46	0.18	13.40	2.04	S
4th	84.43	2.69	81.86	3.19	2.56	0.29	8.72	2.04	S

S = Significance at 95% level of confidence

Table 3: Comparison of blood pressure before and after administration of relaxation technique

N=30

Post-operative days		Pre-test		Post-test		MD	SE_D	Calculated t value	Table value	Significance
		Mean	S.D.	Mean	S.D.					
2nd	Systolic	125.43	10.18	123.63	10.17	1.8	0.43	4.16	2.04	S
	Diastolic	73.1	9.17	70.6	10.12	2.5	0.51	4.88		
3rd	Systolic	119.8	6.64	118.7	5.96	1.1	0.37	2.95	2.04	S
	Diastolic	69.1	7.33	67.36	7.94	1.73	0.34	5.12		
4th	Systolic	119.3	6.66	118.23	6.65	1.06	0.31	3.43	2.04	S
	Diastolic	70.43	4.41	69.43	4.95	1	0.25	4.01		

N=30

Tables 2 and 3 signifies the reduction of heart rate and BP after implementing relaxation techniques as the calculated 't' value was greater than the table 't' value at 0.05 level.

DISCUSSION

This study highlights the importance of postoperative care among open heart surgery clients. It gives the insight for the nurses to plan and to organize postoperative care and improve the skills of assessment using the anxiety and pain scale. Administration of relaxation techniques reduces pain postoperatively and reduces the need of pharmacological interventions in managing postoperative pain in them. It also reduces anxiety which will help in better recovery of post- operative open heart surgery clients.

The investigator used two scales to assess pain and anxiety among postoperative open heart surgery patients. Self-reporting (Numerical Pain Rating Scale) and Modified State Anxiety Inventory Scale.

It was noted that pre-test patients were experiencing very severe to severe pain which was noted by Numerical Pain Rating Scale. After administration of relaxation technique, it was concluded that, the relaxation technique helped to reduce pain score to moderate pain and mild pain. It was also found that pre-test 83.33% of subjects were experiencing moderate anxiety, while 16.67% of the subjects were experiencing severe anxiety.

After administration of relaxation technique, it was concluded that the relaxation technique helped to reduce anxiety score to mild and no anxiety. The calculated 't' value for heart rate, blood pressure and pain was greater than the table 't' value at 0.05 level hence null hypothesis was rejected which showed that relaxation technique was effective.

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IMPACT OF STRUCTURED TEACHING PROGRAM ON KNOWLEDGE OF HOME CARE MANAGEMENT AMONG CAREGIVERS OF HEMODIALYSIS PATIENTS IN HOSPITALS OF NAVI MUMBAI

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ABSTRACT

Background: Patients undergoing hemodialysis has a number of restriction and dietary modifications which have a detrimental impact on the quality of life of patient and their family caregivers. Structured teaching program on home care management is an important strategy to improve the knowledge of care giverand quality of life for Hemodialysis patient. **Objective:** To assess the knowledge among the caregivers of patients undergoing hemodialysis before and after the structured teaching program. **Methods:** A quasi experimental one group pre and post-test design was applied. 60 participants were selected through non-probability convenient sampling. Knowledge on home care management was assessed through structured knowledge questionnaire. **Results:** Statistical analysis shows that the pre-test mean score was 24.76 with SD of 7.27, whereas post-test mean score was 45.90 with SD of 2.15. Wilcoxon Signed rank test; a non-parametric test was applied and the p-value was found to be <0.001 at 95 percentage of the confidence interval ($p < 0.05$). Hence null hypothesis H_0 is rejected. Therefore, the structured teaching program was found to be effective in improving the knowledge regarding home care management of hemodialysis patients. **Conclusion:** The structured teaching program was found to be effective in improving the knowledge regarding home care management of caregivers of patients undergoing hemodialysis.

Keywords: Impact, structured, knowledge, care, caregivers, home care, hemodialysis.

INTRODUCTION

Chronic kidney disease affects 10% of the world's population, and millions die each year because they do not have access to affordable treatment.[1] According to the 2010 Global Burden of disease study, chronic kidney disease was ranked 27th in the list of causes of a total number of deaths worldwide in 1990, but rose to 18th in 2010. This degree of movement up the list was second only to that for HIV and AIDs.[2] According to a recent report published by NHS Kidney Care, chronic kidney disease costs more than breast, lung, colon and skin cancer combined. In Australia, treatment for all current and new cases of kidney failure through 2020 will cost an estimated $12 billion. According to the World Health Organization, in the year 2005, there were approximately 58 million deaths worldwide, with 35 million attributed to chronic kidney diseases.[3] D. Bhowmik and S.C. Tiwari (2012) from the Department of Nephrology AIIMS, New Delhi stated in their report that the first hemodialysis in India was performed in 1961. 50 years later there are more than 800 centers in the country providing hemodialysis.[4] Though dialysis may offer a better quality of life and extend the survival, people undergoing this procedure often have multiple health concerns, which can have an adverse impact on the life expectancy.[5] Salva A. Mohammed conducted a quasi-experimental study in 2014 in Egypt, the study recommends that lifestyle changes, such as exercising more, relieving stress, and healthy and well-balanced diet can help ease fatigue. The results show that after the home care program, weight gain, nausea, vomiting, headache, bone pain, itching, weakness and fatigue decreased and general condition and level of blood urea nitrogen, creatinine, potassium and phosphorus of the blood improved in cases compared to the control group.[6] Once patients commence hemodialysis, unique psychosocial issues related to patient and caregiver burden can emerge. A significant number of dietary, fluids, activity, and medication restrictions is imposed traditionally and uniformly on maintenance dialysis patients[7]. Proactive professional support, peer support, respite care and financial support from healthcare team and government of the country must be a priority for patient care. It is important that patients and their caregivers are educated regarding all aspects of home care management.[8]

PURPOSE OF THE STUDY

The aim of this study was to improve the knowledge of family caregivers of patients undergoing hemodialysis through a structured teaching program on various aspect of home care management and assessing their knowledge before and after the structured teaching program through a structured knowledge questionnaire.

The theoretical framework of the study was based on Johnson's Behavioral System Model, it is a model of nursing care that advocates the fostering of efficient and effective behavioral functioning in the client to prevent illness. Johnson proposed that clients were "stressed" by a stimulus of either an internal or external nature. These stressful stimuli create such disturbances in the client that a state of disequilibrium occurred. Johnson identified two areas of foci for nursing care that are based on returning the client to a state of equilibrium. First, nursing care should reduce stimuli that are stressors, and second, "nursing care should provide support to the client's 'natural' defenses and adaptive process".

MATERIAL AND METHOD

Design and participants: The selection of the research design depends upon the purpose of the study and the conditions under which the study is conducted. For the present study, a descriptive evaluative approach was chosen and quasi experimental one group pretest post-test design was used.

This study was conducted at the dialysis units of selected hospitals of Navi Mumbai, India. These institutions were selected for the study on the basis of ease in availability of the sample, researcher's accessibility and familiarity with the institutions.

A total of 60 study participants were selected through non-probability convenient sampling based upon the inclusion and exclusion criteria. Participant were the caregivers of patients undergoing hemodialysis in selected dialysis units.

For assessment of the knowledge on home care management, structured knowledge questionnaire was used, which was a validated by 17 experts of varied field of nursing, medical and paramedical sciences. Reliability of the tool was assessed through inter rater reliability method and calculated by intra class consistency (ICC), reliability value (r =0.99), tool was highly reliable in assessing caregiver's knowledge on home care management. Tool was translated to national language of India (Hindi) and translated back to English with the help of language experts.

Ethical Consideration

1. Ethical approval was obtained from the Institutional Ethical Review Committee.
2. Permission was also obtained from the guide and authorities of the selected hospitals for data collection.
3. Prior to the data collection, informed consent was obtained from each participant involved in the study.

Data Collection Process

Written permission was taken from the medical superintendents of various hospitals. Data collection was done for a period of four weeks. The samples were introduced to the study; informed consent was obtained from each of them. On the first day, the pre-test was conducted to assess knowledge through structured questionnaire. Then post-test was conducted after 7 days and a complimentary booklet 'Kidney Friendly Kitchen' was given to all participants.

RESULT

Demographic information: Most of the caregivers (56.6%) were in the age group of 40–59 years, out of which 56.7% were females, where 40% were wives, and all they reported that they have not got previous training on home care management of dialysis patient, (44%) were graduate and only a few (13%) were illiterate. Majority the patients, 71.7% were covered under government health scheme and 26.7% were self-financed for expenses related to dialysis.

Figure 1: Distribution of caregivers based on Educational Qualification.

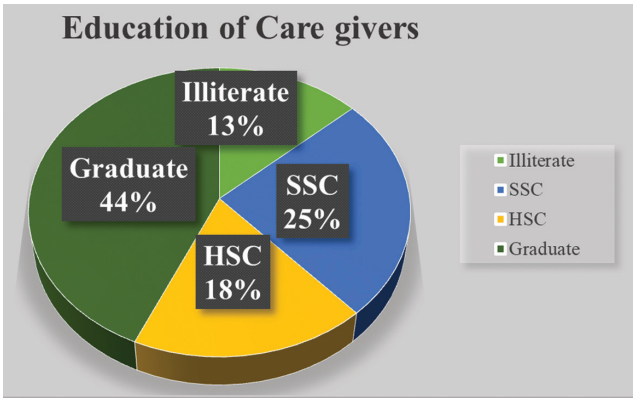

Fig. 1. Shows that most of the caregivers (44%) were graduate and only a few (13%) were illiterate

Distribution of caregivers based on knowledge regarding home care management among caregivers of patients undergoing hemodialysis before and after the structured teaching programme.

Table 1: Overall knowledge score regarding home care management

n = 60

Knowledge	Pre-test		Post-test	
	f	%	*F*	%
Poor (0-12)	2	3	0	0
Fair (13-25)	32	53	0	0
Good (26-37)	22	37	0	0
Excellent (38-50)	4	7	60	100

Table 1 shows that 53% of the samples had fair knowledge on home care management of hemodialysis patients during the pre-test, whereas the majority (100%) had excellent knowledge in post-test.

Table 2: Distribution of sample based on significant difference in pretest and post-test mean knowledge score regarding home care management

n = 60

Knowledge	Mean	SD	50th Percentiles = Median	Wilcoxon signed rank test (Z)	P Value	Level of Significant
Pre-test	24.78	7.27	24	6.738	< 0.001	S ($P < 0.05$)
Post-test	45.90	2.15	46			

Table 2 shows that mean pre-test knowledge was 24.78 with a standard deviation of 7.27, whereas the post-test mean was 45.90 with a standard deviation of 2.15. A non-parametric test equivalent of student t-test, Wilcoxon Signed Rank Test (Z) was applied and the P value of 0.001 (<0.05) indicates that there is statistically significant difference between pre and post-test knowledge. Hence, the null hypothesis (H_0) is rejected.

Table 3: Comparison of overall item wise mean score on knowledge regarding home care management of patients undergoing hemodialysis

n = 60

Item wise total mean score for Knowledge	Pre Test		Post Test	
	Mean Score	%	Mean Score	%
Basic information about Hemodialysis	5.60	56.0	9.10	91.0
Dietary management	2.23	31.9	6.83	97.6
Care of venous access	5.85	53.2	10.12	92.0
Medication management	2.70	45.0	4.92	82.0
Identifying and managing warning signs	4.80	53.3	8.32	92.4
Exercise and daily activities	3.60	51.4	6.62	94.6
Overall mean	24.78	49.6	45.90	91.8

Table 3 shows the significant difference in the mean score of all the aspect of home care management, most significant difference was seen in dietary management aspect where mean of pre-test was 2.23 and it is 6.83 in post-test.

DISCUSSION

In the present study, it was found that there was a significant improvement in mean knowledge score from 24.76 in pretest to 45.90 in post-test after the structured teaching programme on home care management of hemodialysis patients.

This was consistent with the study conducted by Lincemon Thomas[9] (2015) in India to assess the effectiveness of a nurse-led program on self-care management of hemodialysis patients. One group pre-test post-test quasi-experimental design was adopted for the study. The nurse led program comprised of education on self-care management of hemodialysis based on a structured information booklet was given. Post-test was carried out after 7 days of intervention to assess the effectiveness of the program. The study findings revealed a significant difference in the knowledge scores after the intervention (calculated $t = 27.087$, $p < 0.05$) attributing to the effectiveness of the nurse-led program.

CONCLUSION

Findings of the study conclude that, improvement in the knowledge regarding home care management was evident after the administration of structured teaching programme. Moreover, the complimentary booklet on dietary management aspect also will enable them to attain concrete information on dietary aspect.

RECOMMENDATIONS

Based on the findings of the study the investigator proposes the recommendations for future research are as follows:

1. The study can be replicated on larger samples to have a wider applicability by generalization.
2. A similar study can be conducted to assess the effectiveness of information booklet on knowledge regarding home care management among patients undergoing hemodialysis or their caregivers.
3. A descriptive study can be conducted to assess the knowledge regarding care of hemodialysis patients among staff nurses.
4. Research is needed regarding strategies to maintain long-term adherence to self-care practices among hemodialysis patient.

5. A study can be conducted by using different research approach and design like a randomized clinical trial in order to add more empirical values for evidenced-based clinical practices.
6. A similar study can be replicated for caregivers of other chronic disease patients.

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SATISFACTION OF NURSING STUDENTS IN RELATION TO PERCEIVED CLINICAL LEARNING ENVIRONMENT

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ABSTRACT

Clinical education is a fundamental part of nursing education which constitutes more than half part of nursing curriculum. In spite of classroom education, clinical education occurs in complex environment. It includes everything that surrounds students and affects their professional development in the clinical setting. It stimulates students to use their critical thinking skills for problem-solving. The quality of clinical learning environment is a valid indicator to show the quality of nursing curriculum and the level of student satisfaction.**Objectives:** To assess the satisfaction in relation to actual clinical learning environment as perceived by nursing students. **Methodology:** Descriptive research approach with correlational design is adopted for the study. Data was collected from 300 B.Sc. nursing students selected from 3 different institutes of Mumbai, India through non-probability consecutive sampling method by using a structured rating scale under 3 categories; clinical learning environment, supervisory relationship and role of clinical instructor. **Results:** Findings reveal that 74% and 62% of the students were satisfied with the supervisory relationship and role of clinical instructor respectively whereas 41% were unsatisfied with their clinical learning environment. Students were found satisfied at areas of cooperation between staff and clinical instructor, pedagogical atmosphere and leadership style of ward incharges. Clinical learning environment even influences the academic performances of the students ($r = 0.182$, $p < 0.05$). **Conclusion:** The benefits of a supportive clinical learning environment is most influential in providing students with unique learning opportunities in which theory and skills are implemented in the real-life situations. The clinical educational environment enhances their sense of responsibility and provides them with opportunities to demonstrate nursing competence.

Keywords: Nursing education, clinical learning environment, clinical learning, curriculum, nursing education.

INTRODUCTION

The last two decades have seen widespread changes in nursing education.[1] Theoretical nursing education in the classroom is considered fundamental for preparing nursing students to enter the clinical field; however, nursing students practice and acquire the majority of their skills in the clinical settings.[2] Clinical education is a fundamental part of nursing education contributes than half part of nursing curriculum.[3] Clinical learning environment is defined as complex network of forces that are effective on clinical learning outcomes. In spite of classroom education, clinical education occurs in complex environment. It includes everything surrounding the students which affects their professional development in the clinical setting.[4] Students view hospital practice areas as more meaningful and educative because they provide them with opportunities of clinical practice and linking the theoretical aspect of their studies. This will provide important feedback for clinical education and potential curriculum revisions.[4] The clinical practice stimulates students to use their critical thinking skills for problem-solving.[5] The quality of clinical learning environment is a valid indicator to show the quality of nursing curriculum and the level of student satisfaction. Therefore, assessment of clinical learning environment and student satisfaction is a duty of nursing education administrators.[3]

The undergraduate nursing education is an important means in attracting nurses to apply for work in different nursing specialties. Therefore, it is important to improve clinical learning environment.[6] Majority of the Indian studies are focused on the perception of educational environment by nursing students. Researcher's own experience based on feedback from the nursing students after the completion of their clinical postings and lack of Indian studies on correlation between perceptions and satisfaction of nursing students related to clinical learning environment highlights the significance of this study.

Problem Statement

Satisfaction of nursing students in relation to perceived clinical learning environment: A correlational survey.

OBJECTIVE

To assess the satisfaction in relation to actual clinical learning environment as perceived by nursing students.

METHODOLOGY

- **Research Approach:** Quantitative research approach
- **Research Design:** Descriptive correlational design
- **Population**
  - **Target Population:** B.Sc. nursing students from 2nd to 4th year.
  - **Accessible Population:** B.Sc. nursing students (2nd to 4th year) from selected nursing institutes located in Mumbai, India.
- **Sample:** B.Sc. nursing students from 2nd to 4th year from the selected institutes present during the period of data collection.
- **Sample Size:** 300
- **Sampling Technique:** Non-probability consecutive sampling technique
- **Inclusion Criteria:**
  - Students completed at least 8 weeks of their clinical postings.
  - 2nd to 4th year students of B.Sc. nursing programs.
  - Present during the period of data collection.
- **Data Collection Technique**

  Self-reporting technique is used to identify the demographic characteristics. A structured questionnaire with a 5 point Likert scale to assess the actual clinical learning environment and satisfaction of nursing students in relation to perceived clinical learning environment.
- **Tool**
- **Section A:** Demographic data

Section B: Modified Clinical Learning Supervision Evaluation Scale (CLSE) 5 point

- Rating scale with 54 items to assess the actual clinical learning environment and the satisfaction under following three categories and its subcategories as perceived by nursing students.

1. Clinical learning environment
   - Pedagogical atmosphere
   - Leadership style of ward incharge
   - Nursing care in the ward
2. Supervisory relationship
   - Occurrence of supervision
   - Content of supervisory relationship
3. Role of clinical instructor
   - Integration of theory and practice
   - Cooperation between nursing staff and clinical instructor
   - Relationship among student, staff and clinical instructor.

FINDINGS

Distribution of nursing students based on sociodemographic characteristics. Figure 1 showsthat 54% nursing students have their parent hospital for clinical learning.

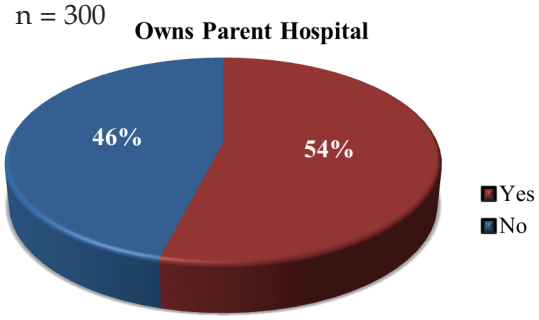

Fig. 1: Distribution of nursing students based on presence parent hospital

Table 1: Distribution of nursing students on categorical satisfaction and actual clinical learning environment

n = 300

Sr No	Items	Unsatisfied	Satisfied
		% (f)	% (f)
1.	Clinical Learning Environment	41 (124)	59 (176)
2.	Supervisory Relationship	26 (77)	74 (223)
3.	Role of clinical instructor	38 (115)	62 (185)

It may be observed from the Table 1 that 74% and 62% nursing students were satisfied with the supervisory relationship and the role of clinical instructor in the clinical areas respectivelyhereas 41% of the students were unsatisfied with the clinical learning environment.

Table 2: Distribution of nursing students based on sub categorical satisfaction and actual clinical learning environment

Sr No	Items	Unsatisfied	Satisfied
		% (f)	% (f)
1.	Pedagogical atmosphere	39 (116)	61 (184)
2.	Leadership style of ward in charge	52 (155)	48 (145)
3.	Nursing care in the ward	33 (99)	67 (201)
4.	Occurrence of supervision	22 (67)	78 (234)
5.	Content of supervisory relationship	28 (84)	72 (216)
6.	Integration of theory and practice	27 (80)	73 (220)
7.	Cooperation between nursing staff and clinical instructor	47 (142)	53 (158)
8.	Relationship among student, staff and clinical instructor	59 (178)	41 (123)

Table 2 shows that 78% and 73% nursing students were satisfied with the occurrence of supervision in the clinical areas, and with the integration of theory and practice through an effective supervision respectively. whereas 59% were unsatisfied with the relationship among student, staff and clinical instructor.

Table 3 shows that nursing students were dissatisfied with availability of articles in the ward (median score 2)

Table 3: Item-wise median scores of satisfaction of nursing students in relation to actual clinical learning environment

n = 300

Item No	Items	Median score (Satisfaction in relation to actual CLE)
8.	Accessible Procedure manuals in the ward/unit.	3
9.	Personal Protective Equipments are adequate to use.	3
10.	Adequate articles are available in the ward/unit	2
11.	Gives orientation of ward routines.	3
13.	Shares the available resources for learning.	3
15.	Provides appreciation for individual student effort.	3
16.	Supports to handle problematic situations.	3
17.	Cooperates for conducive learning.	3
52.	Clinical instructor and the nursing staff works together to improve my learning.	3
53.	The common discussions between nursing staff, clinical instructor and myself enhances the learning process	3
54.	Focuses discussion on my learning needs.	3

*2: Dissatisfied, 3: Neither satisfied nor dissatisfied

Table 4: Association of actual clinical learning environment with demographic characteristics

n = 300

Parameters of care givers	Chi square test (X^2)	P-value	Significant at 5% level
Age group	4.449	0.616	NS
Gender	16.276	0.001	S
Year of studying	7.743	0.258	NS
University	3.408	0.333	NS
Parent hospital	24.871	<0.001	NS
Type of parent hospital	9.926	0.019	S
Nature of parent hospital	8.826	0.019	S
Mother tongue	57.907	<0.001	S
Grades in previous year	32.553	<0.001	S
Place of stay	1.952	0.582	NS
Relative from nursing	2.856	0.414	NS

*S: Significant, NS: Not significant

Table 4 reveals that gender of the students, type and nature of parent hospital, mother tongue of the students and the grades obtained in the previous years has an impact on the perceptions about the actual clinical learning environment.

It may been sensed from Table 5 that the satisfaction of the nursing students completely rely on the existenceof parent hospital for the clinical learning, type and nature of the parent hospital and mother tongue of the students.

Table 5: Association of satisfaction of nursing students with demographic characteristics.

Parameters of care givers	Chi square test (X^2)	P-value	Significant at 5% level
Age group	3.841	0.871	NS
Gender	3.499	0.478	NS
Year of studying	3.815	0.873	NS
University	5.683	0.224	NS
Parent hospital	11.508	0.021	S
Type of parent hospital	28.157	<0.001	S
Nature of parent hospital	28.152	<0.001	S
Mother tongue	34.116	0.001	S
Grades in previous year	20.367	0.060	NS
Place of stay	7.588	0.108	NS
Relative from nursing	4.972	0.290	NS

***S: Significant, NS: Not significant**

Table 6: Association of actual clinical learning environment with satisfaction of nursing students

Sr No	Subcategorical variables	Actual clinical learning environment		Satisfaction of nursing students		Chi square test (X^2)	Level of significance
		Unfavourable (*f*)	Favourable (*f*)	Unfavourable (*f*)	Favourable (*f*)		
1.	Pedagogical atmosphere	129	171	116	184	10.95	S
2.	Leadership style of ward in charge	180	120	155	145	29.89	S
3.	Nursing care in the ward	105	195	99	201	1.428	NS
4.	Occurrence of supervision	68	232	67	234	0.202	NS
5.	Content of supervisory relationship	81	219	84	216	0.932	NS
6.	Integration of theory and practice	86	214	80	220	1.699	NS
7.	Cooperation between nursing staff and clinical instructor	175	125	142	158	21.41	S
8.	Relationship among student, staff and clinical instructor	170	131	178	123	0.875	NS

*S: Significant, NS: Not significant

Table 6 reveals that there is an association of actual clinical learning environment with satisfaction in areas of pedagogical atmosphere, leadership style of ward incharge and cooperation between staff and clinical instructor.

DISCUSSION

This study highlights an association of nursing students satisfaction with actual clinical learning environment at areas of pedagogical atmosphere, leadership style of ward incharge and cooperation between staff and clinical instructor. It is found consistent with the study conducted by D' Souza M et al[7], wherein the 310 nursing students satisfaction was assessed in relation to effectiveness of the clinical learning environment in a public school of nursing in Oman. The results showed that satisfaction of nursing students with the clinical learning environment sub-dimensions was highly significant and had a positive relationship with the total clinical learning environment. The study concluded that nurse educators can improvise clinical learning placements focusing on leadership style, premises of learning and nursing care, nurse teacher, and supervision while integrating student, teacher and environmental factors.

This study identified that there is an association of satisfaction of nursing students in relation to presence of parent hospital, its type and nature. It is consistent with a study performed by Bisholt B et al[8], wherein the learning environment in different clinical settings from the perspective of 185 nursing students was compared by means of a questionnaire involving the Clinical Learning Environment, Supervision and Nurse Teacher (CLES + T) evaluation scale. It has been noticed that the nursing students' satisfaction with the placement did not differ between clinical settings. However, those with clinical placement in Hospital Departments agreed strongly that sufficient meaningful learning situations occurred and that learning situations were multi-dimensional. Some students reported that the character of the clinical setting made it difficult to achieve the learning objectives.

This study identified an association between satisfaction of nursing students with pedagogical atmosphere, leadership style of ward incharge and relationship between staff and clinical instructor. It goes in consistent with a study performed by Serrano-GallardoP et al[9], on 122 nursing students with clinical learning in primary healthcare, to identify the students' perception about the quality of clinical placements and assess the influence of the different tutoring processes in clinical learning. The most commonly identified tutoring process was "preceptor-professor" (45.2%), whereas the clinical placement was assessed as "optimal" by 55.1% and the relationship with team-preceptor was considered good by 80.4% of the cases. The study concluded that the quality of the clinical settings and relationships with supervisors and hospital staff is a matter of concern for the positive perceptions in the students.

CONCLUSION

The benefits of clinical education are well known and a supportive clinical learning environment is most influential in the development of nursing skills, knowledge, and professional socialization. As a result of the limited time and clinical placement resources available, a strategic plan is required to ensure students receive a range of clinical education opportunities. It provides students with unique learning opportunities in which theory and skills are implemented in the real life situations. The clinical instructors' responsibility is shaping the learning environment to meet the students' educational needs starting with appropriate selection of clinical placement. The clinical educational environment and the characteristics enhances their sense of responsibility, and provides them with opportunities to demonstrate nursing competence.[10]

Recommendations

- A similar study can be conducted by using a large sample size.
- Interventional study can be performed to improvise various components of clinical learning environment.
- A comparative study can be performed between different batches to identify the perceptions of clinical learning environment.
- A qualitative study can be performed on first year undergraduate nursing students for identification of their experiences of clinical practice during their first clinical placement.

- A correlational study can be conducted to evaluate the satisfaction of undergraduates in both clinical field placement and nursing laboratories.
- A study can be performed to assess the student's opinion on the learning environment during clinical placement in settings outside traditional hospital.

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EFFECT OF EDUCATIONAL INTERVENTION ON KNOWLEDGE REGARDING HIGH ALERT MEDICATIONS AMONG NURSES IN HOSPITALS OF NAVI MUMBAI

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ABSTRACT

Back ground: Since 1992 FDA has received more than 20000 medication error reports, annually 7000 mortalities have been reported due to medication error. In India medication errors and medication related problems are mainly due to irrational use of medications mainly by nurses. In the light of the above fact it is essential to assess the knowledge of nurses on high alert medications. **Objective:** To assess the knowledge regarding high alert medications among nurses before and after the educational intervention. **Methods:** A descriptive and evaluative quasi-experimental one group pretest post-test design. **Results:** Data were collected from 60 nurses. The mean pre-test knowledge score was 26.15 ± 4.56 whereas the post-test mean knowledge score was 40.53 ± 2.78. The mean difference [MD] of 14.38 was suggestive of significant increase in mean knowledge score among participants at 95% level of confidence. **Conclusion**: The educational intervention was found to be effective in improving the knowledge among nurses regarding high alert medications.

Keywords: Effect; educational intervention, knowledge, practice, nurses, high alert medications.

INTRODUCTION

A safer life is a basic right. It leads to a larger and more productive life. The safety of each is the responsibility of all. Medications are a blessing, if the healthcare providers prescribe, prepare, dispense and administer them to patients safely and appropriately. Administering the wrong dose, strength, preparing look a like and sound-alike drugs, giving medication by the incorrectroute of administration, miscalculating dose, missing the medical equipment, prescribing or transcribing the wrong medications or choosing the wrong patients, it can be affect in both human and economic terms.[1]

High Alert Medication (HAM), is a medication that carries a heightened risk of causing significant harm if it is used in error[2]. Medications classified as HAMs have a narrow therapeutic index. Drugs with a narrow therapeutic index are dangerous because small changes in dosage or blood drug levels can lead to dose- or blood concentration-dependent critical events. With HAMs, adverse events are persistent, life-threatening permanent can lead to disability and the need for hospitalization, or death.[3]

Problem statement

Effect of educational intervention on knowledge regarding HAM among nurses in hospitals of Navi Mumbai.

Objectives

To assess the knowledge regarding HAMs among nurses before and after the educational intervention.

Methodology

A descriptive and evaluative quasi-experimental one group pretest post-test design was used in which each subject undergoes a pretest and receives the intervention and also undergoes post-test.

Population: All nurses working in various hospitals of Mumbai.

Target population: All nurses working in various hospitals of Navi Mumbai.

Accessible population: All nurses working in a selected hospital and fulfil the inclusion criteria.

Sample: The sample comprises of all nurses**.**

Inclusion criteria: Nurses working in the selected hospital and those who are willing to participate in the study.

Exclusion criteria: The nurse who is working on a supervisory and administrative post and those who are not present on the day of data collection.

Reliability: The reliability of the tool was established using the test-retest method and analyzed by Karl Pearson's correlation coefficient formula. The reliability of the knowledge questionnaire was 0.99 and for a self-reported rating scale for practice was 0.99. Hence, the tool was considered to be reliable for proceeding with the main study.

Sample size: 60

Sampling technique: Non-probability, convenient sampling technique.

Data collection technique: Structured questionnaire to assess the knowledge**.**

Tool: It was developed to assess the knowledge of nurses.

- Section A: Demographic variables of nurses
- Section B: Structured questionnaires for the nurses on knowledge regarding HAM.
  Section B: Questionnaire on HAM which included:
  - Definition of high alert medications, and normal values of electrolytes.
  - Doses of selected drugs.
  - Actions of the drugs.
  - Indications of the drugs.
  - Contraindications of the drugs.
  - Side effects of the drugs.
  - Interactions of the drugs.
  - Nurses responsibilities of the drugs regarding administration

Findings

Section 1: Distribution of sample based on demographic characteristics.

Table 1: Demographic characteristics of nurses

		n = 60
Demographic characteristics	**Frequency**	**Percentage**
Age group (years)		
20–24	32	53.3
25–29	20	33.3
30–34	6	10.0
35–39	2	3.3
Gender		
Female	53	88.3
Male	7	11.7
Working experience (months)		
0–12	14	23.3
13–24	22	36.7
25–36	8	13.3
37–48	4	6.7
49–60	8	13.3
>60	4	6.7
Area of work		
Medical ward	12	20.0
Surgical ward	7	11
Cardiac ward	4	6.7
Emergency ward	4	6.7
MICU	10	16.7
SICU	7	11.7
Cardiac ICU	5	8.3
Emergency ICU	1	1.7
OT	1	1.7
		n=60

Contd...

Demographic characteristics	Frequency	Percentage
Ortho ward	2	3.3
Special ward	3	5.0
Psychiatric ward	4	6.7
Regarding training for high alert medication		
Yes	15	25.0
No	45	75.0
Educational qualification		
GNM	27	45.0
B.Sc. nursing	33	55.0
MSC.	0	0.0

Table 1 depicts that 53.3% of nurses were in the age group of 20–24 years, majority 88.3% were female, with regards to working experiences mostly 36.7% had 13–24 months, regarding area of working 20% of the nurses were working in medical ward, about training of high alert medication 75% nurses have not attended any type of training regarding high alert medication, majority (55%) were B.Sc. nursing.

Section 2: Distribution of sample based on knowledge regarding high alert medications among nurses before and after the educational intervention.

Table 2: Overall knowledge score regarding high alert medications

n= 60

Knowledge	Pre-test		Post test	
	Frequency	%	Frequency	%
Poor (0–20)	5	8.33	0	0
Good (21–29)	42	7.0	0	0
Very good (30–43)	13	21.67	53	88.3
Excellent (44–54)	0	0	7	11.7

Table 2 shows that 42 (70%) of the sample had good knowledge regarding high alert medication during pre-test, whereas majority 53 (88.3%) had very good knowledge in the post-test.

Section 2B: Distribution of sample based on the significant difference in pretest and post-test mean knowledge scores regarding high alert medications.

Table 3: Knowledge among nurses before and after educational intervention

n = 60

Knowledge	Mean	SD	Mean Difference	Wilcoxon Signed rank test (Z)	P value	Level of significant
Pretest	26.15	4.56	14.38	6.742 / P< 0.001 (P < 0.05)	S	
Post-test	40.53	2.78				

Table 3 shows that mean pretest knowledge score was 26.15 ± 4.56, whereas the post-test mean knowledge score was 40.53 ± 2.78, Wilcoxon signed rank test (Z) was applied to find out whether there is any significant difference between pre and post knowledge test. The p-value of 0.001 (< 0.05) indicates that there is a statistically significant difference between pre- and post-test knowledge with mean difference of 14.38.

Hence, the null hypothesis (H_0) stating that there is no significant difference in the knowledge regarding high alert medication among nurses before and after the educational intervention is rejected.

Discussion

In this present study, it was found that 8.33% of the nurses had poor knowledge, 70% had good knowledge, 21.67% had the very good knowledge regarding high alert medications.

The educational intervention was found to be effective in improving the knowledge among nurses regarding high alert medications. Which was consistent with the study conducted by Hosilo G and et al. (2016)[4] which shows that pre-intervention mean score of knowledge regarding high alert medications among nurses was

69.13 (SD 7.94); post-intervention mean score of knowledge was 78.53 (SD8.00). This show significantly 9.40 marks of improvement after intervention [p value was < 0.001].

Conclusion

The findings of the study showed that there was a highly significant difference between the pretest and post-test knowledge regarding high alert medications. Hence, the educational intervention was found to be effective in improving the knowledge regarding high alert medications among nurses. The implication of intervention helps in achieving a better result. The findings of the present study become highly relevant.

Recommendations

Based on the findings of the study, the investigator proposes for the following:

- A similar study can be conducted by using a large sample size to generalize the findings.
- A descriptive study can be conducted to assess the knowledge and practice regarding high alert medications.
- Periodically educational intervention can be provided to nurses regarding high alert medications especially those who are working in critical areas.

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****

MINI CLINICAL EVALUATION EXERCISE

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Mini clinical evaluation is a formative assessment method of clinical evaluation which is widely used nowadays as a new evaluation technique wherein the assessor observes the clinical performance of the student/trainee in real life setting. The process of mini clinical evaluation exercise starts with a 15–20 minutes observation by the assessor. The area for evaluation is already discussed with the trainee. The areas involve history collection, clinical examination, investigation and diagnosis, prescribing and management, counselling, communication skills and professionalism. The accepted method of history collection is recognized as asking relevant questions which enhances adequate collection of data. Clinical examination should proceed in order and to be related to the problems of the client. Investigation and diagnosis should be in such a way that it supports the clinical symptoms of the client. Prescribing and management involves prescribing the correct medications considering any allergic reactions in the past. The trainee should be able to explain the need for various investigations and management and convince the patient to do so and guiding the patient to take his/her own decision. They must have adequate communication skills to interact with the patient. Maintaining a professional standard by following ethics of the profession. After the completion of observation by the assessor, there is a feedback session of usually 5 minutes which involves sharing of the evaluation with the trainee. More importance has to be given for the areas to be improved. The role of the faculty is to design an assessment prospectively, perform sound judgement, test with multiple scenarios, prepare multiple assessment and to assess the competency as a whole. The advantages of the mini CEX are it is reliable, valid, acceptable and feasible. But the disadvantage is it is not flexible and requires special training. Mini CEX is a high fidelity evaluation toolwhich helps the assessor as well as trainee to develop their clinical skills.

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MINI CLINICAL EVALUATION EXERCISE

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MINI CEX

Mini clinical evaluation exercise is the formative assessment method of clinical evaluation wherein the assessor evaluates the clinical performance of the student in real life settings.

PROCESS OF MINI CEX

- Assessor observes for 15-20 min
  - History Collection
  - Clinical Examination
  - Investigation And Diagnosis
  - Prescribing And Management
  - Counselling
  - Communication Skills
  - Professionalism
- Completion of mini CEX by assessor
- Sign the rating form by assessor and trainee

ROLE OF FACULTY

- Design assessment prospectively
- Perform Sound judgment
- Test with multiple scenarios
- Prepare of multiple assessment
- Assess competency as a whole

ADVANTAGES

- ❖Reliable
- ❖Valid
- ❖Acceptable
- ❖Feasible

DISADVANTAGES

- *Not flexible
- * Requires Special Training

Presented at National Conference On "Strengthening The Profession Of Nursing: Enhancing Transformation"

CONCLUSION

Mini clinical examination exercise is a high fidelity evaluation tool which helps the assessor as well as the trainee to develop their skills through feedback.

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COGNITIVE APPRENTICESHIP

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ABSTRACT

Cognitive apprenticeship is a process by which learners learn from a more experienced person by way of cognitive and metacognitive skills and processes. Throughout most of history, teaching and learning have been based on apprenticeship. Children learned how to speak, grow crops, construct furniture, and make clothes. But they did not go to school to learn these things; instead, adults in their family and in their communities showed them how, and helped them do it. Even in modern societies, we learn some important things through apprenticeship: We learn our first language from our families, employees learn critical job skills in the first months of a new job, and scientists learn how to conduct world-class research by working side-by-side with senior scientists as part of their doctoral training. But for most other kinds of knowledge, schooling has replaced apprenticeship. The number of students pursuing an education has dramatically increased in the last two centuries, and it gradually became impossible to use apprenticeship on the large scale of modern schools. Apprenticeship requires a very small teacher—learner ratio, and this is not realistic in the large educational systems of modem industrial economies.

Around 1987, Collins, Brown, and Newman developed six teaching methods—modelling, coaching, scaffolding, articulation, reflection and exploration. These methods enable students to cognitive and metacognitive strategies for using, managing, and discovering knowledge.

Modelling

Experts (usually teachers or mentors) demonstrate a task explicitly. New students or novices build a conceptual model of the task at hand. For example, a Math teacher might write out explicit steps and work through a problem aloud, demonstrating her heuristics and procedural knowledge.

Coaching

During Coaching, the expert gives feedback and hints to the novice.

Scaffolding

Scaffolding the process of supporting students in their learning. Support structures are put into place. In some instances, the expert may have to help with aspects of the task that the student cannot do yet.

Articulation

McLellan describes articulation as (1) separating component knowledge and skills to learn them more effectively and, 2 more common verbalizing or demonstrating knowledge and thinking processes in order to expose and clarify them.

This process gets students to articulate their knowledge, reasoning, or problem-solving process in a domain. This may include inquiry teaching (Collins & Stevens, 1982), in which teachers ask students a series of questions that allows them to refine and restate their learned knowledge and to form explicit conceptual models. Thinking aloud requires students to articulate their thoughts while solving problems. Students assuming a critical role monitor others in cooperative activities and draw conclusions based on the problem-solving activities.

Reflection

Reflection allows students to "compare their own problem-solving processes with those of an expert, another student, and ultimately, an internal cognitive model of expertise" . A technique for reflection could be to examine the past performances of both expert and novice and to highlight similarities and differences. The goal of reflection is for students to look back and analyze their performances with a desire for understanding and improvement towards the behaviour of an expert.

Exploration

Exploration involves giving students room to problem solve on their own and teaching students exploration strategies. The former requires the teacher to slowly withdraw the use of supports and scaffolds not only in problem-solving methods, but problem setting methods as well. The latter requires the teacher to show students how to explore, research, and develop hypotheses. Exploration allows the student to frame interesting problems within the domain for themselves and then take the initiative to solve these problems.

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COGNITIVE APPRENTICESHIP

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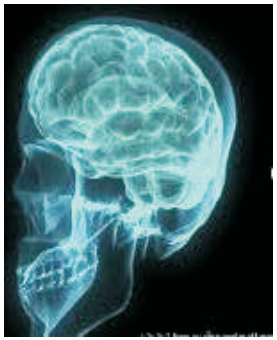

PROCESS OF COGNITIVE APPRENTICESHIP

MODELLING	Providing a conceptual model
COACHING	Knowledge acquisition and development of specific mental modal
SCAFFOLDING	Development and stabilization of cognitive skills or heuristics of problem solving
ARTICULATION	Verbal articulation of thought process, "thinking aloud"
REFLEXION	Evaluation of thought process by comparing them with others
EXPLORATION	Solving new, but similar, task

RECEPTIVE MEANINGFUL LEARNING → METACOGNITION → APPLICATION TRANSFER

DEFINITION:-

Cognitive apprenticeship is a theory that emphasizes the importance of the process in which a master of a skill teaches that skill to an apprentice.

COGNITIVE APPRENTICESHIP FRAMEWORK

CONTENT	SEQUENCING	METHOD	SOCIOLOGY
• presenting concepts facts, procedures. • Providing heuristics to assist learners.	• Increasing in difficulty. • Elaborating on previous taught concepts.	• Modelling • Coaching • Scaffolding • Articulation • Reflexion .	• Promoting social learning • Exploration • Communities of practice.

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National conference on 24th ,25th jan 2019
At MGM New Bombay College of Nursing Kamothe.

DIRECT OBSERVATION OF PROCEDURAL SKILLS

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The Direct Observation of Procedural Skills (DOPS) is an evidence-based assessment that aims to guide trainee learning and achievement of competency. The trainee performs a procedure on a real patient in the workplace and is observed by an experienced and knowledgeable assessor who reviews him against a structured checklist. The assessor provides feedback to the trainee, which allows the trainee, the assessor and the trainee's supervisor to collaboratively identify learning needs and plan future learning opportunities.

By observing a skill, broken into components, in a structured manner, feedback can be focused on the various parts of a procedure. Feedback on each component of the trainee's performance can be of greater value to the trainee than feedback on their overall performance, as areas for improvement and focus for future learning are more easily identified and the importance of considering the procedure as comprised of a number of crucial components is emphasised.

Each institute has a list of procedures from their Advanced Training Curriculum that are suitable for various DOPS procedures are central to practice in each specialty and complex enough to warrant observation and feedback across a number of assessment domains.

Once the trainee has organised a suitable time for an assessor to observe them completing a procedure, the trainee and assess or negotiate which of the listed procedures for their specialty will be assessed. While observing the trainee performing the chosen procedure, the assessor uses the DOPS Rating Form to rate the trainee according to following domains, including:

- Understanding of indications, anatomy and technique
- Pre-procedure preparation
- Technical ability
- Post-procedure management
- Professionalism

For each of the domains observed, assessors rate the trainee on a point scale according to what they would expect of a trainee in that particular year of training. Assessors mark 'not observed' for any domains not observed during that particular DOPS encounter. Following completion of the procedure, the assessor provides feedback to the trainee on observed strengths, any areas which require improvement and the trainee's overall competence in the procedure. Assessors should provide constructive feedbackand identify areas for development, even if these are few. The trainee is then given the opportunity to comment on the assessor's feedback, and together the trainee and assessor develop an action plan for future skill development. This action plan should be reviewed by the trainee's supervisor, if different to the assessor, shortly after development and again during the next trainee–supervisor meeting to assess thetrainee's progress against the action plan. The assessor marks the performance according to the behaviour. These behaviours are considered to be markers of satisfactory performance of the procedure. Rather than a set of definitive criteria, the behaviours should be used as a guide to help assessors discriminate between ratings.

The DOPS details the process of the assessment, including the roles and responsibilities of the trainee, assessor and supervisor.

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DIRECT OBSERVATION PROCEDURE SKILLS (DOPS)

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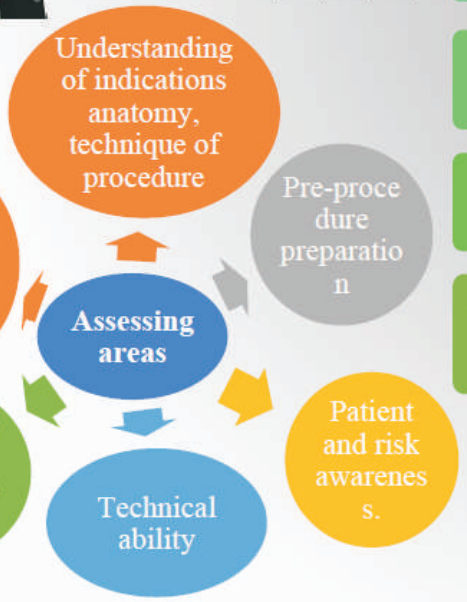
INTRODUCTION;

DOPS is an evidence-based assessment that aims to guide trainee learning & achievement of competency



PROCESS

During rotation, trainee & supervisor discuss responsibilities in organising and completing formative assessments & the importance of DOPS as a component of training.

Trainee and assessor negotiate procedure to be observed

Trainee gets the DOPS rating form & gives it to assessor.

Assessor observes trainee & rates him throughout the procedure according to DOPS form.

Assessor provides immediate feedback to trainees.

Assessor and trainee both sign DOPS rating form.

During their final meeting for the rotation, trainee and supervisor discuss actions required following completion of formative assessments.

Presented at National conference on ***Strengthening the Profession of Nursing: Enhancing Transformation***
on 24-25th Jan 2019

Advantages

1. Observation may sometimes be the only assessment method possible.
2. It is a great way to assess practical skills.
3. There can be no plagiarism or false reports

Disadvantages

1. High levels of learning outcomes
2. Observer's presence
3. Sometimes subjective
4. Full assessment
5. Immediate feedback
6. In-anonymity in Direct Observation

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GUIDED REFLECTION

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Abstract

Guided Reflection: The process that allows practitioners to uncover and expose thoughts, feelings and behaviors. When..?? Immediately after the experience.

Guided Reflection has been defined as a "process that occurs before, during and after situations with the purpose of developing greater understanding of both the self and the situation so that future encounters with the situation are informed by previous encounters" (Sandars, 2009)

Purposes

1. Promotes insightfulness.
2. Leads to discovery of new knowledge
3. New knowledge to be applied in future situations

GIBBS (1988') REFLECTIVE CYCLE

Description what happened? → Feelings what were you thinking & feeling? → Evaluation what was good & bad about the experience? → Analysis what sense can you make of the situation? → Conclusion what else could you have done? → Action plan if it arose would you do?

Benefits:

1. It enhances self-esteem through learning.
2. It facilitates integration of theory and practices.
3. It leads to acceptance of professional responsibility.
4. It encourages critical thinking.
5. It helps nurses to improve decision-making.

Disadvantages

1. The process can be manipulated to meet the expected outcomes of the practice.
2. Reflective practice may cause psychological stress.
3. I usually reflect on negative issues.

- Reflective practitioner competencies
- Self knowledge
- Understanding and insight into one's self-worth, motives, character and capabilities.
- Critical thinking
- The application of logical principles, rigorous standards of evidence and careful reasoning to the analysis, beliefs and issues.
- Inquisitiveness
- The willingness to be curious and inquiring
- Emotional intelligence
- The ability to identify assess and manage one's own emotions and those of other individuals and groups.

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GUIDED REFLECTION

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MGM NEW BOMBAY COLLEGE OF NURSING

Guided Reflection: The process that allows practitioners to uncover and expose thoughts, feelings and behaviors.
When..?? Immediately after the experience.

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Presented at national conference on Strengthening the Profession of Nursing: Enhancing Transformation on 24th and 25th January

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SNAPPS

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SNAPPS strategy was based on cognitive learning and reflective practice theory. This approach emphasizes active learning and casts the precepting encounter as learner led experience.

DEFINITION

SNAPPS is a learner-centered teaching approach to clinical education. In learner-centered education, the learner takes an active role in their educational encounter by discussing the patient encounter beyond the facts, verbalizing their clinical reasoning, asking questions, and engaging in follow-up learning pertinent to the educational encounter. The preceptor takes on the role of a facilitator by promoting critical thinking, empowering the learner to have an active role in their education, and serving as a knowledge presenter rather than a knowledge source.

Six steps of SNAPPS

1. S—Summarize briefly the history and findings. Obtains a history, performs a physical examination, and presents a summary of their findings to the preceptor. The summary should be brief and concise and should not utilize more than 50% of the learning encounter. (3 minutes maximum)
2. N—Narrow the differential to two or three relevant possibilities. Provides two to three possibilities of what the diagnosis could be presents the list prior to the preceptor revising the list.
3. A—Analyze the differential comparing and contrasting the possibilities. Discusses the possibilities and analyzes why the patient presentation supports or refutes the differential diagnosis. Thinks out loud in front of the preceptor.
4. P—Probe the preceptor by asking questions about uncertainties, difficulties, or alternate approaches. Discusses area of confusion and asks questions of the preceptor. Allows the preceptor to learn about their thinking and knowledge base. Prompts discussion from the preceptor on clinical pearls or areas of importance.
5. P—Plan management for the patient's medical issues. Discusses a management plan for the patient or outlines next steps. Commits to their plan and utilizes the preceptor as a source of knowledge.
6. S—Select a case related issue for self-directed learning. Identifies a learning issue related to the patient encounter. Discusses the findings from the learning issue with the preceptor.

Purposes

- Get a commitment
- Teach general rules
- Correct mistakes
- Probe for supporting evidence
- Reinforce what was done right

Advantages

- Easy for educator/student
- Useful for all levels of learner
- High student satisfaction
- Learner-centered
- Develop life-long learning skills

Disdvantages

- Relies on educator taking on a facilitator role
- Student may perceive educator is doing nothing
- Limited opportunity for feedback

Conclusion

SNAPPS represents a paradigm shift in ambulatory education that engages the learner and creates a collaborative learning conversation in the context of a patient care.

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SNAPPS

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INTRODUCTION

SNAPPS strategy was based on cognitive learning and reflective practice theory

DEFINITION

SNAPPS is a learner centered approach to clinical education

ADVANTAGES

- Easy for educator/student.
- Learner-centered.
- Useful for all levels of learners.
- Develops life long learning skills.
- High student satisfaction.

STEPS

S
summarize briefly the history and findings

N
narrow the differential to two or three relevant possibilities

A
analyze the differential comparing and contrasting the possibilities

P
probe the preceptor by asking questions

P
plan management for patient's medical issues

S
select a case related issue for self directed learning

PURPOSE

- Get commitment
- Probe for supporting evidence
- Teach general rules
- correct mistakes

DISADVANTAGES

- Relies on educator
- Limited opportunity for feedback
- Student may perceive educator is doing 'nothing'

Presented at National Conference on 24th and 25th of January 2019

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TITLE OF THE STUDY: JIGSAW TECHNIQUE

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ABSTRACT

Introduction

The Jigsaw technique is a method of organizing classroom activity that makes students dependent on each other to succeed. It breaks classes into groups and breaks assignments into pieces that the group assembles to complete the (jigsaw) puzzle.

Objectives of the study

- Meaning of Jigsaw method
- Purposes of Jigsaw method
- Advantages of Jigsaw method
- Steps of Jigsaw method
- Challenges of Jigsaw method.

MEANING

The **Jigsaw method** is a teaching strategy of organizing student group work that helps students collaborate and rely on one another.

PURPOSES

- To provide group task individually
- To emphasize self-learning
- To give positive feedback
- To promote group interaction.

ADVANTAGES

- Gives students opportunity to work in group
- All the students have equal opportunity of success
- Develops leadership qualities in the children
- Promotes a sense of individual responsibility among all the students
- Develops positive attitude among children
- Promotes cooperation among children
- Promotes self learning.

STEPS

There are 10 basic steps to be followed while implementing this theory

1. Step 1: Divide students into 5–6 person Jigsaw group.
2. Step 2: Appoint one student from each group as a leader.
3. Step 3: Divide the day's lesson into 5–6 segments.
4. Step 4: Assign each student to learn one segment.
5. Step 5: Give students time to read over their segment at least twice and become familiar with it.
6. Form temporary expert group by having one student from each Jigsaw group join other students assigned to the same segment.
7. Step 7: Bring the students back to their original Jigsaw groups.
8. Step 8: Ask each student to present their segment to the group, and encourage other members of the group to ask questoins.

9. Step 9: Float from group to group observing the process, help he presenter as required.
10. Step 10: At the end of the session give a quiz on the material.

CHALLENGES

- Lack of student's interest in performing the task and do the given activity
- Lack of student's skill in presenting the given topic
- If the groups formed are uneven then topics will not be able to divide properly
- Lack of student's confidence in presenting the topic.

Conclusion

Jigsaw helps students learn cooperation as group members share responsibility for each others learning by using critical thinking and social skills to complete an assignment. It also helps to improve listening, communication, and problem-solving skills.

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JIGSAW TECHNIQUE

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INTRODUCTION

It was designed by social psychologist ELLIOT ARONSON invented and developed in early 1970's at university of TEXAS and university of CALAFORNIA

PURPOSES

- *To provide group task individually*
- *To emphasize self learning*
- *To promote group interaction*
- *To give positive feedback*

ADVANTAGES

- Group work
- Sustainability of study
- Heterogeneity
- Equal opportunities for success
- Leadership
- cooperation
- Positive solidarity
- Individual responsibility

JIGSAW TECHNIQUE

STEPS

1. Divide students into groups
2. Appoint one student leader
3. Divide topics into sections
4. Assign 1 student, 1 section
5. Give preparation time
6. Form expert group
7. Bring students back to there group
8. Ask each student to present there topic
9. Float from group to group
10. Assess the material and students

CHALLENGES

- Lack of student's interest
- Lack of student's skill
- Uneven groups
- Lack of student's confidence

MEANING

The jigsaw classroom is a research based cooperative learning technique of organizing classroom activity that makes students dependent on each other and promote self learning

National conference on 24, 25 Jan 2019 in MGM institute of health science, kamothe

CONCLUSION

Jigsaw method can be very beneficial in daily practice for classroom learning this will provide self learning to the students if the challenges are overcome.

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NARRATIVE PEDAGOGY

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ABSTRACT

Definition

"The facilitation of an educative journey through which learning takes place in profound encounters, and by engaging in meaning-making and deep dialogue and exchange."(Goodson & Gill, 2011)

Introduction

Narrative pedagogy is an approach to teaching and learning developed by Nancy Diekelmann after many years of conducting research in nursing–1995.

Narrative pedagogy is a method which creates mental simulation as the students and the teacher exchange narration in the vein of emotional experience of the subject, with creative presentation. The process is carried out in sequence where the teacher assigns the students topics from the syllabus, the students then work on it and come up with narrative essays, and E–presentations with dialogues and patterns of constructive emotions as noted or expressed by the subject undergoing it or the situation under evaluation. Then the students' presents the matter prepared using the narrative pedagogy approach of subjective and creative narration to which the teacher adds on and evaluate.

Narrative pedagogy as a method of teaching: Narrative pedagogy is used as a means of complementing a more conventional method of teaching and learning. By focusing attention on the human element of healthcare, teachers and learners together explore meanings from the interpretation of stories. Learners consider the emotional experiences of participants, challenging conventional wisdom and otherwise constructing their new understandings and perspectives. Storytelling within the classroom has taken the form of literature and film, among other forms of presentation. Individual stories are embedded within the narrative. Stories are used to highlight the human response to illness and health. Interpreting those stories is a reflective practice for analysing these real-world situations. In this reflective practice within narrative pedagogy, students systematically think about one's actions and responses to improve future actions and responses.

Conclusion

Narrative pedagogy is a method which can be used as one of a teaching strategy. Where students listen and draw conceptual picture of the subject under study. Various researches have been done to prove the effectiveness of narrative pedagogy which has stated it as a useful and essential tool for creative evidence-based teaching methodologies. Hence teacher while presenting her lecture and students while developing their assignments can use narrative pedagogy as one of the aspect, which will enhance concept clearance.

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NARRATIVE PEDAGOGY

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DEFINITION:-"The facilitation of an educative journey through which learning takes place in profound encounters, and by engaging in meaning-making and deep dialogue and exchange."(Goodson & Gill , 2011)

Narrative Pedagogy is an approach to teaching and learning developed by Nancy Diekelmann after many years of conducting research in nursing education using Heideggerian hermeneutic phenomenology -1995

NARRATIVE PEDAGOGY IN NURSING EDUCATION

Individual stories are embedded within the narrative. Stories are used to highlight the human response to illness and health.

TEACHER

OUTCOME

POOLING OF STUDENTS AND TEACHERS NARRATION -

ALLOTMENT OF TOPICS

Enhanced learning

CONVENTIONAL TEACHING

PREPARES FOR NARRATION
-ESSAY
E-PRESENTATION

STUDENT

"The only English patients i have ever known refuse tea. Have been typhus cases; and the first sign of their getting better was their craving again for tea."

-Florence nightingale

Presented at National Conference on strengthening the Profession of Nursing::Enhancing Transformation

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PEER MENTORING

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Abstract

Peer mentoring is a form of mentorship that usually takes place between a person who has lived through a specific experience, peer mentor, and a person who is new to that experience, the peer mentee. It would be an experienced student being a peer mentor to a new student, the peer mentee, in a particular subject, or in a new school. Peer mentors are also used for health and lifestyle changes.

Critics of peer mentoring insist that little is known of the nature of peer mentoring relationships and that there are few consistent studies indicating the outcomes of peer mentoring beyond good feelings among peers and the development of friendships. Peer mentoring led by senior students may discourage diversity and prevent critical analysis of the higher education system. It provide good opportunities for increased social interaction between mentors and mentees. It provides compatibility. The quality of the peer mentoring relationship is important for mentees to experience positive results. A mentor relationship is more successful when the mentor cares for the whole person and not just the academic or career side of a person. Successful mentors tend to be available, knowledgeable, educated in diversity issues, empathic, personable. It provides encouraging, supportive and passionate. Peer mentoring in education was promoted during the 1960s by educator and theorist Paulo Freire.

"The fundamental task of the mentor is a libratory task. It is not to encourage the mentor's goals and aspirations and dreams to be reproduced in the mentees, the students, but to give rise to the possibility that the students become the owners of their own history. This is how I understand the need that teachers have to transcend their merely instructive task and to assume the ethical posture of a mentor who truly believes in the total autonomy, freedom, and development of those he or she mentors. Peer mentoring in higher education has enjoyed a good name and is seen favorably by both educational administrators and students.

During the last decade, peer mentoring has expanded and is found in most colleges and universities, frequently as a means to outreach, retain, and recruit minority students.

The lack of role models or volunteers forces administrators and student leaders to use students as peer mentors of other students—usually first year students, ethnic minorities, and womenin order to guide, support, and instruct junior students. Because peer mentoring programs require a low budget for administration and/or development, they become a cheap alternative to support students perceived as likely to fail. One of the main criticisms of peer mentoring is the lack of research to show how peer mentoring relationships work, how they develop, and what their outcomes are. Peer mentoring can offer employees a valuable source of support and information in the workplace. Peer mentoring offers a low cost way to train new employees or to upgrade the skills of less experienced workers.

Mentees may feel more comfortable learning from a peer than in a hierarchical setting. Mentors as well as mentees may also benefit from the bonds they form with colleagues. Peer mentoring has been shown to increase resistance to stress-related anxiety and depression in patients, or clients, affected by chronic illness or mental health issues. Mental health peer mentors and peer support groups help clients change their lifestyle and adhere to a more productive healthy lifestyle by adjusting habits and helping them realize helpful ways of coping and taking on personal responsibility.

Peer mentors can also help patients prepare for medical and surgical procedures and adhere to treatment regimes.

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PEER MENTORING

Peer mentoring is a form of mentor that usually tashipkes place between a person who has lived through a specific experience (peer mentor)and a person who is new to that experience (the peer mentee)

CRITERIA FOR PEER MENTOR

- Sensibility
- Confidence
- Social skills reliability
- Knowledge
- Availability

ADVANTAGES

- Exploration
- Experience
- Sharing responsibility
- Regulation of peer groups

CRITICISM

- Deficiency model for weaker section of society.
- Lack of Research
- Lack of direct supervision.
- Strive to imitate or emulate.

CONCLUSION

- Peer mentoring not only develops good feelings but also friendship.
- Further researches need to be conducted to understand nature of peer mentoring relationship.

IN EDUCATION

- Found in most colleges & universities.
- Older adult mentors a young person have similar backgrounds.

- Senior Students
- Health Assistance
- Junior Staff

IN WORK PLACE

- Mentees offer employees valuable source of support in the work place.
- Mentees feel more comfortable learning from peer than in hierarchical setting.
- Develop bond with colleagues.

- **Supervisor**
- **Staff**
- **Trainer**

IN HEALTH CARE

- To increase resistance to stress-related anxiety & depression.
- Change clients lifestyle.
- Adhere to a more productive healthy lifestyle by adjusting habits.
- Prepare for medical & surgical procedures.
- Adhere to treatment regimes.

- Health Assistants
- Supervisor/Trainer

- Client with similar disease condition or disability who has overcome the situation

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THINK–PAIR-SHARE

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Abstract

Think-Pair-Share is a strategy that is designed to have students think about a given topic and then reflect with another classmate. It was developed by Frank Lyman of the university of Maryland in 1981. It strongly encourages individual participation. Think-Pair-Share (TPS) is a collaborative learning strategy in which students work together to solve a problem or answer a question about an assigned reading. This technique requires students to think individually about a topic or answer to a question and share ideas with classmates. Discussing an answer with a partner serves to maximize participation, focus attention and engage students in comprehending the reading material. It helps to decide on how to organize students into pairs, pose a discussion topic or pose a question. It give students at least 10 seconds to think on their own ("think time"), ask students to pair with a partner and share their thinking and call on a few students to share their ideas with the rest of the class. The benefits of Think-Pair-Share are when students have appropriate "think time" and the quality of their responses improves when students are actively engaged in the thinking and thinking becomes more focused when it is discussed with a partner. It is beneficial for both students as well for teachers. Students get peer support and acceptance. Improvement in academic and increased self-esteem can be achieved. Teachers get more response from students and students are engaged on task. More of the critical thinking is retained after a lesson if students have an opportunity to discuss and reflect on the topic. Many students find it safer or easier to enter into a discussion with another classmate, rather than with a large group. There is no specific materials are needed for the strategy, so it can easily be incorporated into lessons. The purpose of think learn share strategy is to allow time for students to think increase the quality of their response, students participate as active learners and students are able to retain given material. Pairing with classmates allows students to be open minded and are more likely to participate in the small group setting. Think-Pair-Share is a cooperative learning strategy that can promote and support higher level thinking. The teacher asks students to think about a specific topic, pair with another student to discuss their own thinking, and then share their ideas with the group.

Allow time for students to think. Increase the quality of their response. Students participate as active learners. Students are able to retain given material. Pairing with classmates allows students to be open minded. Students are more likely to participate in the small group setting.

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THINK ...PAIR..SHARE..

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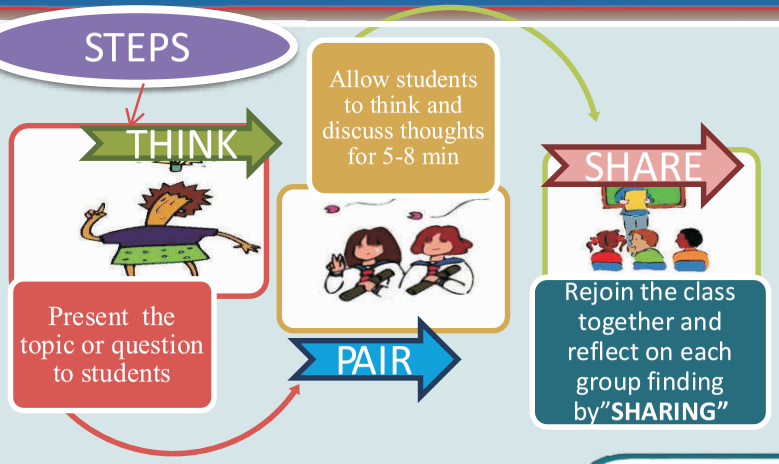
WHAT IS TPS ???
Think Pair Share is a strategy that is designed to have students think about a given topic and then reflect with another classmate. It was developed by Frank Lyman of the university of Maryland in 1981. It strongly encourages individual participation. It is a great way to keep students focused and on task while working collaboratively with other students.

STEPS



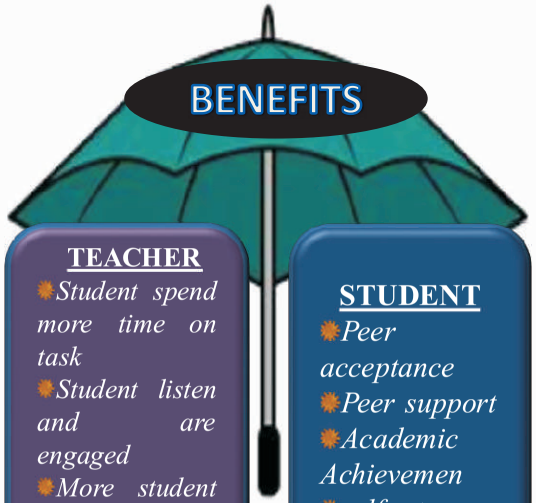
IMPORTANCE

- Structured Content
- Accountability
- Exchange Of New Ideas
- Decreased Anxiety

Conclusion…

It acts as a facilitator, and poses a question or a problem to the student sits is designed to help students to understand concept of the topic, develop ability to filter information and formulate idea and conclusion.

BENEFITS



TEACHER

- *Student spend more time on task*
- *Student listen and are engaged*
- *More student respond*
- *Quality of work increase*

STUDENT

- *Peer acceptance*
- *Peer support*
- *Academic Achievemen*
- *self esteem*

PURPOSE

- ✓ Allow time for students to think.
- ✓ Increase the quality of their response.
- ✓ Students participate as active learners.
- ✓ Students are able to retain given material.
- ✓ Pairing with classmates allows students to be open minded.
- ✓ Students are more likely to participate in the small group setting.

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VIRTUAL LEARNING ENVIRONMENT

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Abstract

Virtual learning environment is not just a set of webpages. It is a set of webpages along with social interaction. This consist of synchronous versus asynchronous communication, one to one or one to many, text based versus audio and video. This includes indirect communication such as sharing objects. Virtual Learning Environment (VLE), an online environment of e-resources for undergraduate and postgraduate level. It provides the learners an interacting, stimulating and enjoyable environment, providereal-world scenarios, trial and error in a risk-freesetting, reduces face to face time and learning resources, and controlled access with feedback. It is also associated with the disadvantages such as disciplinary issues, time consuming, internet issues, expensive and require high technical skill. The components of VLE are curriculum mapping and planning, content management, communication and collaboration, learner engagement and administration and real time communication. The benefits of the VLEs far more than the disadvantages to both the students and the institutions. The decreasing cost of technology and the rising technical knowledge in educational institutions shows that there is a chance for virtual learning environments to grow and have its own space in education in future.

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VIRTUAL LEARNING

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VIRTUAL LEARNING

A set of webpages does not constitute a virtual learning environment unless there is a social interaction about or around the information. This includes synchronous versus asynchronous communication, one to one versus one to many, text based versus audio and video. This includes indirect communication such as sharing objects.

VIRTUAL LEARNING ENVIRONMENT

Virtual Learning Environment (VLE), an online environment of e-resources caters to several disciplines taught at undergraduate and postgraduate level. It is an initiative of the University at Institute of Life-Long Learning.

ADVANTAGES

- Interactive, stimulating, enjoyable
- Provide realistic or real world scenarios
- Trial and error in a risk free setting
- Reduce face-face time and learning resources
- Wide availability
- Controlled access with feedback

DISADVANTAGE S

Internet issues

Expensive

Technical skills

Time consuming

Security issues

Disciplinary issues

CONCLUSION

The benefits of the VLEs far outweigh the disadvantages to both the students and the Institutions. The decreasing cost of technology and the rising technical knowledge within educational institutions mean that virtual learning environments is bound to grow in future.

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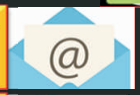
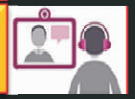
COMPONENTS OF VLE

Content management – creation, storage, access to and use of learning resources.

Communication and collaboration – email, notices, blogs, chats and wikis.



Real time communication – live video conferencing and audio conferencing



Learner engaged and administration – managed access to learner information and resources and tracking of progress and achievement

Curriculum mapping and planning – lesson planning, assessment and personalization of the learning experience.

National conference(strengthen the profession of nursing: enhancing transformation) on 24th and 25th January 2019 at MGMIHS, Kamothe

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The One Minute Preceptor

This monograph was developed by the MAHEC Office of Regional Primary Care Education, Asheville, North Carolina. It was developed with support from a HRSA Family Medicine Training Grant and the resulting materials are public domain.

Healthcare providers face many challenges in the day to day pursuit of their careers, and those who choose to teach health professions students face the further challenge of efficiently and effectively providing teaching to these learners. No matter what type of learner–resident, medical student, physician's assistant or nurse practitioner–and no matter what their level of skill or training, the challenge of integrating teaching into your day to day routine remains. Fortunately, tools and techniques have been developed to assist the preceptor. A tested and valuable approach is the One Minute Preceptor.

Initially introduced as the "Five-Step 'Microskills' Model of Clinical Teaching" (Neher, Gordon, Meyer, & Stevens, 1992), the One Minute Preceptor strategy has been taught and tested across the nation (Irby 1997a, 1997b; STFM, 1993) and has been welcomed by busy preceptors. The dissemination of this technique has been allowed and encouraged, and we are pleased to be able to present it to you as part of our Preceptor Development Program. One Minute Preceptor Authored by: PAEA's Committee on Clinical Education published in February 2017.

The One Minute Preceptor teaching method guides the preceptor-student encounter via five micro skills. This method is a brief teaching tool that fosters assessment of student knowledge as well as provision of timely feedback. The strengths of this teaching method include: increased involvement with patients, increased clinical reasoning by the students, and the student receiving concise, high-quality feedback from the preceptor. When to use this: During the "pregnant pause" (i.e., when you find yourself wanting to rush things along and give the students the answer, rather than asking for their thoughts) What not to do: Ask the student for more information about the case or fill in all of the gaps that you noted in the student's knowledge base and presentation skills at once.

Microskills

1. **Get a Commitment:** Focus on one learning point. Encourage students to develop their critical thinking and clinical reasoning skills. Actively engage the student, establishing their readiness and level of competence. Push the student just beyond their comfort zone and encourage them to make a decision about something, be it a diagnosis or a plan.
   For example: "So, tell me what you think is going on with this patient."
2. **Probe for supporting evidence:** Uncover the basis for the student's decision—was it a guess or was it based on a reasonable foundation of knowledge? Establish the student's readiness and level of competency.
   For example: "What other factors in the HPI support your diagnosis?"
3. **Reinforce:** What was done well the student might not realize they have done something well. Positive feedback reinforces desired behaviours, knowledge, skills, or attitudes.
   For example: "You kept in mind the patient's finances when you chose a medication, whichwill foster compliance, thereby decreasing the risk of antibioticresistance."
4. **Give guidance:** About errors/omissions approach the student respectfully while concurrently addressing areas of need/improvement. Without timely feedback, it is difficult to improve. If mistakes are not pointed out, students may never discover that they are making these errors and hence repeat them.
   For example: "I agree, at some point PFTs will be helpful, but when the patient is acutely ill, the results likely won't reflect his baseline. We could gain some important information with a peak flow and pulse oximeter instead."
5. **Teach a general Principle**: Sharing a pearl of wisdom is your opportunity to shine, so embrace the moment! Students will apply what is shared to future experiences. Students tend to recall guiding principles, and of ten the individual patient may serve as a cue to recall a general rule that was taught.

For example, "Deciding whether or not someone with a sore throat should be started on empiric antibiotics prior to culture results can be challenging. Fortunately, there are some tested criteria that can help…" Summarize Consider summarizing or concluding, ending with next steps (e.g. plan for the patient, reading assignment for the student, schedule for follow-up with the student, etc.).

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One Minute Preceptorship

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INTRODUCTION : "One Minute Preceptor" teaching model was developed in Washington at the Department of Family Medicine at the University of, Seattle in 1992.

MEANING:
The one minute preceptorship is a widely accepted teaching model that summaries five important task of micro skills is known as time efficient teaching method

Process

Orient Your Learners → Pitfalls in Clinical Teaching → Teacher Reasoning and Action → Conclusion → Give Feedback

Purpose

1. A Student-oriented, patient-centered method that helps make the student's learning needs visible
2. Increases preceptors confidence in their ability to rate students' knowledge and clinical reasoning skills

Patient encounter (history, examination, etc)

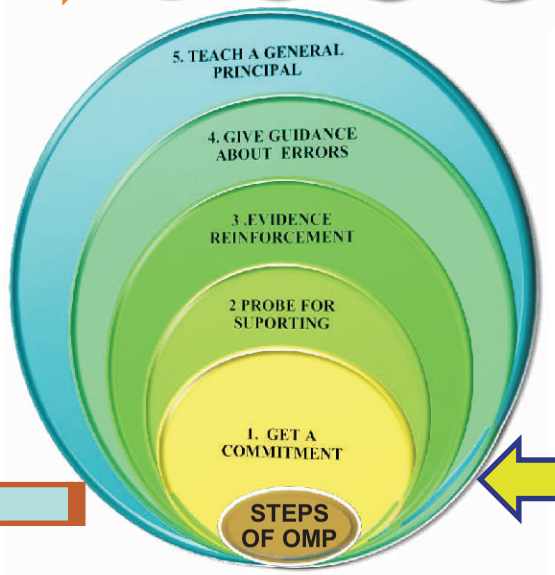
Get a commitment ("What do you think is going on?")

Probe for underlying reasoning ("What led you to that conclusion?")

Reinforce what was done well ("Your diagnosis of X was well supported by the history...")

Teach general principles ("When that happens, do this...")

Help learner identify and give guidance about omissions and errors ("Although your suggestion of Y was a possibility, in a situation like this, 2 is more likely, because...")



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Presented at National conference on Strengthening the Profession of Nursing : Enhancing Transformation on 24th and 25th January .

INTERPROFESSIONAL COMMUNICATION

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Effective communication is essential both within an individual team and between teams to ensure cooperation and coordination of care.

Steps to achieve effective interprofessional communication

1. Introduce yourself and clarify your role.
2. Listen attentively and allow people to complete their thoughts.
3. Ask questions.
4. Check for understanding of what has been said.
5. Invite opinions from those who have not spoken.
6. Be aware of communication barriers.
7. Use objective not subjective language.
8. Show mutual respect.
9. Consider setting: Right place, adequate time, no distractions.
10. Be aware of body language.

Tools used by the professionals

1. Team brief and debrief: A team brief is a short session, at the start of a shift or clinical activity, that enables the team to come together to discuss objectives, outcomes, roles, responsibilities and safety issues.
   The following questions are recommended by the team,
   - Who is on the team?
   - Do all members understand and agree goals?
   - What is your plan of care?
2. SBAR
   Adapted from UN Navy.
   S—Situation
   B—Background
   A—Assessment
   R—Recommendation
3. Call out and check back: Call out is a technique used to communicate critical information in an emergency. The clinician calls out questions and commands, ensuring that all team members are simultaneously informed of updates and can anticipate the next steps.
   Check out is where confirmation is sought that information given by the sender is received and understood. It is a closed loop communication strategy, the sender initiates a message which the receiver accepts and confirms, the sender then verifies the message.
4. Two challenge rule: The two challenge rule is designed to empower all team members to stop and activity is they sense a safety concern. This rule is adapted from aviation. The first challenge should be in the form of a question, the second challenge should provide some support for the team members concers. The team member challenged must acknowledge the concerns.
5. Critial language-CUS: A mechanism to overcome the heirarchial nature of medicine is to adopt the use of critical language, derived from the CUS programme at United Airlines. CUS stands for; 'I am concerned' 'I am uncomfortable' 'this is unsafe'. This 3 steps process that provides clarity, ensures that everyone stops and listens and is alerted to the seriousness of the situation. The CUS tool should be used only for serious and urgent issues.
6. Checklists and read back protocols: A check list outlines the criteria for consideration is a particular process. These are useful in some clinical situation, they provide a memory prompt, thereby decreasing the risk of error. Perhaps the best known of these is the WHO surgical safety checklist.

7. Huddles: Complementary to brief and debrief, huddles occur part way through a shift or team task. Team members come together to review activity, allowing re-establishment of situational awareness.

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INTERPROFESSIONAL COMMUNICATION

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M.G.M NEW BOMBAY COLLEGE OF NURSING, KAMOTHE

Introduction:

Interprofessional communication is a situation when professionals and the community communicate together in an open, collaborative and responsive manner (O'Daniel & Rosenstein,2008)

STEPS

- Introduce
- Listen
- Ask question
- Check for understanding
- Opinion
- Communication barrier
- Use objectives
- Mutual respect
- Body language

TOOLS

- Team brief and debrief → **Short session at the start of a session**
- Call out and check back → **Communic-ation in emergency**
- Two challenge rule → **'Stop' if any safety concern**
- SBAR → **Situation Background Assessment Recommendation**
- Critical language CUS → **I am Concerned I am uncomfortable This is unsafe**
- Check list and read back → **Used in surgical procedures**
- Huddles → **Review activity by team**

Presented at National Conference (strengthening the Profession of Nursing: Enhancing transformation) on 24th,25th Jan 2019 at MGM IHS

Conclusion :. Communication tools enhances efficient communication that promotes effective collaboration, improves patient outcomes, and increases patient satisfaction with care

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INTRODUCTION OF SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION (ISBAR) INTO NURSING PRACTICE

Ms. Nishima Sagar, In charge Emergency Medical ICU, MGM College and Hospital, Kamothe, Navi Mumbai
Email id: nishimasagar77@gmail.com

ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in transfer of critical information. ISBAR was introduced by rapid response teams at Kaiser Permanente in Colorado in 2002, to investigate patient safety. ISBAR has been adapted from SBAR, a tool developed by the US Navy to improve communication. This tool is also recommended by Joint Commission and World Health Organization (WHO). This tool aims in improving communication with team work among healthcare workers.

Elements of ISBAR

It consists of five simple elements shown below:
I: Identification (Who are you and what is your role?)
S: Situation (What is happening?)
B: Background (What are issues?)
A: Assessment (What is the problem?)
R: Recommendation (What should be done to correct the situation?)

Content of ISBAR tool

- **Identify**
  - Identify yourself by name, position and unit.
  - Identify your patient: Full name and medical record number, age, sex and location
- **Situation**
  - State the problem, concern, and chief complaint.
  - What is the current situation, concerns and observations
- **Background**
  - State the patient reason and date of admission
  - Significant and relevant medical, surgical, family and social history.
  - List of current medication, allergies, IV infusion treatment and procedure as required.
- **Resuscitation status**
  - Isolation
- **Assessment**
  - State what you think is going.
  - Give your interpretation of the situation.
  - Include your degree of certainty.
  - Be objective.
- **Recommendation**
  - Explain what you need
  - State request
  - Clarify expectation
  - For any telephone order read back to ensure accuracy.
  - Ask questions: Are there any tests required? For example: CXR, ECG, etc. Are there any medications/ fluids required? What change in the treatment plan is required? How often do you want vital signs? If the patient does not improve when should they be called again?

Benefits ISBAR tool

- Knowing the significance details of the patient.
- Easy to maintain the continuity of care.
- Avoids reinventing the wheels (as issues are already addressed).

- Saves times as the information is handy.
- Enhancing better patient care.
- Improves communication between health providers.

Nursing Implications of ISBAR

1. ISBAR form modified to organizational requirement can play an important role in transferring of information of a client from one nurse to next during bedside shift handoff.
2. And also in communication between nurse and physician, especially when the doctor is not available in the premises and vital information regarding patient status need to be communicated.
3. Though ISBAR is regularly used in Western world and has been found to be effective, it is time that Indian nurses understand the importance of a standardized approach to bedside shift handoff and implement in their clinical practice to bring about a positive outcome for patients and thus play an important role in ensuring patient safety.

Conclusion

ISBAR, as a formalized tool gives us a remarkable outcome in improving quality of care ensuring patient safety with teamwork and communication.

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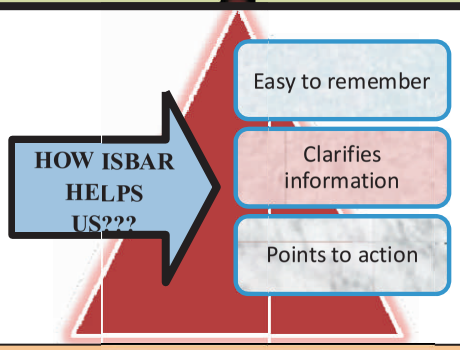
INTRODUCTION OF IDENTIFICATION, SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION IN HEALTH CARE SETTINGS

MS.NISHI A SAGAR (CHN), EMS ICU (INCHARGE), MGM HOSPITAL AND MEDICAL COLLEGE, NAVI MUMBAI.

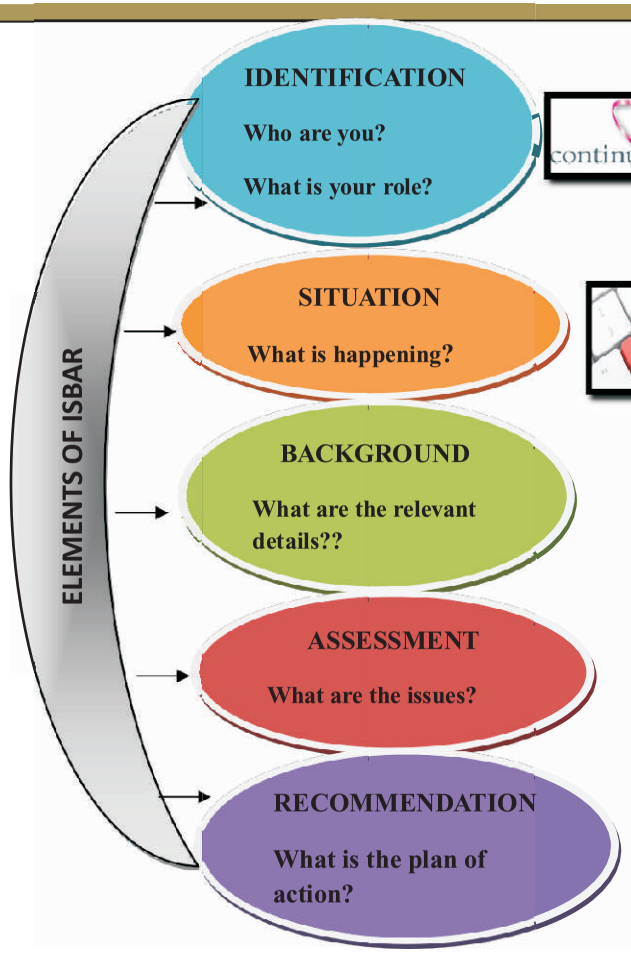
INTRODUCTION

ISBAR is a tool created to im rove safety in transfer of patient information. ISBAR was introduced by rapid response team at Kaiser Perman nte in Colorado in 2002, to investigate atient safety. ISB R has been adapted from SBAR, a tool eveloped by the US Navy to improve communication. This tool is als recommended by Joint Commission and World Healt Organization (HO).



PROCESS F ISBAR

- I - "Ii, I'm Sue, an ANUM on Ward 2"
- S - "I would like you to come and see a 21 year old man who has had a significant skin reaction to an IV antibiotic"
- B - "He was admitted this morning for treatment of an appendicectomy wound infection. He is a type 1 diabetic. He has just had his first dose of Gentamicin, Metronidazole and Ampicillin"
- A - "He is anxious and appears flushed with an erythemous rash on his chest and arms. His blood pressure is normal"
- R - "Are you able to see him urgently?" "What would you like me to do in the meantime?"



CONCLUSION

ISBAR, as a formalized tool gives us a remarkable outcome in improving quality of care ensuring patient safety with team work and communication.

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NATIONAL CONFERENCE ON 24-25TH JANUARY 2019 IN MGM INSTITUTE OF HEALTH SCIENCES.

LEADING TRANSFORMATION IN NURSING EDUCATION

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Introduction

Nursing is one of the most versatile occupations within the healthcare workforce.[1] In the 150 years since Florence Nightingale developed and promoted the concept of an educated workforce of caregivers for the sick, modern nursing has reinvented itself a number of times as healthcare has advanced and changed (Lynaugh, 2008).

As a result of the nursing profession's versatility and adaptive capacity, new career pathways for nurses have evolved. Nurses have been an enabling force for change in health care along many dimensions (Aiken et al., 2009). Among the many innovations that a versatile, adaptive, and well-educated nursing profession have helped make it possible. A competent nursing workforce is a critical building block for an effective health system.[2]

Need: Nurses form the backbone of the health system and are a universal access point for almost 90% of healthcare users.[3] According to a 2010 report by the Institute of Medicine, more than three million nurses make the profession the largest segment of the nation's healthcare workforce. The Lancet Commission reported a gap between health needs, competency care and educational outcomes.[4] Competency based learning strengthens individual-based outcomes and so transformative education demands that curricula be responsive to the needs of the society especially the neglected and marginalize poor populations.[5]

Methods: Extensive reviews done on nursing transformations related to education depicts that considering the healthcare environment is increasingly becoming complex, dynamic with changing demands, transformation of nursing education is needed than before. Improvement in nursing education needs to match these changes if the nurses are to effectively perform and positively impact on patient and care outcomes. Building capacity of nursing faculty, clinical nurses will ensure that nursing student acquire the necessary knowledge, skills and competencies to provide quality and safe care. Provision of adequate resources and a conducive learning environment strengthens the teaching and learning.[3]

Futuristic nursing regarding the delivery of nursing services and the expected capacity of the nursing education system, includes many innovative aspects for nursing.

Conclusion

With every passing decade, nursing has become an increasingly integral part of healthcare services, so that a future without large numbers of nurses is impossible to envision. Nurses have great potential to lead innovative strategies to improve the health care system.

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LEADING TRANSFORMATION IN NURSING EDUCATION

Introduction: Nursing is one of the most versatile occupations within the health care workforce.[1] Modern nursing has reinvented itself a number of times as health care has advanced and changed. Nurses have been an enabling force for change in health care along many dimensions.[2] Innovations that educated nursing profession have helped make it possible. A competent nursing workforce is a critical building block for an effective health system.[3]

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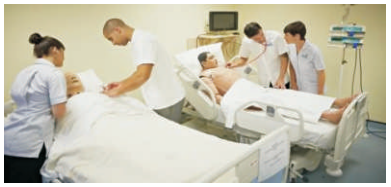
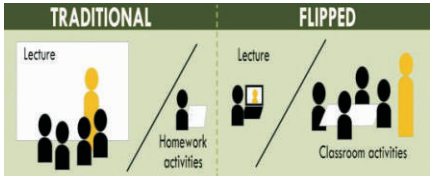
Method: Extensive reviews done on nursing transformations related to education depicts that considering the healthcare environment is increasingly becoming complex, dynamic with changing demands, transformation of nursing education is needed than before. It is needed for effective performance and positive impact on patient care outcomes.

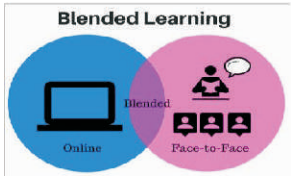
Nursing education is changing from the traditional classroom to web-based clinical instruction.

Along with the transition come the challenges which nursing educators must identify and remedy .From enabling, encouraging, and coaching the technologically naïve student to success and continue making nursing education a dynamic field.

- **Simulation -** creating realistic scenarios, encourages critical thinking. Low, middle and high simulation methods to be used.
- **Concept Mapping -** relationships b/w ideas, visual maps, creates logical thinking and motivation.
- **Online courses, e-learning** - integrated learning, easy accessibility, student centered, learning flexibility.
- **Games** - enjoyable learning, replication of real life situations.
- **Role playing** - dramatization of an event, learn cultural practices of community, conflict solutions.
- **Jigsaw classroom** - Cooperative learning, learns empathy.
- **Case studies** - realistic, complex, contextuality with situation.
- **Flipped Classroom** - online lectures or reading online then students do activities in the classroom to put in practices the concept they learned.
- **Blended Learning -** learning via electronic and online media as well as traditional face-to-face teaching.
- **Debating -** presenting 'pro' & 'cons', problem solution learning, higher order learning ,synthesis and evaluation is learned.
- **Tele-teaching, video conferencing** – online model, where learner directly interact with teacher.
- **Clinical Conference**, seminars.
- **Context based learning** – creativity, self directing.
- **Lifelong learning**.







Conclusion: Educators must be fully trained & incentivized to use new technologies as well practice conducive environment

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CREATING A POSITIVE WORKPLACE CULTURE: A LITTLE KINDNESS GOES A LONG WAY

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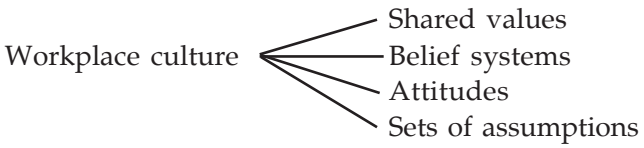
INTRODUCTION

Culture is the environment that surrounds us all the time. A positive culture in the workplace is essential for fostering a sense of pride and ownership among the employees.

DEFINITION OF POSITIVE WORKPLACE CULTURE



ELEMENTS OF POSITIVE WORKPLACE CULTURE

- Begin with gratitude
- Create a safe environment
- Establish clear ethos and values for the organization
- Promote positive communication
- Increase awareness
- Encourage positive thinking
- Appreciate the little wins
- Smile
- Recruitment
- Employee loyalty
- Foster social connection
- Listen
- Consistency is key
- Do not sacrifice the important for the urgent.

PROS AND CONS OF POSITIVE WORKPLACE CULTURE

Result of studies conducted on workplace cultures hows positive environment produce positive benefits specifically to engagement, relationships, health and bottom line. Conversely, one of the biggest downfalls to a negative or fear-based environment is higher healthcare costs due to workplace stress and lower engagement. This in turn typically results in higher turnover.

According to the Gallup organization, disengaged workers had 37% higher absenteeism and 60% more errors and defects.

Another research by Deloitte has shown that 94% of executives and 88% of employees believe a distinct corporate culture is important to a business success. Her survey also found that 76% of these employees believed that a clearly defined business strategy helped create a positive culture.

CONCLUSION

A happy employee will spread around the word very effectively and be instrumental in attracting talent to the organization. People today are constantly looking for change and new opportunities in search of a happy, satisfied and balance work life.

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CREATING A POSITIVE WORKPLACE CULTURE: A LITTLE KINDNESS GOES A LONG WAY

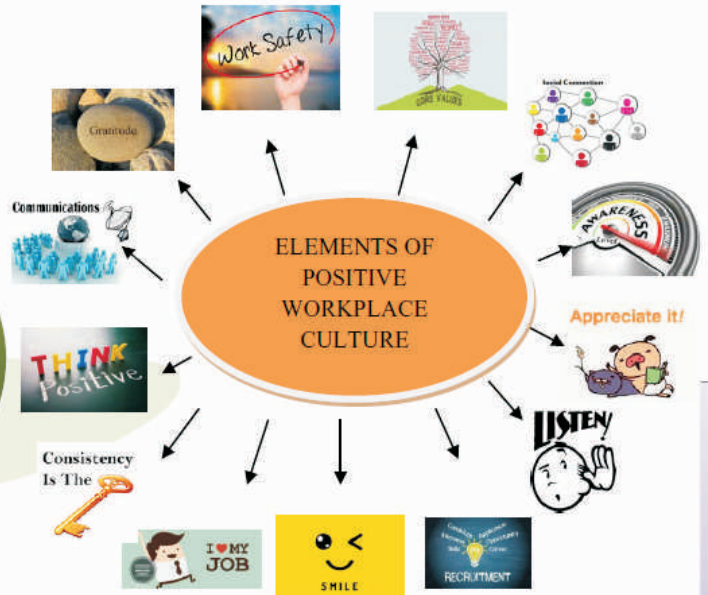
MS. BEENA POTHEN M.Sc (OBG),EMS ICU SENIOR STAFF NURSE, MGM INSTITUTE OF HEALTH SCIENCES

NAVI MUMBAI

INTRODUCTION

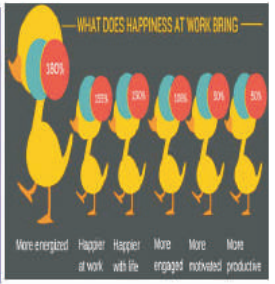
Culture is the environment that surrounds us all the time. The positive culture in the workplace is essential for fostering a sense of pride and ownership among the employees.

- Shared values
- Belief systems
- Attitudes
- Sets of assumptions



SURVEY BY RERSEARCHERS

Over the past few years, increased research shows positive environment produces benefits specifically to engagement, relationships, health and bottom line. Conversely, one of the biggest downfalls to a negative or fear based environment is higher health care costs due to workplace stress and lower engagement. This in turn typically results in "HIGHER TURNOVER"



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National conference on 24 - 25th Jan 2019 in MGM Institute of Health Sciences, KAMOTHE

TOPIC-HEALTHY WORK ENVIRONMENT

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Definition

According to AACN, healthy work environment "Support and foster excellence in patient care and are imperative to ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial viability. It also recognizes the inextricable links among the quality of a nurse's work environment, excellent nursing practice, and patient care outcome." (Vollers, Hill Roberts, Dambaugh & Hill, 2009).

Purpose

It is important to find methods to identify poor work settings to prevent absenteeism due to sickness. The paper aims to discuss these issues.

HEALTHY WORK ENVIRONMENT

1. Authentic leadership
2. Skilled communication
3. True collaboration
4. Effective decision-making
5. Appropriate staffing
6. Meaningful recognition

Creating a Healthy Work Environment

- Use substitutes for hazardous materials
- After hazardous process and engineering controls
- Enclose or isolate hazardous processes
- Issue clothing to protect against hazards
- Improve ventilation.

Advantages

To the organization	To the employee
1. A well-managed health and safety programme	1. A safe and healthy environment
2. Reduced health care/insurance costs	2. Enhanced self-esteem
3. Improve staff morale	3. Reduce stress
4. Improve staff morale	4. Improved morale
5. Reduce absenteeism	5. Increased job satisfaction
6. Increased productivity	6. Increase skill for health protection
7. Reduced healthcare/insurance costs	7. Improved health
8. Reduced risk of fines and litigation	8. Improved sense of well-being

Conclusion

There is evidence that unhealthy work environments contribute to conflict and stress among health professionals.

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HEALTHY WORK ENVIRONMENT

MR. AVINASH P. RATHOD. II yr. NURSE PRACTITIONER IN CRITICAL CARE, MGM NEW BOMBAY COLLEGE OF NURSING,NAVI MUMBAI .

Definition : - According to AACN , Healthy work environment " Support and foster excellence in patient care and are imperative to ensure patient safety, enhance staff recruitment and retention , and maintain an organization's financial viability. It also recogni zes the inextricable links among the quality of a nurse's work environment, excellent nursing practice, and patient care outcome."
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National Conference on 24- 25th Jan 2019 at MGM New Bombay College of Nursing, Kamothe.

BRIEF SUMMARY AND EVALUATION OF CONFERENCE

National Conference on Strengthening the Profession of Nursing: Enhancing transformation was conducted for two days by MGM New Bombay College of Nursing, Kamothe on 24th and 25th Jan 2019.

The event brought together total 197 participants from various universities across the country. Twenty-seven resource persons from reputed Institutes and Universities of India like NITTE University, Mangalore, PGI, Chandigarh, Bharti Vidyapeeth Deemed University Sangali, Symbiosis International Deemed University Pune, Pravara Institute and Medical Sciences Loni, CMC Vellore Tamil Nadu, Maharashtra University of Health Sciences, Nashik and MGM Institute of Health Sciences. To add on successful and eminent professionals from intellectual property Consultancy and Legal advisory firm, Higher Education Forum, Suasth Health Care, Mumbai, Arjo Huntleigh Health Care India Pvt. Ltd.

The conference began with welcome address by Mrs. Sarika Nair followed by an Invocation song at 9.15 am. The formal inaugural session commenced with welcome note by Mrs. Ponchitra. The chief guest Dr. Punita Ezhilarasu, Senior consultant INC and Former dean was facilitated by hon' Vice Chancellor Dr. Shashank K Dalvi.

Dr. Prabha K Dasila unfolded the theme of the national conference by emphasizing the facts of the current scenario in the healthcare system. Nursing education, the need for transformation to cater the current generation students Gen 2 who are the primary stakeholders.

The lamp was lighted by the dignitaries on dias which was followed by address of Dr. Sudhir N Kadam who explained about the pathway of development nursing institutions in MGMIHS. He also narrated the importance of transformation of nursing education and the need to have integrated education and practice model.

The key note address by Dr. Punita Ezhilarasu provided an overview of the challenges faced by nursing profession, 'Nursing now' global campaign to empower nurses, triple impact nursing 2016 and the initiative taken by INC and Government. She also pointed out the driving forces to enhance the transformation through people and through system.

Honorable Vice Chancellor also addressed the gathering and appreciated the initiative for organizing the conference with the right theme at the right need of the hour.

After a short tea break session 1 commenced with Dr. Fathima narrating the history of nursing education from 250 BC and connected it to the changes in the present nursing education. She also mentioned the curricular innovations, regulatory reformation and the educational pathway of nursing in the global context.

Dr. Sandhya Ghai stated the factors influencing the future of nursing education, future perspectives of nursing and emphases the importance of paradigm shift in nursing education. She concluded by stating evidence based practice in education vs. practice based evidenceand transcultural nursing.

Dr. Siddharth Dubashi stressed on the need for Academic Leadership through the faculty development and retention, improvement of outcome and sustainability. He highlighted the scope of team process, positive leadership traits and concluded with 10 commandments to be a leader.

A panel of 4 members Dr. Sivabalan, Dr. Fatima, Dr. Nilima Bhore and Dr. Shardha Ramesh deliberated on Need for Curricular Reform chaired by Dr. Mary Mathews and Mrs. Preethi Mathew. Dr. Mary Mathews began the panel by describing what is curriculum, the context of nursing, current status of nursing curriculum, conventional pedagogy, academic practice, perspectives and compared the traditional model of curriculum with Spices Model.

Dr. Sharadha Ramesh highlighted the factors influencing the content saturation by displaying the requirements of syllabus and meticulously calculated hours of the faculty to the run to complete and discussed about how to face the challenges.

Dr. Sivabalan expressed his concerns about the curriculum by comparing the syllabus outside India, and the difficulty in introducing and incorporating credit and choice-based curriculum. He also thought a loud regarding benchmark indicators for curriculum development and evaluation from various stakeholders.

Session 2:

Dr. Sivabalan started the session by explaining Generation Typology and who is Gen Z. He also recorded evidence and who is Gen Z and concluded by mentioning the effective ways of teaching Gen Z by correlating with 12 challenges to teach Gen Z.

Dr. Nilima Bhore made a quick review on Classroom management strategies to mention a few like stimulating classroom environment, visualization, inquiry based learning, web based learning, etc.

Post lunch the most awaited session 3 by Dr. A. K. Sengupta on entrepreneurship with interesting real case scenario was enlightening, encouraging and motivating.

Mrs. Susheela Samuel shared her career experience and explored about nursing career ladders, expanding nursing terrains, advanced career options, pathways and emerging roles of nursing.

Session 4

Dr. Gopa Nair underscored the growing need for innovation and provided a detailed account on innovation, invention, patent, IP evolution, copyright, IPR, trademarks, types of patent, claims and patent filling strategies.

Dr. Sharadha Ramesh added about conditions of patentability and described in detail about patent application, draft writing, trademark office, stagesand process involved, IPR policy, precautions for inventors and concluded by nursing patented designs such as suction and oxygen equip storage device, nurse designed IV assessment tool, nurse-led medicine bag, nurses designed ground breaking resuscitation trolley, hook on portable light weight drip stand, etc.

Concurrently poster presentation occurred where 16 conceptual posters were displayed which was evaluated by Dr. Dubhashi and Dr. Rita Khakadikar.

The day ended with cultural activities by the students of MGM New Bombay College of Nursing. The students performed vibrant classical dance, beautiful song and and interesting mime.

Day 2:

The session started with Mrs. Ida Nirmal briefing about the evolution of APN concept, functions, difference between RN and APN, core competencies required for APN. She also elaborated the process of establishment and specialist nurse role like stoma care nurse, wound care nurse and continence nurse in CMC Vellore.

Ms Oberoi also shares her experience as an administrator for achieving quality patient care through advance nursing practice.

Dr. Gayathri Bhosale defined the roles and responsibilities of IP team, the limitations to be drawn for each professional in the team and the need for emphasizing IP CP and IPE in accreditation and education.

Dr. Sagar Sinha added his views on IPC by highlighting the risks of IPC like law suit and patient-doctor relationship. He emphasized on 6 strategies: Nurse-led protocols, interdisciplinary reviews, clinical audits, administrative roles, trust escalation matrix and compassion and 3 desires-intent, skills and faith for inter-professional collaboration.

Dr. Sripriya Gopal Krishnan firstly provide an overview about the changing workplace culture, role of HR in workplace and 5 M's-Mindfulness, Mentoring, Movement, Motivation and Meaning. She also quoted various reference studies and explained the characteristics of good workplace culture related to real situation.

Dr. Rakesh Gildiyal secondly deliberated on the same topic by explaining about poor working environment leading to psychological distress. He quoted do not allow stress to distress you and differentiated good culture and bad culture.

Post lunch 18 oral paper presentation was done by faculty, Ph.D. Scholars and PG students which were evaluated by Dr. Mary Mathews, Dr. Meruna and Dr. Mohanty.

Ms. Susan extended vote of thanks to all who participated directly or indirectly to make the conference a grand success.

Ms. Jyoti Chaudhari described about evaluation process of paper and poster presentation and announced the prizes of poster and paper presentation. Dr. Prabha K. Dasila honoured the winners of poster presentation, viz. Arathi (1st), Jitendra (2nd) and Priyanka (3rd) by giving certificates. Dr. Mary Mathews felicited the winners of paper presentation by giving certificates-Ms. Richa Sharma (1st), Ms. Gargee Karadkar (2nd) and Ms. Sindhu Thomas (3rd). From delegates Ms. Shubhangi Jadhav and Mr. Vipin Vageria gave the feedback about the conference. Delegates expressed feeling of contentment with scientific knowledge and way forward shared during the conference by various speakers as well as hospitality of the staff. Conference got over with national anthem by 5 pm.

Recommendations

- In the current curriculum, the name of the competencies needs to be developed by the student nurses are already mentioned in the logbook and various evaluatory and non-evaluatory assignments. It is time for teachers to be the facilitator and role model for the student. The teacher needs to give basics and for remaining things should be learned by student by himself under mentorship and facilitatorship of teacher.
- There should be less of theory hours for classroom teaching and more hours for problem-based learning and its output in the form of concept mapping, presentations, debate, etc.
- It is recommended that let educational institute should have modern technology and equipment for virtual learning.
- Teachers should be trained in newer methods of teaching learning and evaluation of performance of the students through workshops, etc. They should be given a time to work on instructions for the students for effective learning.
- Proficiency and competency assessment—there is need for newer methods of competency and proficiency assessment not only during practical examination but even on day to day practice such as OSPE/OSCE, DOPS, etc.
- It is recommended to provide autonomy for nurse practitioner which has very less power at present regarding decision-making and action taking.
- It is recommended to generate curiosity and facilitate students to work on ideas, challenge existing nursing care, protocol, etc. Let nurses should feel that there is a scope for innovation and overcoming the challenges.
- There should be facility for online education programme for nurses made in a way to assess the clinical reasoning and critical thinking.

MGM NEW BOMBAY COLLEGE OF NURSING

CONFERENCE COMMITTEE

Organising Chairperson: Dr Prabha K Dasila

Organising secretary: Mrs Ponchitra R

Coordinator: Mrs Renu Nagar

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2.	Organising Committee	Mrs. Susan Jacob	Mrs. Manju Varghese Mrs. Sarika Sukesh Mrs. Sherin Thumpy Mrs. Ritika Gawade Mr. Nitin Pawar Mrs. Pranali Bhosale
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5.	Finance and budgeting	Mrs. Vandana Kumbhar	Mrs. Jayalakshmi Panikar Mrs. Sarika Lokhande Mrs. Renu Nagar
6.	Cultural program		Mrs. Remya Philip

List of Participants

Sr.No.	Name of the participants	Institute
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