Review Article

Community and Public Health Nursing
Vol. 7 No. 3, September - December 2022
DOI: http://dx.doi.org/10.21088/cphn.2455.8621.7322.5

A Comparative Study to assess the Knowledge at the Age Group of 40-50 Year Women Regarding Menopausal Symptoms in Selected Rural and Urban Areas in a view to Develop an Instructional Booklet

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How to cite this article:

Alka Tajne, Kokani Alpana J, et. al/Effectiveness of Video Assisted Teaching on Knowledge of Cancer Cervix Among Women/ Community and Public Health Nursing. 2022;7(3):121–123.

Abstract

Menopause is a natural step in the aging process represent the end of menstruation after the last menstrual periods in the previous 12 month. It occurs gradually in women and indicate the transition from the reproductive to the post reproductive era of women's life. ***Objective of the Study:*** (1) To assess the knowledge on menopausal symptoms among 40-50 years old regarding at selected urban areas. (2) To assess the knowledge on menopausal symptoms among 40-50 years old regarding at selected rural areas (3) To compare the knowledge score of women in urban and rural areas. (4) To determine the relationship between the knowledge with selected socio demographic variables such as education, occupation, previous knowledge. ***Method:*** A non-experimental, comparative study with a quantitative research approach was utilized to test the proposed hypothesis. Instructional booklet was papered regarding menopausal symptoms and its management. ***Result:*** The knowledge mean score of urban areas is 52.2 and rural mean score is 36.6. Compare the knowledge of urban and rural menopausal symptoms women.

Keywords: Menopausal Symptoms; Women's Life; Socio Demographic Variables; Women's Life Events.

INTRODUCTION

A normal healthy woman's reproductive phase is usually known by the terms such as menarche which means the age of first menstruation, menstruation denotes the periodic and cyclical shedding of endometrium, puberty is the period of increased general body growth and development of secondary sexual characters and sex organs and girls become capable of reproduction, and menopause is the cessation of menstruation due to rapid decrease in the production of female sex hormones by the ovaries at the age of about 45-55 years. (Rashid Latif, 2006). The term "women's health is very important in understanding the health issues of the women. The American Academy of Nursing's 1996 expert panel on women health reported that women 's health incudes their entire life span and involves health promotion, maintenance and restoration. The term women health recognizes that the health of the women is related to the biological, social and cultural dimensions of women's lives. Moreover, women's normal life events or rites of passage such as menstruation, child birth and menopause are considered as part of normal female development rather than disease or syndrome. This broad emphasis on women's health is in contrast to the view of women solely in terms of their reproductive health or their role in parenting children.

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Received on: 27.07.2022 **Accepted on:** 15.09.2022

OBJECTIVE OF THE STUDY

- To assess the knowledge on menopausal symptoms among 40–50 years old women regarding at selected urban areas.
- To assess the knowledge regarding menopausal symptoms among 40–50 years old women regarding at selected rural areas.
- To compare the knowledge scores of women in urban and rural areas.
- To determine the relationship between the knowledge with selected socio demographic variable such as age, marital status, religion, education, occupation and previous knowledge.

HYPOTHESIS

H_0: There is no significant relation between knowledge level of women and demographic variables.

$H_0$1: There is significant relation between knowledge level of Women and demographic variables.

MATERIAL AND METHODS

The methodology of research indicates the general patterns of organizing the producer of gathering valid and reliable data for an investigation. (pilot, hungler 2004)

Research Approach: Non experimental

Research Design: Descriptive research.

Socio Demographic Variables

Demographic variables such as age, religion, marital status, educational status, occupational status, obstetrical history of the family and sources of previous knowledge regarding menopausal symptoms and management.

Sampling criteria:

The following criteria are set to select the sample:

- **Inclusion criteria:** Menopausal women who are age between 40-50 years.
- **Exclusion criteria:** Menopausal women who are belowthe age of 40 and above the 50.

Setting of the study: The study was conducted in selected rural & urban area.

Population: Women hawing manopausal symptoms.

Sample/ sample size: 30 sample in urban and 30 rural.

Sampling technique: Non probability convenient sampling

FINDING OF THE STUDY

- The majority of the urban and women were belongs to Hindu 6,7(20%, 23%)
- The majority of women is primary education 15, 17 (50%, 23%)
- The majority of women is house wife 22,21 (73%, 70%)
- The majority finding in women having problem in reproductive organ and other problem 18, 17 (60%, 23%).

Knoledge Level of Urban Women Regarding Menopausal Symptoms and its Management

Level of knowledge is divided into three categories for easy understanding.

- Poor
- Average
- Good

Result of the study revealed that 20% of women having poor knowledge, 60% of women having average knowledge and 20% of women having good knowledge regarding menopausal symptoms and its management.

The overall knowledge score of urban women is 52.2%.

Knowledge of Rural Women Regarding Menopausal Symptoms and its Management

Result of the study revealed that 50% of women having poor knowledge, 33.33% of women having average knowledge and 17% of women having good knowledge regarding menopausal symptoms.

The overall knowledge score of rural women is 36.6%.

Comparison of Knowledge Score of Urban and Rural Women

The overall knowledge score of urban women is 52.2% and of the rural women is 36.6%. When the compared to rural women knowledge score, the knowledge score of urban women is high. So the

knowledge of the urban women was more than that of rural women.

Association of Socio Demographic Variables with Knowledge of the Women

The chi-square test is used to find out the association between demographic variables such as education, occupation and received information about the menopausal symptoms.

Chi-square analysis is found that there was an association between knowledge and educational status of the women in both rural and urban areas. In rural area there is no significant relation between knowledge level and demographic variables. In urban area there is significant relation between knowledge level and demographic variables such as education, occupation and received information about menopausal symptoms.

CONCLUSION

- The overall knowledge score of the urban women was more (52.2%) of the rural women (36.6%).
- The study reveals that the knowledge of women regarding menopausal symptoms and its management more in urban areas women as a compare to rural areas women.

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Review Article

Community and Public Health Nursing
Vol. 7 No. 3, September - December 2022
DOI: http://dx.doi.org/10.21088/cphn.2455.8621.7322.6

The Impact of Delayed Card Clamping After Birth

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How to cite this article:
Danish Ahmad, Priyanka Thakur/The Impact of Delayed Card Clamping After Birth/Community and Public Health Nursing;2022;7(3):125–129.

Abstract

Delayed umbilical cord setting appears to be salutary for term and preterm babies. In term babies, delayed umbilical cord setting increases hemoglobin situations at birth and improves iron stores in the first several months of life, which may have a favorable effect on experimental issues. There's a small increase in the prevalence of hostility that requires phototherapy in term babies witnessing delayed umbilical cord setting. Accordingly, obstetrician-gynecologists and other obstetric care providers espousing delayed umbilical cord setting in term babies should insure that mechanisms are in place to cover and treat neonatal hostility. In preterm babies, delayed umbilical cord setting is associated with significant neonatal benefits, including bettered transitional rotation, better establishment of red blood cell volume, dropped need for blood transfusion, and lower prevalence of necrotizing enterocolitis and intraventricular hemorrhage. Delayed umbilical cord setting wasn't associated with an increased threat of postpartum hemorrhage or increased blood loss at delivery, nor was it associated with a difference in postpartum hemoglobin situations or the need for blood transfusion. Given the benefits to utmost babe and accordant with other professional associations, the American College of Obstetricians and Gynecologists now recommends a detention in umbilical cord setting in vigorous term and preterm babies for at least 30-60 seconds after birth. The capability to give delayed umbilical cord setting may vary among institutions and settings; opinions in those circumstances are stylish made by the platoon minding for the mother- child duo.

Keywords: Hemorrhage; Obstetricians and Gynecologists; Delayed Card Clamping.

INTRODUCTION

Before the medial 1950s, the term before hand setting was defined as umbilical cord setting within 1 nano second of birth, and late setting was defined as umbilical cord setting further than 5 twinkles after birth. In a series of small studies of blood volume changes after birth, it was reported that 80 – 100 mL of blood transfers from the placenta to the invigorated in the first 3 twinkles after birth.

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Received on: 09.06.2022 **Accepted on:** 18.08.2022

and up to 90% of that blood volume transfer was achieved within the first few breaths in healthy term infants Because of these early compliances and the lack of specific recommendations regarding optimal timing, the interval between birth and umbilical cord setting began to be docked, and it came common practice to fix the umbilical cord shortly after birth, generally within 15 – 20 seconds. Still, more recent randomized controlled trials of term and preterm babies as well as physiologic studies of blood volume, oxygenation, and arterial pressure have estimated the goods of immediate versus belated umbilical cord setting (generally defined as cord setting at least 30 – 60 seconds after birth) Delayed umbilical cord setting appears to be salutary for term and preterm babies. In term babies, delayed umbilical cord setting increases hemoglobin situations at birth and improves iron stores in the first several months of life, which may have a favorable effect on experimental

issues. In preterm babies, rates of intraventricular hemorrhage and necrotizing enterocolitis are lower, and smaller babe bear transfusion when delayed umbilical cord setting is employed. This growing body of substantiation has led a number of professional associations to recommend delayed umbilical cord setting in term and preterm babies. For illustration, the World Health Organization recommends that the umbilical cord not be clamped earlier than 1 nanosecond after birth in term or preterm babies who don't bear positive pressure ventilation. Recent Neonatal Reanimation Program guidelines from the American Academy of Pediatrics recommend delayed umbilical cord setting for at least 30 – 60 seconds for utmost vigorous term and preterm babies. The Royal College of Obstetricians and Gynecologists also recommends postponing umbilical cord setting for healthy term and preterm babies for at least 2 twinkles after birth. Also, the American College of Nanny – Midwives recommends delayed umbilical cord setting for term and preterm babies for 2 – 5 twinkles after birth. The widespread execution of deferred umbilical rope clasping has raised concern. Delay in umbilical rope clipping might postpone convenient revival endeavors, if necessary, particularly in preterm babies. None the less, in light of the fact that the placenta keeps on performing gas trade after conveyance, wiped out and preterm newborn children are probably going to benefit most from extra blood volume got from proceeded with placental bonding. Another worry is that a deferral in umbilical string clipping could expand the potential for unreasonable placental bonding. Until now, the writing doesn't show proof of an expanded gamble of polycythemia or jaundice; in any case, in certain investigations there is a marginally higher pace of jaundice that meets measures for phototherapy in term babies. Given the advantages to most babies and concordant with other expert associations, the American College of Obstetricians and Gynecologists currently suggests a postponement in umbilical string clasping for no less than 30-60 seconds after birth in incredible term and preterm newborn children.

Process and Technique of Delayed Umbilical Cord Clamping

Delayed umbilical cord setting is a straight forward process that allows placental transfusion of warm, oxygenated blood to inflow passively into the invigorated. The position of the invigorated during delayed umbilical cord setting generally has been at or below the position of the placenta, grounded on the supposition that graveness facilitates the placental transfusion . Still, a recent trial of healthy term babies born vaginally plant that those babe placed on the motherly tummy or casket didn't have a lower volume of transfusion compared with babies held at the position of the introitus. This suggests that immediate skin-to-skin care is applicable while awaiting umbilical cord setting. In the case of cesarean delivery, the infant can be placed on the motherly tummy or legs or held by the surgeon or adjunct at close to the position of the placenta until the umbilical cord is clamped.

During delayed umbilical cord setting, early care of the infant should be initiated, including drying and stimulating for first breath or cry, and maintaining normal temperature with skin-to-skin contact and covering the child with dry linen. Concealment should be cleared only if they're riotous or appear to be gumming theairway. However, plans for delayed umbilical cord setting can continue, If meconium is present and the baby is vigorous at birth. The Apgar time keeper may be useful to cover ceased time and grease an interval of at least 30 – 60 seconds between birth and cord clamp.

Delayed umbilical cord setting shouldn't intrude with active operation of the third stage of labor, including the use of uterotonic agents after delivery of the invigorated to minimize motherly bleeding. However, similar as in the case of abnormal placentation, placental abruption, If the placental rotation isn't complete. Also, motherly hemodynamic insecurity or the need for immediate reanimation of the invigorated on the warmer would be an suggestion for immediate umbilical cord setting.

The capability to give delayed umbilical cord setting may vary among institutions and settings; opinions in those circumstances are stylish made by the platoon minding for the mama – child duo. There are several situations in which data are limited and opinions regarding timing of umbilical cord setting should be personalized. For illustration, in cases of fetal growth restriction with abnormal umbilical roadway Doppler studies or other situations in which utero-placental perfusion or umbilical cord inflow may be compromised, a discussion between neonatal and obstetric brigades can help weigh the relative pitfalls and benefits of immediate or belated umbilical cord setting.

Data are kindly disagreeing regarding the effect of delayed umbilical cord setting on umbilical cord pH measures. Two studies suggest a small but statistically significant drop in umbilical roadway pH (drop of roughly 0.03 with delayed umbilical

cord setting) Still, a larger study of 116 babies plant no difference in umbilical cord pH situations and plant an increase in umbilical roadway pO_2 situations in babies with delayed umbilical cord setting 25. These studies included babies who didn't bear reanimation at birth. Whether the effect of delayed umbilical cord setting on cord pH in nonvigorous babies would be analogous is an important question taking farther study.

MATERIAL AND METHODS

MATERNAL OUTCOMES

Immediate umbilical cord setting has traditionally been carried out along with other strategies of active operation in the third stage of labor in an trouble to reduce postpartum hemorrhage. Accordingly, concern has arisen that delayed umbilical cord setting may increase the threat of motherly hemorrhage. Still, recent data don't support these enterprises. In a review of five trials that included further than women, delayed umbilical cord setting wasn't associated with an increased threat of postpartum hemorrhage or increased blood loss at delivery, nor was it associated with a difference in postpartum hemoglobin position or need for blood transfusion. Still, when there's increased threat of hemorrhage (eg, placenta previa or placental abruption), the benefits of delayed umbilical cord setting need to be balanced with the need for timely hemodynamic stabilization of the woman.

NEONATAL OUTCOMES

Physiologic studies in term babies have shown that a transfer from the placenta of roughly 80 mL of blood occurs by 1 nanosecond after birth, reaching roughly 100 mL at 3 twinkles after birth.[7,8,9] Original breaths taken by the invigorated appear to grease this placental transfusion.[10] A recent study of umbilical cord blood inflow patterns assessed by Doppler ultrasonography during delayed umbilical cord setting[11] showed a pronounced increase in placental transfusion during the original breaths of the invigorated, which is allowed to be due to the negative intrathoracic pressure generated by lung affectation. This fresh blood inventories physiologic amounts of iron, amounting to 40 – 50 mg/kg of body weight. This redundant iron has been shown to reduce and help iron insufficiency during the first time of life.[12] Iron insufficiency during immaturity and nonage has been linked to disabled cognitive, motor, and behavioral development that may be unrecoverable.[13] Iron insufficiency in nonage is particularly current in low- income countries but also is common in high-income countries, where rates range from 5 to 25 13.

A longer duration of placental transfusion after birth also facilitates transfer of immunoglobulins and stem cells, which are essential for towel and organ form. The transfer of immunoglobulins and stem cells may be particularly salutary after cellular injury, inflammation, and organ dysfunction, which are common in preterm birth.[14,15] The magnitude of these benefits requires farther study, but this physiologic force of hematopoietic and pluripotent stem cell lines may give remedial goods and benefit for the child latterly in life.[16]

WHEN YOU SHOULD AVOID DELAYED CORD CLAMPING ?

There are a few reasons that postponed cord clamping ought to be stayed away from," Barnes says. "For instance, in women with unusual placentas, ladies encountering a discharge or children who are conceived requiring quick clinical consideration, postponed line clipping isn't suggested.

- Needs to be resuscitated by the staff in the neonatal intensive care unit (NICU).
- Has heart rate abnormalities.
- Comes out depressed (limp or gray or blue in color).

In these cases, doctors will clamp the cord immediately to focus on the health of mother and child.

CONCLUSION

Term and preterm infants appear to derive enjoy delayed duct clamping; therefore, delayed duct clamping for a minimum of 30–60 seconds is suggested in term and preterm infants except when immediate duct clamping is important due to neonatal or maternal indications. In term infants, delayed duct clamping increases hemoglob in levels at birth and improves iron stores within the first several months of life, which can have a positive effect on developmental outcomes. There is a little increase in jaundice requiring phototherapy in term infants undergoing delayed duct clamping. Consequently, obstetrician gynecologists and other obstetric care providers adopting delayed cord clamping in term infants should make sure that mechanisms are in situ to watch and treat neonatal jaundice.

Similarly, evidence also supports delayed duct clamping for a minimum of 30–60 seconds in

preterm infants. Delayed duct clamping is related to significant neonatal benefits in preterm infants, including improved transitional circulation, better establishment of red blood corpuscle volume, decreased need for transfusion, and lower incidence of NEC and intraventricular hemorrhage.

In terms of maternal outcomes, delayed duct clamping doesn't increase the danger of postpartum hemorrhage or the necessity for transfusion. Additionally, postpartum maternal hemoglobin levels aren't suffering from delayed compared with immediate duct clamping.

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Review Article

Community and Public Health Nursing
Vol. 7 No. 3, September - December 2022
DOI: http://dx.doi.org/10.21088/cphn.2455.8621.7322.7

Role of a Nurse in a Palliative Care Setting

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How to cite this article:
Bhavna Gupta, Pallavi Ahluwalia, Anish Gupta/Role of a Nurse in a Palliative Care Setting/Community and Public Health Nursing;2022;7(3):129–131.

Abstract

Providing expert skilled assessment and nursing care, supporting the patient and the family to make informed choices, and encouraging the patient to continue to make autonomous decisions about their care towards the end of their life are the responsibilities of a palliative care nurse who works as an integral part of a multidisciplinary team. To better support patients in maintaining their physical, mental, and emotional health, nurses who specialise in palliative care utilise an integrative and interdisciplinary therapeutic strategy. They make an effort to gain an understanding of each patient's unique requirements in order to devise a treatment strategy that is individualised and results in sustained comfort.

Keywords: Nurse, Palliative care, Telemedicine.

INTRODUCTION

Because dying patients are frail and vulnerable due to their physical and emotional state, their treatment and management during this final stage of life must be of the highest professional and ethical standards. The Nurse and other team members should strive to do their best for the patient and their family. This includes respecting autonomy by providing accurate information and assisting them in setting realistic goals while providing genuine attentive care throughout the course of the illness. To provide individually tailored palliative care to patients with life threatening illnesses and their families, nurses must have a thorough understanding of basic nursing principles. Situations place demands on nurses in the practical, relational, and moral dimensions of care, and place comprehensive demands on their role.

The goal of palliative care is to improve both the quality of life of persons coping with a terminal illness and those close to them by employing specialized techniques to foresee, alleviate, and forestall suffering. This form of care for terminally ill patients considers and attends to every facet of the patient's wellbeing, from the patient's physical health to the patient's mental state to the patient's emotional condition and finally to the patient's spiritual dimension. If a patient receiving palliative care does not receive a holistic approach, the patient's physical, social, spiritual, and emotional misery may worsen. The hospice model does not account for care given with curative treatment or life prolonging measures like palliative chemotherapy. The concurrent model of palliative care may play a pivotal role in providing treatment in countries with low and intermediate incomes, where access to curative therapy is limited.[1]

Palliative care frequently uses interdisciplinary teams to address the complex needs of patients who are coping with a terminal sickness. These teams typically include medical experts, social workers, spiritual care practitioners, and nurses.

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Received on: 18.06.2022 **Accepted on:** 26.09.2022

Most patients and the people closest to them have difficulty coming to terms with the imminent prospect of passing away. When trying to figure out what kind of medical care is ideal for a person getting close to the end of their life, it is essential to consider whether a specific treatment will be beneficial in the long run. The quality of life may have something to do with these different alternatives. When potentially life-saving therapies are discontinued, the patient will frequently pass away (e.g., ventilator support, dialysis, vasopressors or inotropes, chemotherapy, antibiotics, etc.). [1,2]

It is typical for nurses to be in a position to counsel patients and families as they deal with emotionally stressful events, such as the diagnosis of a condition that could drastically alter one's life or the passing of a loved one. When making healthcare decisions for patients who end their lives, it is common to consider the patient's quality of life. A nurse's duty is crucial to provide emotional support for the patient, the patient's loved ones, and anyone involved in the patient's care. Nursing care entails not only the management of disease but also the provision of attention to the patient's physical comfort and the acknowledgement that their wellbeing is comprised of psychological, interpersonal, and spiritual components in addition to those that pertain to their physical health. It is important to highlight not just the part that the nurse plays in the decision-making process for palliative and end-of-life care but also the nurse's capacity to relieve patients suffering from severe or life-threatening illnesses of pain and other painful symptoms.[3]

Registered nurses deliver the most helpful forms of emotional support. They always guide patients through a productive and therapeutic conversational process while under their care. When patients verbalize their sentiments, nurses must be there at their bedsides and make an effort to listen with an open heart and an awareness of all of the patient's sensations. A terminally sick patient will frequently make an effort to conceal the fact that they require constant guidance, both from their loved ones and from anybody else, with their primary care physician being the person they try to keep this secret from the most. The nurses are there to offer patients assistance that, in some way, will make their suffering a little bit easier to bear. To provide patients with information concerning terminal diseases, nurses frequently jeopardize their safety. When it comes to educating patients about their current health conditions, nurses perform a significant role as educators, similar to the role teachers' play with children. Patients are instructed in various self-care practices that will enable them to assume responsibility for their health and wellbeing. Since the entirety of a nurse's shift is devoted to ensuring the wellbeing and security of all patients, this profession is commonly acknowledged as the primary caregiver role. The moment a patient yells out in pain, the nurse immediately rushes to provide relief in any feasible way. If a patient is incapable or unable to confide in a family member, the nurse may be the recipient of the patient's most profound thoughts and feelings. Because of this, it is the nurse's job to fulfill every patient request. These days, regardless of the time of day or night, individuals are more likely to seek emergency care from a nurse because nurses are often located closer to their homes than other medical professionals. The day-to-day assessments of patients, the administration of medications, the creation of chart-based orders, and the discharge of patients are their key responsibilities. In a medical emergency, nurses are typically the first to arrive to the scene to attempt to preserve a patient's life. Being a nurse is a lot like being a mother; both moms and nurses desire the most significant possible outcomes for the patients in their care. Every nurse who works in palliative care needs to be able to communicate with patients and the people closest to them in a way that benefits all parties concerned.

Patients who require palliative care services typically want answers to their questions about their condition, treatment options, and prognosis that non-medical professionals easily understand. As a result, nurses who work in this field must be able to explain even the most complex ideas in a manner that is easy to understand. It is essential for nurses who specialize in palliative care to have the ability to share their knowledge with patients and family members of those patients. Nursing practice includes having in-depth conversations with patients and their families about the various alternatives for end-of-life care, including the administration of medications. During the active dying phase, the nurse's role is to support the patient and family by educating them on what to expect during this time, honestly answering their questions and concerns, being an active listener, and providing emotional support and guidance.

Palliative care nurses can provide specialized guidance to patients in the privacy and convenience of their own homes. Care provided to patients at the end of their lives, the management of symptoms, and the coordination of care are all examples of such activities. Instances in which patients would

benefit from receiving palliative care in the comfort of their own homes include those in which patients would benefit from longer, more intensive, or more frequent visits; instances in which patients would benefit from travelling to and from an outpatient facility would be too taxing; instances in which there is no readily available outpatient palliative care practice; and instances in which there is no outpatient palliative care practice. For health assessment, education, consultation, and remote examination or procedure, telemedicine, also known as telehealth, is a rapidly growing area of clinical medicine that involves the transmission of medical information over long distances using electronic media such as the telephone, the Internet, video, and other networks. Within the telemedicine field, interactions can occur either in a clinic or in a patient's home. Because nurses make such substantial contributions to the field of palliative care, the available data suggests that they should be employed either as members of palliative care consulting teams or as independent practitioners. Whether they are doing a restricted or broad set of activities, nurses can play a key role in addressing various needs that patients and their families suffering with cancer have. Nurses can meet these needs in a variety of ways. It is of the utmost significance that evidence supporting independent practice be readily available in settings with limited resources, such as those in which nurses may play a key role in monitoring community health and the work of lay workers or volunteers.

CONCLUSION

Nurses must arm themselves with expert knowledge of symptom control and be well aware of ethical issues related to palliative care to help cope with these high demands and continue to maintain the delicate balance between what patients want and what health professionals believe the patient needs. Nurses must also maintain open and active communication with their peers and other facility members. To conclude, role of nurse in palliative care is very complex and unique and is an integral part of multidisciplinary care.

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Case Report

Community and Public Health Nursing
Vol. 7 No. 3, September - December 2022
DOI: http://dx.doi.org/10.21088/cphn.2455.8621.7322.8

Case Report on Kawasaki Disease

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How to cite this article:
Switi A Besekar, Prachi Falke/Case Report: Kawasaki Disease/Community and Public Health Nursing;2022;7(3):133–136.

Abstract

Kawasaki disease (KD), also known as Kawasaki syndrome, is an acute febrile illness of unknown cause that primarily affects children younger than 5 years of age. The symptoms of Kawasaki disease are similar to those of an infection, so bacteria or a virus may be responsible. But so far a bacterial or viral cause hasn't been identified. As Kawasaki disease isn't contagious, it can't be passed from one person to another. ***Aim:*** 1. To know general idea about the condition of the disease. ***Objective: 1.*** Exploring knowledge of pharmacology, management of medicine and nursing. ***Result:*** Patient was discharge and he has to come for follow up after 15 days. Conclusion: Kawasaki disease can affect children and teenagers of all racial and ethnic backgrounds. In most cases, children will recover within a few days of treatment without any serious problems. Recurrences are uncommon. If left untreated, Kawasaki disease can lead to serious heart disease. Kawasaki disease has a positive outcome when diagnosed and treated early.

Keywords: Kawasaki disease; Immunoglobulin therapy; Febrile illness.

INTRODUCTION

Because Kawasaki disease also known as Kawasaki syndrome, is an acute febrile illness of unknown cause that primarily affects children younger than 5 years of age. The disease was first described in Japan by Tomisaku Kawasaki in 1967, and the first cases outside of Japan were reported in Hawaii in 1976. The symptoms of Kawasaki disease are similar to those of an infection, so bacteria or a virus may be responsible. But so far a bacterial or viral cause hasn't been identified. As Kawasaki disease isn't contagious, it can't be passed from one person to another. The Kawasaki Disease Foundation estimates that Kawasaki disease affects more than 4,200 children in the United States each year. Kawasaki disease is also more common in boys than in girls and in children of Asian and Pacific Island descent. However, Kawasaki disease can affect children and teenagers of all racial and ethnic backgrounds. In most cases, children will recover within a few days of treatment without any serious problems. Recurrences are uncommon. If left untreated, Kawasaki disease can lead to serious heart disease. Read on to learn more about Kawasaki disease and how to treat this condition. Kawasaki disease occurs in stages with tell tale symptoms and signs. The condition tends to appear during late winter and spring. In some Asian countries, cases of Kawasaki disease peak during the middle of summer Kawasaki disease is a disease that causes inflammation in your body, mainly the blood vessels and lymph nodes. It mainly affects children under the age of 5, but anyone can contract Kawasaki Disease. The symptoms are similar to a fever, but they show up in two distinct stages. A persistent, high fever that lasts for more than five

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Received on: 20.05.2022 **Accepted on:** 12.07.2022