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Editorial Comment



Andy Anso
(Executive Editor)

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ASSESSING THE IMPACT OF HERBAL MEDICINAL PRODUCTS RESEARCH OUTCOMES IN NIGERIA (A DILEMMA OF UNIVERSITIES SOCIAL RESPONSIBILITY AND PUBLIC BUREAUCRACY)

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Abstract

This study tried to assess the impact of herbal medicinal products (HMP) on research outcomes on health of the people and to know factors hindering or enhancing fulfillment of Universities social responsibility in this regard.

The study settings are hospitals and research centers in Nigeria. Through stratified sampling method, three were selected out of the six geo-political zones in Nigeria and these are: South West, South South and North West. Also, through multistage sampling method, nine health care institutions, and three universities were chosen in the three geopolitical zones. The populations of the study are mainly Pharmacists working in secondary and tertiary health care centres. In addition, Pharmacy lecturers conducting research in HMP in the three Universities were part of the study population.

The study is non-experimental and it employed descriptive research design to describe data. The total sample size is 600 respondents. Quantitative data was obtained from the total sample while qualitative data, gotten through in-depth interview and key informants' methods, was obtained from a total of 57 qualitative respondents drawn from the total sample. The survey employed 30 in-depth interviews and 27 key informants' methods in collection of qualitative data. These were divided into 10 in-depth interviews and 9 key informants' methods per each zone. Also quantitative data were collected using 600 structured questionnaires, 200 per zone, served to the pharmacists selected in the study centres. Purposive sampling method was utilized to select samples in each study centre. Responses from these two methods constituted the raw data processed and analyzed. The three instruments employed in collection of primary data include: in-depth interview, key informant interview and quantitative (structured questionnaire). The key informant interviews and in-depth interviews were analyzed through content analysis and ethnographic summary. This involved verbatim quoting of respondents to buttress certain arguments rose in the course of the study. Content analysis involves critical evaluation of the respondent's position on any issue.

Results showed that the perception of health care workers, policy makers and researchers about HMPs are positive and favourable. The acceptability in the respondents is over 90%. The major problem observed in the work is communication problem. The available information cannot be adequately utilized because of communication gap, bureaucracy, undue formalities as a result of civil/public service gazette and hierarchical settings. It was discovered that lack of government attention regarding funding and suspicious were the bane to effective collaboration. It was suggested that the concept of effective communication and information dissemination should be stressed among the populace to showcase the effectiveness of HMPs in treatment of ailments.

Introduction

During the last decade, use of traditional medicine has expanded globally and has gained popularity. It has not only continued to be used for primary health care of the poor in developing countries, but has also been used in countries where conventional medicine is predominant in the national health care system. With the tremendous expansion in

the use of traditional medicine worldwide, safety and efficacy as well as quality control of Herbal Medicines and traditional procedure-based therapies have become important concerns for both health authorities and the public (WHO 2000). According to Iwu (1993), medicine is one of the oldest arts in the world. Society is sustained by medicine because it is the means of

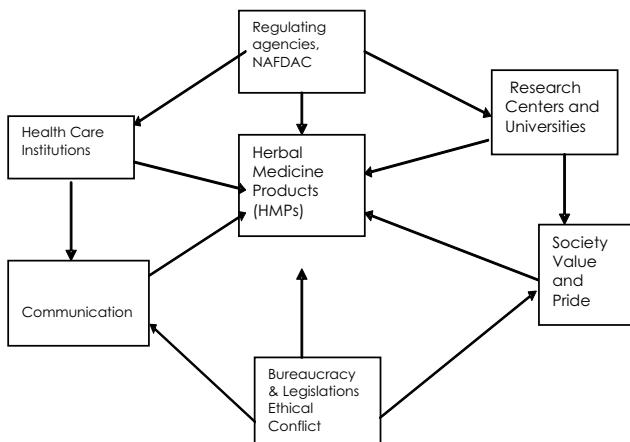
improving the health status and quality of life. There is no society without its own art of healing. But the ecological and sociocultural environments as well as historical antecedents of the people determine the type and method of healing in every society. Thus, there are varied health systems all over the world. The only common denominator among them all is "healing". The opinion of Iwu (1993) was collaborated by the view of WHO (2000) on Traditional Medicine as an ancient medical practice that existed in human societies before the application of modern science to health. It has evolved to reflect different philosophical backgrounds and cultural origins. This includes diagnosis, prevention and treatment.

Traditional Medicine can be defined thus as the knowledge skills and practices of holistic health care, recognized and accepted for its role in the maintenance of health and the treatment of diseases. It is based on indigenous theories, beliefs and experiences that are handed down from generation to generation either explicable or non-explicable, without any documented evidence of adverse effects (Elujoba, 2005). The practitioners of Traditional Medicine are described as a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods (Elujoba, 2003); serving as the nurse, pharmacist and physician at the same time. They have many specialists like herbalists, bonesetters, traditional psychiatrist, traditional pediatricians, and general practitioners. They are certainly more readily available, accessible and approachable than the orthodox physicians while their services are sometimes more affordable than modern medical facilities (Elujoba, 2005 and WHO, 2000). Also, Parfitt (1978) found out that Traditional Medicine was originally instrumental to early Pharmaceutical drug discovery and industry. Sofowora (1993a) reported that by the early nineties screening work on African Medicinal plants has advanced with publications arising from the following research areas: antimicrobial (16%); Molluscicidal (11%); antimalarial (7%) toxicology (7%); antitumor-related studies (4% and others 54%). In spite of Government lackadaisical attitude to herbal medicine (HM) in Nigeria some individuals and corporate bodies, such as Iris Medical Foundation, have registered their products for exportation to America, South Africa, Ghana and Indonesia, and the economic benefits gained include low cost cures in health delivery (Inyang, 2004 and Moses, 2004).

In spite of the existence and continual use of herbal medicinal products (HMP) for over many centuries and its popularity and extensive use during the last two decades, HMP have not been sufficiently given its right place in some countries including Nigeria. Consequently, education, training and research in this area have not been accorded due attention and support deserved. The quantity and quality of the safety and efficacy data on HMP are far from sufficient to meet the criteria needed to support its use worldwide. One of the university's social responsibilities is to solve the problems of the world through

conduction of research, its publication and application of research findings. The university in African is yet to fulfill adequately this important aspect of its existence (Ayensu, 1978). University research findings in HMP are not adequate and this is affecting their acceptability among the populace. This is significant because the lacuna (gap of knowledge) need to be investigated so as to get the desirable benefits from HMP. Therefore, aims of the study are to assess the impacts of HMP research outcomes on health of the people and to know factors hindering or enhancing fulfillment of Universities social responsibility in this regard.

CONCEPTUAL FRAMEWORK ON HERBAL MEDICINE PRODUCTS (HMPs)



OLUYEDUN H.A, 2010

Methods

The study settings are hospitals and research centers in Nigeria. Through stratified sampling method, three were selected out of the six geo-political zones in Nigeria and these are: South West, South South and North West. Also, through multistage sampling method, nine health care institutions, and three universities were chosen in the three geo-political zones. The three geo-political zones in Nigeria constitute mainly the Yoruba speaking people in the South West of the country, the Minorities in the South - South and the Hausas in the North West. In each zone, the following settings were chosen: one teaching hospital, two state hospitals and one university faculty of pharmacy. The populations of the study are mainly Pharmacists working in secondary and tertiary health care centres. In addition, Pharmacy lecturers conducting research in HMP in the three Universities were part of the study population.

The study is non-experimental and it employed descriptive research design to describe data. The total sample size is 600 respondents. Quantitative data was obtained from the total sample while qualitative data, gotten through in-depth interview and key informants' methods, was obtained from a total of 57 qualitative respondents drawn from the total sample. The survey employed 30 in-depth interviews and 27 key informants' methods in collection of qualitative data. These were divided into 10 in-depth interviews and 9

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The key informant interviews and in-depth interviews were analyzed through content analysis and ethnographic summary. This involved verbatim quoting of respondents to buttress certain arguments rose in the course of the study. Content analysis involves critical evaluation of the respondent's position on any issue.

Results

Responses On Questionnaire

The demographic factor showed that 100 (16.7%) of the respondents had the 11-15 year length of service, 180 (30%) had 1-5 year and 135 (23%) had 6-10 year while only 35 (5.7%) respondents had >20 year of service. The results showed that 94.7% of the respondents believed in the efficacy of herbal medical products while 5.3% were of the opinion that of HMPS is not effective. See Table 1

Table 1: Respondents' perception on HMPS efficacy.

Variable	South West	South South	North West	Total	%
Yes	190	186	192	548	94.7
No	10	14	8	32	5.3
Total	200	200	200	600	100

It was also shown that there was no official collaboration between the health facilities and research centres on HMP as 98% respondents agreed to this; only 2% believed there is unofficial (personal) interaction between them on researches on HMP. The results revealed the level of collaboration between the health care institution and research centers. A total of 98% believed that there was no collaboration between secondary health care institutions and research centers on HMPs, while only 2% believed there was collaboration. Also, 80% of the respondents believed that information about HMPS from Research center to health facilities was not adequate while only 20% believed that there was adequate information sharing between them.

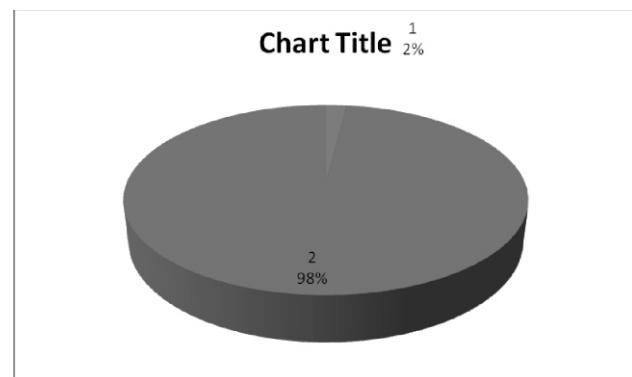
Table 2: Source of Information on HMPS from Research center.

Source	SW	SS	NW	Total	%
Journals	6	4	2	12	2
Bulletin	6	4	2	12	2
Conference	6	6	10	24	4
Training of professionals	162	160	158	480	80
Internet	24	18	18	60	10
Others	5	5	2	12	2
Total	200	200	200	600	100

The table showed that 80% received information on HMPS from Training and continuous education organized by pharmacy council of Nigeria (Mandatory Continuous Programme Development on Education) and west African Postgraduate college of Pharmacists. Internet is another major source of information.

The results also showed that HMPS, as observed by the respondents, contributed less than 2% to concept of pharmaceutical care in the health facilities. See figure 1

Figure 1



On the availability of HMPs in health facilities, the results showed that only 5% of the respondents testified to availability of HMPS in their facilities, the rest 95% believed HMPs were not available in their health care institution. Comparing imported and locally prepared HMPS in the facilities, the respondent asserted that over 90% of HMPs were mainly imported. The results further showed that 80% of respondents believed that Universities and Research center met their social responsibility in terms of work on HMPs. Majority of the respondents (93.3%) also believed that bureaucracy on the part of government affected the availability of HMPs and 89.3% believed that undue and unnecessary NAFDAC's stress unleash on HMPs dealers was affecting their availability Nigerian's health facilities.

Perception Of Health Care Personnel On HMPs

Most of the respondents, in key - informants interviews, revealed that herbal medicinal products were real and efficacious. In fact, one of the respondents had this to say;

"In short, there is faith in HMPS treatment regimen and motivation to continue the usage is high by our clients / patients but this is not guarantee by law."

A respondent have this to say about his client that is receiving HMPS for diabetic.

"The sugar levels of three known diabetic patients are already stable and they are purely on HMPs gotten from a research centre."

All the respondents have overwhelming believed that HMPS is efficacious. This was buttressed by a respondent that say;

"HMPs are quite effective, though we have not done any clinical trials here, we based our confidence

in NAFDAC labeling and laboratory test done abroad as our assurance"

The beliefs in efficacy of HMPs are very vital to acceptability. This is affirmed in the works of Daziel (1973), Koh H-L and Woo S-O.(2000).

Level Of Collaborations And Communications Between The Health Care Institutions & Research Centres

Fiske (1990) defines communication as one of those human activities that everyone recognizes but a few can define, while Hybels and weaver 11 (2001) define it as any process in which people share information, ideas and feelings. Communication functions as a tools to facilitate understanding and insight, enhances establishment of meaningful relationships and a tool of influence and persuasion.

A respondent who is a researcher had this to say;

"We researchers need to do more on information dissemination and bridging communication gap. Our research outcomes need to be disseminated to the right channels and institutions"

Another in-depth interviewed respondent said;

"I think there is collaboration with the Teaching Hospitals but we need to do more in the secondary and primary Health care institutions and the grass roots. Our work needs to be communicated to health care institution"

These views were supported by one respondent interviewed in the South West:

"The HMPS prepared in our laboratory locally had been documented through University Special Research project and at least four HMPS are well acclaimed but communication gap between University authority and Researchers on one side and Researchers and Health institutions on the other hand still persist. Assessing the impacts of NAFDAC policy"

WHO (2000), General guidelines for methodologies on research and evaluation of traditional medicine gave a guidelines for the assessment of Herbal Medicines, research guidelines for evaluating the safety and efficacy of Herbal Medicines, the guideline focus on the current major debates on safety and efficacy of traditional medicine, and are intended to raise and answer some challenging questions concerning the evidence base. The guidelines present national guideline using WHO QOL user manual.

An interview with Pharmacovigilance and Regulating Agent is reported thus:

"We follow WHO QOL user manual with local modification to license HMP. After toxicity, test we give a renewable license for 2 years for HMPS. We in laboratory and Pharmacovigilance believed 2 years is enough to observed and record any adverse drugs reactions (ADRs) of any HMPs"

In another in-depth interview, the following statement was revealed about fear of NAFDAC.

"If people are doing the right thing at the right time, they do not need to fear NAFDAC. The agency is there to regulate and control good manufacturing

practices and enforce compliance"

One in-depth interviewee in discussion on NAFDAC has this to say.

"We do not punish or reward anyhow but we organized seminar based on available funding for training. Right now, there are 3 seminars on HMPS going on in the 6 geo-political zones in Nigeria."

Social Responsibility Researchers

A respondent explained that:

"The efficacy and potency of HMPS is never in doubt but the politicking and supremacy tussle couple with right of potency is the major set back for knowledge advancement in HMPS. To meet the social responsibility to the society we need inter and intra disciplinary approach and inter ministerial joint actions."

The above view is collaborated in the work of Madu (2006) titled "the sense and the nonsense of traditional medicine in Africa". Moody reported that two ethno medically important plants (*Terminalia catappa L* and *cissus polypulnea L*) among others, have been shown for the first time by work in collaboration with University college Hospital, Ibadan to possess anti-sickling activities.

A respondent from in-depth interview reported that;

"Many seminars, advocacy and show-care of HMPS had been held and more will still be held. The political will of the Government and hard posture of Health care practitioners are the major hindrance to effective used of HMPS. Nevertheless, the researcher should not be crucified for not meeting social responsibility."

Effects Of Bureaucracy

A key informant interview said:

"The public and civil servants in which the Health care institution in the three tiers of Government belongs to are bounded left and right by Bureaucracy."

A bureaucracy traditionally does not create policy but, rather, enacts of law policy, and regulation normally originates from a leadership, which creates the bureaucracy to implement. The bureaucracy may be self-serving and corrupt, rather than serving society. Indeed, the cynical Parkinson's law suggests that bureaucracies grow in-depth of their function. Au HM (2000) buttressed this by saying: "the slowness, ponderousness, routine, complication of procedures and the maladapted responses of the bureau critic organization to the needs which they should satisfy". Other key informant interview said.

"If bureaucracy is not there, there is compelling need to revert to the use of HMPS in our Health care system to address the emerging ADRS and toxicities of the orthodox medicine. Bureaucracy is a big factor hindering collaboration between researchers, policy makers and implementations."

Au HM (2000) said that the relationships between the legislatures, the interest groups, bureaucrats and the general public have an effect on each other. Without one of the pieces, the entire

structure would completely change.

Pharmaceutical Care & HMPs

A respondent reported that:

"The product of our research work like Niprisan® with active ingredients NICOSAN is accepted worldwide for sickle cell patients and also catharanthus roseus G. Don (Rose periwinkle) is reputed in Herbal Medicine for the treatment of diabetes, but recent work by Eli-Lilly scientists showed that it is good for the treatment of acute child blood leukemia (vincristine), Hodgkin's disease (vinblecne)."

The above statement is supported by the work of Clark (1996). Also, in Nigeria Rauwolfia serpentina (Apocynaceae) is renowned for treating snake bites and Rauwolfia vomitoria (ewe Asofeyeje in Yoruba Language) is well known as anti hypertensive drugs. Evans (2009).

Conclusion

The WHO projects that the global market of herbal-products would be worth 5 trillion USD by the year 2050 (Moody, 2010). The sad aspect is that in Africa, where year 2000 - 2010 was declared a decade of Traditional Medicine, with emphasis on HMPs, the scientists and clinicians are still skeptical because of the lack of evidence of safety and efficacy and have not derive worthwhile economic benefit from HMPs. Nigeria particularly neglects this important natural health care gift heritage to her own disadvantage.

The perception of health care workers, policy makers and researchers about HMPs are positive and favourable. The acceptability in the respondents is over 90%. The major problem observed in the work is communication problem. The available information cannot be adequately utilized because of communication gap bureaucracy, undue formalities as a result of civil/public service gazette and hierarchical settings. It was discovered that lack of government attention regarding funding and suspicious were the bane to effective collaboration.

The time has come for a more proactive and holistic approach in facing the factors hindering the acceptability and accessibility of HMPs research outcomes in Nigeria. The criticism, condemnation and complaining should give room for genuine interest for effective health service delivery through HMPs. To achieve this, the concept of effective communication and information dissemination cannot be over emphasized. Obviously, there are challenging areas like issue of clinical trials, adverse drug reactions and seasonal variation in the herbal harvest. Nevertheless, for many people in the three regions, which served as the study location, HMPs is still accessible, affordable and culturally acceptable.

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HEALTH IMPLICATIONS OF CHILD LABOUR IN CALABAR SOUTH LOCAL GOVERNMENT AREA, CROSS RIVER STATE

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Abstract

The core years in the life of any child are between the ages of ten and eighteen. This is when a tremendous amount of growth and development take place physically, mentally, and psychologically. Yet, in the lives of many children of poor families these developments do not happen due to their being forced into work force as child labourers. They are thus deprived of proper education and participation in normal child hood activities with friends and age mates. This study on health implications of child labour was carried out in Calabar south local government Area, using a self-administered questionnaire and focus group discussion. Four hundred (400) child workers between the ages of 10-18 years were identified and interviewed using a multistage sampling technique in shops, motor-parks, mechanic workshops and some market places in the area covered in the study. Information sought included socio- demographic characteristics of the child workers and their parents, their working conditions and environment as well as work exposure and health hazards. Data was analyzed using descriptive statistics and chi-square. Results showed that 64.5% were males, while 35.5% were females making amale female ratio of 2:1. It was observed that 89% of the children lived with their parents. The group most involved in child labor was found to be children between the ages of 10-14years [45.5%]. Child labour was mostly found among hawkers [52.5%] and at least mechanic apprentices [1.3%]. The most reported health problems reported by these children were exhaustion, headache, backache, muscle pains, constituting 17.3%, and the rest was typhoid fever [4.3%]. Among social health hazards pilfering ranked highest constituting 75.5%, rape [8.3%] and the least was occupational accidents with 7.0%. It was concluded that child labour exposes the children to exploitative working conditions where there are numerous risks, hazards and other negative influences. However, it is believed that with the implementation of reforms and polices such as the National Economic Empowerment and Development Strategy [NEEDS], Universal Basics Education [UBE] programme by governments at all levels, a coordinator approach to solving the problem of child labour would have been brought to bear in Calabar South L.G.A. Lastly, the child right act of [2003] which includes rights to education, should be enforced for the benefit of these groups of children.

Introduction

The development of every nation is achieved by a good and sound preparation and education of the youth for responsible and productive life. This great goal can only be achieved if this segment of the population is cared for early; guided and properly trained for such attainment. But, there are many obstacles that affect the effective growth of these children, amongst which child labour is the foremost .It endangers their lives, deterring physical, psychological and emotional development.

Worldwide, child labour remains a widespread and growing phenomenon. In 1959, the General Assembly of the United Nations issued "The Declaration of the Rights of the child" in which it stressed the right of the child to enjoy special protection from neglect, cruelty and exploitation. On the subject of employment of children in various occupations the

Declaration stated "the child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused to engage in any occupation or employment which would prejudice his health or education or interfere with his physical, mental or moral development" (UNICEF, 1991). Prior to this time in 1989, the convention on the right of the child made this declaration. Already, few countries and/or communities have reached a stage of development that no longer requires an economic contribution from children. Child labour today is used to denote the act of employing minors, especially in works that may interfere with their education or endanger their health.

The International Labour Organization (ILO) (1991) defined child labour as children's work which is of such a nature or intensity that is detrimental to their schooling or harmful to their health and development. In other words, those children are denied the basic right

to education and compelled to work under difficult conditions harmful to their physical and mental growth.

According to the ILO (1991), the estimated population of children workers is about 18% of all children aged 10-14 years in developing countries. Forastri (1992) indicated that studies done in developing countries have shown that economic instability, poverty and unemployment, rural to urban immigration and a rising cost of living have increased the incidence of child labour.

According to WHO (1987), children differ physiologically and anatomically and psychologically from adults and these differences make them more vulnerable to occupational hazards. Sequele and Boyden (1988) observed that for many children, work is an ordeal, a source of suffering that is characterized by long hours, heavy workloads, poor remuneration and exposure to toxic and physically injurious agents and processes. Many of these children are deprived of adequate nutrition, education and health care, which all result in poor physical development, social exhaustion and abuse, occasional psychological trauma. They are sometimes treated like slaves, and are exposed to drugs, violence, rough life and sexual exploitation.

In Nigeria, poverty and rural -urban migration are on the increase. An unstable educational system has made the situation worse by increasing the number of children idle or in the labour market, as a result of industrial strike actions. Child labour is common in farming sector, motor repair workshops, soap making factories, sales shop. Children are used as domestic servants, baby sitters, beggar's assistants, hotel boys and girls and street hawkers, just to mention a few (Okeahialam, 1984; Obikeze, 1986, and Asogwa, 1986). Theoretically, an apprenticeship system for children exists in Nigeria, whereby children supposedly receive training for a stipulated period in a particular vocation. While many of these children consider themselves in training, they are really working (Sequele and Boyden, 1988).

Working children, like adults, need information and training to develop their skills and be aware of hazard in the work place. It is doubtful whether they receive this training (Salazar, 1988; Forastisri, 1992). According to Bequele and Boyden (1988), some children however work part-time while schooling. Long hours of work while attending school can have negative consequences on the health and performance of the child in school.

In combating child labour, it is necessary therefore-to consider carefully its various forms, making a distinction between work and exploitation, and analyzing the developmental and cultural contexts. It is worth noting that Canada, for example, has not signed the ILO minimum Age Convention (Atoyebi, 1998).

The Nigerian Labour Act establishes 12 years as the minimum age for employment and apprenticeship, except in the case of light agricultural or domestic work performed for the family. It also prohibits children below 12 years from lifting or carrying any load likely to cause physical injury t and establishes a minimum age of 15 years for industrial work and

employment aboard a vessel. In addition, children under 16 years may not work underground; on machine at night or for more than four consecutive hours. Forced labour is also prohibited by the Labour Act and the Nigerian Constitution.

Today, it is expected that with the high level of development, child labour would gradually decrease with the hope of eradicating child exploitation .A massive reduction of child labour can only be achieved through political commitment, with specific policies and developmental programmes. Though there is restriction on child labour, in most nations, many children do work. Their vulnerable state leaves them prone to exploitation. According to Sequele and Boyden (1988), the international labour office reported that children work the longest hour and are the worst paid of all labourers.

Statement of the Problem

Child labour is one of the fast emerging social problems in Nigeria and the world as a whole. Due to poor economic condition, poor education and breakdown of traditional values in the country, children are forced to engage in one form of labour or the other ranging from street trading to all sorts of menial jobs to supplement income at home. According to ILO (2003)' the number of children aged 5 to 14 years working worldwide is estimated at 250 million; nearly half, about 120 million are working full time and 70% are doing work that is hazardous and exploitative. Sixty one percent (61% are in Asia, 32% in Africa, 7% in Latin America. Developing countries have the highest (200 million) between 5 and 14 years (ILO, 2003).

Child labour in Asia and Africa together accounts for more than 90% of total child employment. Nigeria has about 12 million child workers. (Omowole, 2006). There were 1.7 million unpaid agricultural workers in rural Anambra State; 289,000 (17.6%) were children below 15 years of age. (Oloko, 1998). Children between 10 - 14 years represented 690/0 of these 289,000 workers (Oloko, 1998).

It is in recognition of these universal and multi-dimensional problems associated with child labour that the International Labour Organization adopted Convention 182 and Recommendation 190 in 1999 (ILO, 2003) on the elimination of the worst forms of child labour which Nigeria ratified in 2000 (ILO,2001). A memorandum of Understanding was also signed between Federal Ministry of Labour and Productivity and ILO on 8th August, 2000 on ways to eliminate child labour.

In spite of these laws, children are still seen on the streets of Calabar South Local Government Area selling during school hours; some are staying late waiting for their wares to be exhausted before going home. Around the beach some children below the ages of 18 years are selling fresh fish with parents instead of being in school. Some are carrying and splitting wood at the bay side. Some are selling beef at the abattoir. Some are also seen carrying heavy basin of pure water which may be too heavy for them physically. Some others serve as domestic servants. It is thus necessary to investigate the socio-economic level

of parents and health hazards these children are exposed to in course of working.

Purpose of the Study

The purpose of the study was to determine the health implications of child labour in Calabar South Local Government Area of Cross River State, Nigeria.

Specific Objectives

- 1) To identify cause and type of child labour prevalent in Calabar South Local Government Area
- 2) Identify the age group of children mostly involved in child labour in Calabar South Local Government Area
- 3) Identify the consequences of child labour in Calabar South Local Government Area
- 4) To determine the health problems/hazards commonly faced by children in Calabar South Local Government Area

Significance of the Study

A thorough study of the health implications of child labour in Calabar South Local Government Area would be important for the following reasons:

The results of the study revealed the immediate and remote social motivation of perpetuating child labour. The outcome of the study will sensitize and educate parents and guardians on the degree to which even domestic work could be equivalent to child labour.

The results will draw government's attention to the need to reinforce laws on child labour and at the same time design alternative means of livelihood for idle or unemployed children (street children mainly).

Finally, the study will reemphasize the value of life and the importance of protecting children and by extension, securing a good foundation for responsible and healthy citizens who will develop the nation. As an original study in Calabar South, it will pave the way for more extensive ones in the future.

Research questions 1

- 1) What kinds of practices can be considered as child labour in Calabar South LGA?
- 2) What types of child labour were most prevalent in Calabar South?
- 3) What age-group of children was mostly involved in child labour in Calabar South LGA?
- 4) What were the health problems commonly faced by children engaged in child labour?

Limitations of the study

One major factor that adversely affects the result of this study was the unwillingness of children to cooperate especially with strangers. Some were shy or hostile. Similarly, the aggressive nature of some parents or guardians hindered the smooth investigative process. Natural phenomenon such as the rain also constituted an obstacle for meeting with the children. Another factor was the observer error as the researcher could underrate the maturity and honesty of the children in answering questions.

Study Setting

Calabar South Local Government Area (CSLGA) is located in the southern part of the former Calabar Municipality. The Local Government Area is bounded in the North by Calabar Municipality Local Government Area, in the East by the Great Qua River and in the West by the Calabar River. The landmass of the area is about 80,000 square kilometers. According to the National Population Commission (2006), the population of Calabar South Local Government Area is estimated at about 191,231.

There are 12 geopolitical wards in the Local Government Area and the major ethnic groups in the area are the Efuts and the Efiks. Other tribes include the Ibibios, Annangs, Bekwara, Ejaghama and Ibos. Indigenous from other neighbouring Local Government Areas are also found there.

In the wharf area, children are found selling and drinking "combine" (mixture of illicit gin and Indian hemp) while their friends sell cow beef alongside their parents at the abattoir. The major occupations of adults in the area are farming, trading and fishing. This justifies the presence in the area of the two most populous markets; Mbukpa and Watt Market.

Literature Review

Study Design

The study design was a cross sectional survey using a questionnaire to elicit information on child labour. This numerical data was complemented with Focus Group Discussion (FGD).

Scope of the Study

The study was limited to Calabar South Local Government Area alone and not extended beyond its areas. It was carried out on children below 18 years who were found working in places that require older workers than them or children involved in risky labour that exposed them to physical, health or social hazards.

Population of Study

The population of study was made up of children aged below 18 years and who were involved in one form of work or the other that was either too tasking for their age or exposes them to risks that are unhealthy for them (for economic purpose). They were mostly hawkers in the parks, markets, domestic servants, those learning mechanic works, shops and factories.

Sample and Sampling Technique

The sample of the study consisted of 400 children who were selected using a multi-stage sampling to get five wards out of the 12 wards in Calabar South Local Government Area.

Method of Data Collection

Questionnaires were used to collect data and a Focus Group Discussion (FGD). The questionnaire comprised of thirty-three items grouped under three sections namely; the socio-demographic characteristics of children and their parents; working

conditions and environment, and finally, work exposure and health hazards. This instrument was administered to the respondents (i.e. the children) on a face-to-face basis and completed on the spot. All filled copies of the questionnaire were returned immediately and taken for analysis.

Method of Data Analysis

The data collected through the questionnaire were shown in Tables and percentages were calculated. Focus Group Discussion was analysed in matrices, and the hypothesis was tested using chi-square statistic (χ^2).

Ethical Consideration

Approval for the study was given by the Department of Public Health. Approval was also obtained from the Chairman of Calabar South Local Government Area while informed consent was obtained from each of the children and their parents.

Results

Table 1 presents the types of jobs considered as child labour. Hawking on the streets and motor parks constitutes a major form of child labour, males 128 (31.8%), females 82 (20.3%).

Table 1: Types of work that Constituted Child Labour by the respondents (N = 400)

Types of work	Gender Male (%)	Female (%)	Total
Hawking	128 (31.8)	82 (20.3)	210 (52.5)
House help	69 (17.3)	31 (7.8)	100 (25)
Sales assistant	29 (7.3)	24 (6.1)	53 (13.4)
Craftsman	13 (3.3)	7 (1.8)	20 (5.0)
Factory worker	14 (3.5)	5 (1.3)	19 (4.8)
Mechanic	5 (1.3)	-	5 (1.3)
Total	258 (64.5)	142 (35.5)	400 (100)

Table 2 shows the age group and gender of children involved in child labour in Calabar South Local Government Area. Majority of the children involved in child labour (45.5%) were aged between 10-14 years. Overall male children (64.5%) were more involved than females (35.5%).

Table 2: Age group and gender of children involved in child labour in calabar south local government area (N = 400)

Age group (Years)	Gender Male (%)	Female (%)	Total
< 10	54 (13.5)	18 (4.5)	72 (18)
10 – 14	90 (22.5)	92 (23)	182 (45.5)
15 -18	114 (28.5)	32 (8)	146 (36.5)
Total	258 (64.5)	142 (35.5)	400 (100)

Table 3 shows the inability of parents to pay school fees and send their children to school; with a frequency of 268 out of 400 representing 67% as the most prevalent reason for getting involved in child labour.

Table 3: Reasons Proffered For Involvement In Child Labor By Gender In Calabar South (N = 400)

Reasons for participation	Gender Male (%)	Female (%)	Total
Inability of parents to send them to school	182 (45.3)	87 (21.6)	269 (67)
Voluntary decision by children	41 (10.3)	32 (8)	73 (18.3)
Did not have a working opportunity	35 (8.8)	22 (5.5)	57 (14.3)
No reason	1 (0.3)	1 (0.3)	2 (0.5)
Total	258 (64.5)	142 (35.5)	400 (100)

The information in table 9 shows that 45% of children are aware of physical hazard while 1.2% of children are aware of biological hazard.

Table 4: Categories Of Hazards/Risks To Which Children Are Exposed As A Result Of Child Labour (N = 400)

Types of risk	Gender Male (%)	Female (%)	Total
Physical hazard (shock, burn)	123 (31.3)	54 (13.7)	177 (45)
Mechanical hazard (sharp objects)	76 (19.3)	38 (9.7)	114 (29)
Psychological (stress, frustration)	7 (1.8)	5 (1.3)	12 (3.1)
Biological hazard (bacterial, viruses)	5 (1.3)	2 (0.5)	7 (1.8)
Total	252 (64.1)	141 (35.9)	400 (100)

Table 11 shows that children involved in child labour mostly have backache, muscle ache, headache (17.3%), fever (17%), malaria (16.3%), minor injuries e.g. wounds (14.5%), respiratory conditions (9.8%), diarrhea (8.5%), rashes (7.8%), eye conditions like conjunctivitis (4.8%) and typhoid (4.3%).

Table 5: Health Problems/Complaints Of Children Engaged In Child Labour By Gender (N = 400)

Health problem (sickness)	Gender Male (%)	Female (%)	Total
Exhaustion/headache/backache/muscle ache	55 (13.8)	14 (3.5)	69 (17.3)
Fever	38 (9.5)	30 (7.5)	68 (17)
Malaria	45 (11.3)	20 (5)	65 (16.3)
Minor injuries e.g. cuts, wounds and bruises	24 (6)	34 (8.5)	58 (14.5)
Respiratory conditions e.g. cold/catarrh/cough	22 (5.5)	17 (4.3)	39 (9.8)
Diarrhea	29 (7.3)	5 (1.3)	34 (8.5)
Rashes	25 (6.3)	6 (1.5)	31 (7.8)
Eye conditions e.g. conjunctivitis	13 (3.3)	6 (1.5)	19 (4.8)
Typhoid	7 (1.8)	10 (2.5)	17 (4.3)
Total	258 (64.5)	142 (35.5)	400 (100)

Discussion

The International Labour Standard permits children between the ages of 13-15 years to do light work and prohibits hazardous employment for young persons below the ages of 18 years (ILO, 1992). These standards have been adopted by the Nigerian Labour Act (1990). Unfortunately, like the legislations in most countries, these laws are not enforced. Children less

than 18 years of age are still seen hawking during school hours begging for alms (Almajeris).

In this study involving 400 children engaged in child labour, 258 (64.5%) were males while 142 (35.5%) were females. Of these, 52.2% were involved in hawking, 25% involved in housekeeping, and 11.3% as in sales assistants, 5% in craftsmanship, 4.5% involved in farm work and 1.5% in motor mechanic work. These findings are similar to those of Okeahialm (1984), Obikeze (1986), Asoqwa (1986) and Omowole (2006) who opined that many working children were engaged in street hawking, as domestic servants and auto mechanics. It agrees also with the report of Child Welfare League (1996) which reported that in Lagos alone, there were about 100,000 boys and girls working on the streets. This study was also found to be in line with the finding of Omowole (2006), who reported that street trading was the most common form of child labour. It is also clear from the study (Table 1) that hawking and house helps were the most common child labour in Calabar South Local Government Area.

The age group mostly involved in child labour was between 10 and 14 years of age, and is followed by 15 and 18 years of age and below 10 years. The age range of children used in child labour contravenes or is in violation of ILO recommendation and Section 59 of the Nigerian Labour Act (1990). It agrees with ILO (1991) estimation that 24.6 percent of children between the ages of 10 and 14 in Nigeria were working.

The results of this study also agree with earlier findings by Omowole (2006) that in the riverine communities of Ondo, Edo, Rivers, Bayelsa, Cross River and Akwa Ibom States, children as young as eight years paddle miles along rivers and into the Atlantic Ocean to fish with nets and hooks. Also, it is uncommon in the northern part of the country to see a young boy of 8-12 years with stick in hand shepherding a herd of cattle. The study also conforms to the findings of Oloko (1998) reported at the two day sensitization workshop on child labour in Nigeria; which showed that out 1.7 million unpaid agricultural workers in rural Anambra, 298,000 or 7.6% of them were children below 15 years of age. Children between 10 and 14 years represented 69% of this 298,000 child workers (Omowole, 2006).

Main reasons given by the majority of the children for dropping out of school were financial problems such as inability to afford cost of schooling. Augi (1990) noted that the educational system in Nigeria is unable to sustain the confidence of the children and their parents and many parents preferred their children to go into trades or farm works. Nangia (1989) and Asoqwa (1986) findings indicated that schools held no attraction for the children and in some cases were inaccessible.

The current health problems reported in Table 11 of the study were backache, muscle ache, headache and exhaustion 69 (17.3%), fever 68 (17%), malaria 65 (16.3%), minor injuries (cuts, wounds and bruises) 48 (14.5%), respiratory conditions (cold, catarrh/cough) 39 (9.8%), diarrhea 17 (8.5%), rashes 31 (7.8%), eye conditions like conjunctivitis 19 (4.8%) and typhoid 17 (4.3%). This supports the findings of Nangia (1989) that these children may suffer skin diseases and

while collecting these rusted iron pieces, may sustain cuts or laceration exposing them to tetanus. These findings also agree with the finding of Nayar (1992), Wick (1993), Nangia (1989) that children working in agriculture are particularly exposed to fatigue resulting from doing physically demanding work that their body and strength cannot accommodate for long periods.

These children suffer from these health problems, for example respiratory diseases and eye infection because in walking long distances they are exposed to dust and most of these diseases are air borne. Diarrhea may be due to buying any food on the streets and eating without paying any attention to the sanitary condition of the food.

Conclusion

This study showed that child labour exposes them to exploitative working conditions where there are numerous risks, hazards and other negative influences. These children are subjected to long hours of work, lack of social and medical services, chemical, physical and psychological hazards which are responsible for the health conditions observed in the study.

It is recommended that; education of children should be made a priority especially at primary and secondary schools levels by the government, legislation relating to child labour should be enforced and put to effect; the campaign against child labour should be taken to the churches and mosques. Religious leaders, in their preaching, should emphasize on the duty of the parents to the child.

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MANAGEMENT OF A ROAD TRAFFIC ACCIDENT VICTIM WITH COMPRESSION FRACTURE OF T12 VERTEBRAE WITH COMPLETE DISPLACEMENT Spondylolisthesis

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Abstract

This Medical and Nursing care study centers on the management of a patient with compression fracture of T12 vertebrae with complete displacement spondylolisthesis.

Causes of fracture and types of fracture were reviewed. Medical management of the case and the nursing care of the patient were presented. It was concluded that all patients suffering such an ailment could still regain their motion if proper management is instituted at an appropriate time and they yield to nursing care render.

Introduction

Globally, people move about conducting their normal social and business activities with the aid of motor vehicle. Automobiles, Lorries, Buses and Trucks have been the popular means of transportation for nearly a century. Recently another means of vehicle has been introduced to compete with the known popular ones; this is motorcycle. When it was first introduced, people used it as a form of personal and individualized taxi to short distances within the township interior. At that time it was not many when one compares it quantity with the four-wheeled vehicles on the road; it could only be seen occasionally among many other vehicles. When traffic jams, hold-ups and "go slows" stated manifesting and people now take longer time to reach their destinations, motorbike otherwise called motorcycle increased in proportion and assumes commercial status to ease the transportation system of Nigerians.

However, massive adoption of motorbike came with disastrous consequences on the health of the people. Road crashes increased in proportion resulting in injuries and many a times death.

The motorbike otherwise called "Okada" accident is peculiar in that the injury sustained by the victim is always severe because, unlike that of four-wheel vehicle, there is no vehicular body to reduce the impact of the accident on the victim. As a result a relatively small collision of okada and vehicle which could have resulted in small dents if it were cars always lead to severe fractures and injuries and even instant deaths.

According to Nylandar 1, road traffic collisions kill nearly 1.2 million people yearly around the world. Obviously, the large proportion of the death occurs in developing countries because accident-facilitating factors are always found in the countries. These include: impatient while driving, poor roads maintenance that has turned them to death traps;

driving under the influence of alcohol; overloading of rickety vehicles; overtaking at dangerous portion of the road; parking of faulty vehicles on the roads; sharing of narrow roads by various shades of vehicles, motorbikes and pedestrians; and many more road safety violation practices.

WHO reported that 50% of road traffic fatality worldwide involves young adults aged 15 -44 years and that road traffic accident ranks second to HIV/AIDS as the leading cause of ill health and premature death 1. Despite this, road safety is still being regarded as something beyond the scope of health personnel; yet the consequences of road traffic accident is their full responsibility.

Profile of the Victim

Name:	O. W.
Age:	19 years
Sex:	Male
Occupation:	Bricklayer
Address:	Alakia area, near the Nigerian Brewery Company, Ibadan.

History of The Accident

On 15th May 2009, Mr. O.W. was returning from workplace - Iyana church around 6.00 p.m. when he boarded a commercial motorbike heading to monatan. As usual of the practice among "Okada" rider in that vicinity, there was one passenger already before Mr. O.W. joined. With him they were three on the Chincheng brand motorbike - one driver/rider and two passengers. They were competing with the commercial bus drivers as well as private car owners on the popular Ibadan - Iwo bound highway. They were

all in high spirits, chatting and laughing along. Then it happened! Without any signal or warning for them to clear off the way, the bus coming behind their Okada suddenly hit them, throwing them into the side gutter. Instantly they fainted and knew no more of the happening in the terrestrial world.

At that time, it was getting dark, nobody care less about them as the killer driver absconded, probably without a slight dent on his bus. They were later found bathing in their own pool of blood two hours later by a good Samaritan who took them to the hospital in that half dead state.

They were taken to DF Hospital - the nearest hospital to the scene of the accident where their respective relations were contacted.

After series of investigations including the X-ray of the spine, Mr. O.W was referred to the Accident and Emergency unit of the Adeoyo State Hospital, Ring Road, Ibadan for proper management.

According to Dr. O.T.O the attending physician at DF hospital, Mr. O.W reported in his hospital with bilateral paralysis of the lower limbs and inability to walk as a result of the accident. The physical examination and the radiological (x-ray) investigation of the lumbo sacral region he sent him for confirmed compression fracture at T12 vertebra with complete displacement spondylolisthesis.

The x-ray itself was taken by Dr. J.I.E - a Consultant Radiologist at TDS Diagnostic Services Ibadan.

Upon hearing the magnitude of Mr. O.W. condition, his relatives were perplexed and frustrated. Because they feel they could not afford the cost of Mr. O.W. treatment and the realization that he might not walk again no matter how much they spent, they did not go to Adeoyo State Hospital, Ring Road. Rather they went home resigning to fate.

Review Of The Condition

Fracture

Fracture has been described as a break in the continuity of a bone, separating it into two or more fragments **2**. The soft tissues in the area surrounding the fracture are also injured. It is mainly a result of violence incurred by falls, blows or rotational stresses. In each case the force is in excess of the bone's resistance and may have been applied directly or indirectly. Occasionally a fracture may be due to a sudden forceful contraction of attached muscles. This according to Smith **3** is called avulsion fracture. Sometime too, a fracture can occur as a result of disease of the bone which has weakened its structure to the point it can no longer withstand the normal stresses and strains of everyday life. Morgan **4** explained this as pathological fracture.

Types of Fracture

Lamb and Hernandez **5** classified fracture using table I as follows:

Table 1

S/No.	Type	Description
1.	Traumatic or Pathological	The result of traumatic fracture is violence while pathological one is spontaneous or the result of disease
2.	Incomplete	Break not all the way through bone; e.g greenstick fracture in children
3.	Complete	Bone is separated into two distinct parts.
4.	Closed (simple)	Overlying skin intact
5.	Open (compound)	A wound exists over the fracture establishing communication between the fracture and the outside air.
6.	Complicated	Fracture includes injury to adjacent structures, e.g. blood vessels, nerves or organs.
7.	Comminuted	More than one line of fracture and more than two fragments.
8.	Transverse	Line of fracture is at right angles to the long axis of bone.
9.	Spiral	Curves in spiral fashion around bone.
10.	Impacted	One fragment is driven into another (cancellous bone usually involved).
11.	Crushed or Compression	Fracture occurs in cancellous bone which is compressed beyond limits of tolerance.
12.	Avulsion	A ligament or tendon under excessive stress fractures or tear away its bony attachment.
13.	Depressed	A segment of cortical bone is depressed below the level of surrounding bone.

Specific problems of a patient with fracture are listed with their respective causes in table 2

	Patient Problem	Causes
1.	Sudden severe pain at site (may or may not persist)	Injury, impaired nerve function, muscle spasm, tissue damage
2.	Deformity or shortening of limb.	Displacement of bone fragments, muscle spasm.
3.	Impaired mobility and loss of function	Disruption of bone. Nerve compression by bone fragments.
4.	Loss of circulation	Arterial compression by bone fragments.
5.	Swelling	Bleeding and/or escape of fluid into tissues; after 2-5 days area may become discoloured (ecchymosis)
6.	Crepitation (grating sound)	Movement of bone fragment at fracture end.

The Vertebral Column

The cranium, vertebral column, ribs and sternum constitute the axial skeleton. The bones of the limbs and limb girdles make up the appendicular skeleton.

The vertebral column (spinal column, spine or backbone) is the central part of the skeleton, which

supports the head and encloses the spinal cord. Its construction combines great strength with a moderate degree of mobility. These features depend on the spine having a number of separate bones united by ligament and by tough discs of fibrocartilage (the intervertebral discs) which act essentially as hydrostatic shock absorbers. The muscles of the disc are 85° water and it is bounded by a fibrous ring, the annulus **6**. The bones give origin to a number of muscles.

The vertebral column is made up of 33 vertebrae which are grouped (from above downwards) as follows:

7	Cervical (discrete, true or movable)
12	Thoracic or Dorsal
5	Lumbar
5	Sacral forming the sacrum } Fused, false or fixed vertebrae
4	Coccygeal forming the coccyx } Fused, false or fixed vertebrae

The bones become increasingly large as the column descends, reaching their maximum width at the upper part of the sacrum, only to become greatly reduced in size as it tapers off into coccyx.

When looked at from the side, the spine will be seen to have several curves.

- It is convex forwards in the cervical region
- The thoracic region is convex backwards.
- The lumbar region is markedly convex forwards.
- The sacrum and coccyx form a marked forward concavity.

Prognosis of Fractured Spine

Fractured spine portrays great danger to the victim in that the delicate spinal cord could be easily punctured leading to partial or total paralysis. In that situation, all body structures below the paralysed aspect of the cord (that are innervated by that nerve) automatically becomes paralysed too. Therefore, performance of the normal physiologic function of the affected structures becomes impossible again.

Management of Mr. O. W. Admission and Treatment at Owoanik Memorial Health Centre Ibadan - Report

Few days after leaving the DF hospital, a relation of his came to commiserate with him at home. He heard about the steps taken so far, the referral to Adeoyo State Hospital and refusal to go because of their perceived escalating cost of treatment as well as the poor prognosis of the condition even after treatment. Being a regular client of Owoanik Memorial Health Centre, he offered to take them to the place with the hope that with a greatly reduced cost, the patient will get well. The relatives accepted.

He was therefore received at the hospital on 2nd July 2009. The results of the radiological examination as well as the referral letter were studied in a bid to utilize the useful information inherent on Mr. O.W's

management.

Admission - He was admitted on a fracture bed. This consists of normal hospital bed with flat board underneath the mattress. This prevents sagging of the mattress when lying on it. The foot of the bed was elevated with about 50 cm long bed elevator.

Therapy - Bilateral skin traction was done on the lower limbs and the cords were severely fastened to the bed rails at the foot of the bed.

Skin traction, according to Judd **7** is the application of adhesive or non-adhesive tapes to the medial and lateral surfaces of the limb. These are secured by firm encircling crepe or elasticated bandage. The skin extension tapes extend beyond the foot and attach to a spreader, which is wide enough to prevent the tapes from rubbing the malleoli and gives sufficient distance from the foot to allow for planter flexion. A cord, connected to the spreader, passes over a pulley on a crossbar at the foot of the bed and suspends a prescribed weight to the traction force.

In the case of Mr. O.W, his weight was used as a counter traction to the cord attached to the foot of bed; hence the bed was elevated up to about 45° angle from the floor. He was placed on the bed for 6 weeks from 2nd June to 14th July, 2006

Chemotherapy - He was placed on the following oral drugs for the 6 weeks period:

- Tab Ascorbic acid 100 mg tid x 6weeks
- Tab Ibuprofen 400mg tid x 4weeks
- Tab Tramadol 100mg tid x 3weeks
- Tab diazepam 5mg bid x 2weeks

Alternated with Tab Phenobarbitone 30mg nocte x 2weeks

- Tab Ferrous Sulphate 60mg tid x 6weeks
- Folic Acid 5 mg daily x 6weeks
- Tab calcium Lactate 30mg tid x 6weeks

Nursing Care

This includes:

Positioning: Though he maintained supine position throughout the 6 weeks period, he was encouraged to shift slightly after resting on a side for up to 4 hours.

Oral Care: In order not to put strain on the rested vertebral column, he always had his oral care done for him. He only participated by obeying instructions while the care was being done.

Bed Bath: Since he was not ambulatory, he was bed bathed daily throughout the period. His choice of water for the bath was always used - hot, cold or tepid water as this was dependent on the daily environmental condition.

Care of Pressure Area: Bony prominences that were absorbing pressure while lying on bed were cared for appropriately.

Care of Bowel and Bladder: Defecation was made easy by offering him bedpan daily before bed bath. Urinal too was offered to him on request.

Nutrition: To ensure adequate calus formation at the fracture site, food rich in calcium were given. Although calcium supplement was given daily, adequate substitute was made in diets to guide

against any possible mal-absorption of calcium supplement. Tilapia fish, prawn, crabs and milk feature in his weekly menu plan. He was encouraged to chew and swallow fish bone along with the fleshy part. The food also included, rice, beans, yam, amala, bread and beverage. Also fruits such as orange, banana, mango and vegetables were included. The foods served were generally highly caloric, proteinous, semi solid, small at a time, and frequently served rather than three bulky meals daily. The foods were non-constipating and no gas forming. He was assisted in feeding at the first four weeks since sitting on bed was not yet possible.

Psychological Care: As the patient was fully conscious, nursing staff play with him most of the time. In some occasions he watched plays on T.V set and video CD placed in his ward. His fear of permanent lose of locomotion was allayed and he coped well throughout hospitalization.

Convalescence: By the end of the fourth week, Mr. O.W suddenly sat on bed by himself and requested for his meal; he eat without any assistance. Since then he started eating on his own. By the sixth week, observation of his movement on bed was convincing enough that calus had formed and that the body weight could be carried successfully on his lower limbs. The traction was removed and he stood up by himself. He was however retrained on leg movement in locomotion.

Post traction x-ray done showed a fully healed fracture site. He was still admitted for observation for the following four weeks for rehabilitation.

By fourth weeks after traction removal, he was fully okay and therefore discharged after comprehensive health education on avoidance of strainous job involving bending of backbone.

Mr. W.O case, after healing, corroborates the views expressed by Henderson⁸ that the patient sometimes recover from injury and or accident when he is placed in the best position for the nature to act on him. In this study, nature contributed immensely to the patient's recovery.

Conclusion

Mr. O.W is now fully okay and he is already doing his job. He is abiding by the pieces of advice given to him to avoid placing heavy load on head and to avoid straining the backbone for the next few years. He is very happy and vouches never to ride/board motorbike again in his life.

Appreciation We sincerely appreciate the contributions of the relatives of Mr. W.O in his management. We are particularly grateful for abiding by the pieces of advice we gave them in the care of Mr. W.O which assisted us greatly in successful management of the patient. We also appreciate the contributions of nursing staff in the care of the patient.

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INFLUENCE OF PERSONALITY TRAITS ON EFFECTIVENESS OF NURSES

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Abstract

This study examined the influence of personality and demographic variables on effectiveness of nurses in both general hospitals and teaching hospital in Rivers State. A correlational design was used to examine the relationship between personality trait and effectiveness of nurses. By means of proportional stratified sampling techniques, 600 nurses were selected for the study. A personality assessment questionnaire (PAQ) and job performance appraisal form (JPAF), with a reliability value of 0.97 and validity value of 0.72 was used for data collection. The mean, analysis of variance (ANOVA), Post Hoc Multiple Comparism, Sheffe, were used for testing the hypothesis at 0.05 level of significance. Findings revealed that the selected personality traits namely: extraversion, openness to experience, agreeableness and conscientiousness influenced nurses effectiveness on the job. While personality traits of neuroticism had negative relationship on the nurses effectiveness on the job. Also the selected demographic variables namely: status, years of experience, age, influenced nurses effectiveness on the job. Results further reveals that personality trait of neuroticism have a negative influences on effectiveness of nurses on the job. Based on the findings, it was recommended that the nurse managers should see the result of this study as a reason to modify present supervisory method on nurses assigned to critical task area, to enhance reduction in mortality and morbidity rate. Also, the education stakeholders/nurse educators should take immediate steps to improve academic achievement/nursing skills by organizing seminars, conferences, workshops, in-service education. Nurse administrators should consider the age or see it as a prerequisite for admission into Schools of Nursing. Also, the government, be it State or Federal parastatal should allocate increase funding to health sectors for manpower development, infrastructures, free healthcare for the needy/the poor to promote health for all 2015.

Background to the Study

Many professions abound in Nigeria including nursing profession. Each profession has its peculiar roles to play in the general economy of Nigeria as well as modalities of operation in order to achieve the desired goals. The extent to which the practitioners or members of a particular profession achieve the desired results by performing the duties and roles ascribed to the profession; to that extent they are effective. Past studies on nurses effectiveness had always been based on cognitive and psychomotor domain; little or no attention has been made on the personality traits and demographic variables of the nurses as a contributory factor to effectiveness in health industries, more especially in the general hospitals on which this study focused attention.

Mangal (2008) sees personality traits as "the sum total of all the biological innate dispositions, impulses, tendencies appetites and instincts of the individual and the dispositions and tendencies acquired by experience". It is also important; to note that there has been intense curiosity about the nature of man. In order to work and live as harmoniously as possible with others, especially with the consumers of health industries, man must know why people think and

feel and act the way they do. In support of this, Maddi (1996, p. 163) stated that: "personality traits are the stable set of characteristics and tendencies that determines those commonalities and differences in the psychological behaviour (thoughts, feelings and actions) of people that have continuity in time and that may or may not be easily understood in terms of the social and biological pressures of the immediate situation alone".

Although Ryckman (2004) is of the view that personality trait is "a dynamic and organized set of characteristics possessed by a person that uniquely influences his or her cognitions, motivations, and behaviours in various situations". However, psychological concept of personality traits goes further and deeper than mere outward behaviour. Most personality theories consider behaviour predictable, controllable and consistent.

Trait theorist, Cattell, R.B. (1990) affirmed that personality dispositions determine the probability of success in a particular task domain. Studies on meta-analysis by Barrick and Mount (1991) linking traits from the 5-factor model of personality to overall job satisfaction revealed that stability and consistency increased as individual stays longer on the job. Richard

and Burl (2005), stated that each person possesses a unique and stable pattern of traits that can be measured; and that a unique pattern of traits are required in a critical tasks of any job for optimal performance. This is in line with this study.

The Five-Factor Model (FFM) (or 'Big Five') model of personality postulated by McCrae and Costa (1992) who developed a test that fits their version of the model. The current version of the test, the revised NEO Personality Inventory (NEO PI-R-Costa & McCrae (1992) provided scores on the major dimensions, or domains of personality and on 30 other traits or facets, that identify each domain. The five major domains or Neuroticism (N), Extraversion (E), openness to Experience (O), Agreeableness (A) and Conscientiousness (C) their respective facets are listed thus:

Neuroticism-anxiety, anger, hostility, depression, self consciousness, impulsiveness, vulnerability.

Extraversion-warmth, gregariousness, assertiveness activity, excitement-seeking, positive emotions.

Openness to Experience-Trust, straightforwardness, altruism, compliance, modesty, tenderness.

Conscientiousness-competence order, dutifulness, achievement, self-discipline, deliberation.

The scales of the NEO PI-R was designed as a measure of "normal personality traits" but Costa and McCrae recommended that the instrument be used in clinical and other applied setting as well as in research. Most of the scale of measurement were: Need for achievement, Deference, Exhibition, Introspect, Dominance, Nurturance, Abasement, Affiliation, Aggression, Autonomy, Counteraction, Defence, Harmavoidance, Introvoidance, Other, Play, Rejection.

Method of Data Analysis

The method of analysis of the two standardized instruments – the Personality Assessment Questionnaire (PAQ) and the Job Performance Appraisal (JPA) were done by correlation statistics (SPSS) in which the correlation ρ was calculated to determine the relationship between the individual nurse's demographic variables and their work effectiveness; and personality traits and their work effectiveness; and One-Way Analysis of Variance was used to determine the significance between (1) demographic variables and work effectiveness of nurses (2) personality traits and effectiveness of nurses, at 0.05 alpha level of significance respectively.

Experience shows that the nurses present diverse types of behaviour in their workplace and to the patients too. Some are awful, hateful, admirable, caring and responsible. Some show unruly behaviour of lateness to work and disobedience to authority. Bauman (2007, p.136) pointed out that some nurse are practical, others are sympathetic and friendly, others still, are enthusiastic and insightful, others are logical and well organized. Thus while some nurses are seemingly effective in their job, others seem to be

ineffective.

The nurses relatively enjoy similar salary and non-salary conditions of services in all the government hospitals in the South South Zone of Nigeria. Their differentials in work effectiveness therefore raise an issue of concern. Probably the type or nature of the person the nurses are may play a key role in being effective in the discharge of their duties are responsibilities. Here, the type or nature of person the nurses are implies the type of personality they are: Thus personality of nurses may play a key role in the discharge of their duties and overall effectiveness. This research study investigated the relationship between personality traits of nurses and their work effectiveness in the general hospitals in 23 Local Government Areas of Rivers State using Five Personality Traits Assessment Questionnaire (PAQ)

Data Presentation And Results

This chapter deals with the presentation of analyzed data and the results with respect to the researched questions and hypothesis stated in the study. The data and result of each research question are presented first, followed by those of the hypotheses.

Table 1: Pearson(r) on Neuroticism and Effectiveness of Nurses

Variable	n	Mean	sd	r	sig.	Decision
Neuroticism	600	42.8361	8.8823	-.3156	.000	Not Significant
Effectiveness	600	62.7350	6.4909			

Table 1 showed a correlation co-efficient of -.3156. The result therefore is that there is a weak negative relationship between personality trait of neuroticism and effectiveness of nurses.

Table 1: The result showed that personality trait of neuroticism correlated negatively with job effectiveness of nurses by scoring a correlation co-efficient of -.3156. This negative influence on job effectiveness of nurses is based on the fact that people with personality trait of neuroticism are marked with negative distressful emotion, anxiety, anger, hostility, depression, self-consciousness, impulsiveness, vulnerability. These attributes lead to poor performance, and negative influence on effectiveness of nurses. This is with the explanation of Momberg (2005) who stated that there is a unique pattern of traits required for successful performance of a critical tasks of each occupation. This is in support which the study carried out by Judge Heller and Mount (2002) on personality trait and job satisfaction where a score on personality trait of neuroticism were (r) .07, (r) .06, (r) .09, which also revealed a negative correlation co-efficient, hence negative influence on job satisfaction.

Table 2: Pearson(r) on Extraversion and Effectiveness of Nurses

Variable	n	Mean	sd	r	sig.	Decision
Neuroticism	600	58.9017	6.5491	.6152	.001	Significant
Effectiveness	600	62.7917	6.4978			

Table 2: showed a correlation co-efficient of .6152.

The result therefore indicated a positive relationship between personality trait of extraversion and effectiveness among nurses. When subjected to a test of significant r-value of 0.6152 was found to be significant. There is therefore a significant relationship between extraversion and job effectiveness.

Table 2 showed that personality trait of extraversion had a correlation co-efficient of 0.6152. This indicated a positive relationship with job effectiveness of the nurses. This may be because the personality trait of extraversion is marked with warmth, gregariousness, assertiveness activity, excitement-seeking, positive emotions. These attributes enhances efficiency, thus positive influence on the job. This is in line with the result on personality trait of extraversion (r) .82, on the study of Barrick & Mount (2004) which denotes positive influence on job effectiveness.

Table 3: Pearson(r) on Openness to Experience and Effectiveness of Nurses

Variable	n	Mean	sd	r	Sig.	Decision
Openness to experience	600	60.0533	5.6998	.8231	.001	Significant
Effectiveness	600	62.7917	6.4978			

Table 3: Showed a correlation co-efficient of .8231.

The result therefore is that there is a high relationship between personality trait of openness to experience and effectiveness of nurses. The relationship is also statistically significant.

This is because; personality trait of openness to experience is marked with: trust, straightforwardness, altruism, compliance, modesty, tender mindedness. These attributes enhance proficiency, thus positive influence on job effectiveness. This result is in line with the study of Zellers, Perrewe, Hochwater (2000) openness to experience score (r) .80 which represent a positive correlation on job effectiveness.

Table 4: Pearson (r) on Agreeableness and Effectiveness of Nurses

Variable	n	Mean	sd	r	Sig.	Decision
Agreeableness	600	60.4461	5.9889	.8332	.001	Significant
Effectiveness	600	62.7761	6.5100			

Table 4: showed a correlation co-efficient of .8332. The result therefore is that there is a strong positive relationship between the personality trait of agreeableness and effectiveness of nurses. The relationship is also statistically significant.

This is because personality trait of agreeableness is associated with: compassionate, willing to comprise his/her interest feelings with other people, trust, empathy, and patient. These attributes enhances good interpersonal relationship with patients and mutual trust for one another and helps the nurse to know and understand the patients problems more plan and implement care towards wellness continuum. In support of this result, a study on personality trait and job satisfaction embarked by Zellers, Perrewe and

Hochwater (2000) reveled that personality trait of agreeableness scored (r) 0.80 which denotes positive relationship with job satisfaction.

Table 5: Pearson(r) on Conscientiousness and Effectiveness of Nursing

Variable	n	Mean	sd	r	Sig.	Decision
Conscientiousness	600	63.1362	5.4374	.6162	.001	Significant
Effectiveness	600	62.889	6.5257			

Table 5: showed a correlation co-efficient of .6162. This is because people with personality trait of conscientiousness are marked with: competence, order dutifulness, achievement, self-discipline. In support of this study, the study embarked by Judge, Heller & Mount (2000) revealed a score of (r) 0.79 by personality trait of conscientiousness which denotes positive correlation co-efficient. Thus personality trait of conscientiousness positively influences job effectiveness. In support of this study Goldberry (2004) stated that those high in conscientiousness are well prepared, orderly, detail oriented, cautious, dutifully. They aim for achievement.

Table 6: Mean and Standard Deviations of Effectiveness of Nurses by Personality Trait

Variable	n	Mean	Sd
Neuroticism	12	56.	2.91
Extraversion	107	63.17	5.89
Openness to experience	109	65.42	2.35
Agreeableness	138	66.73	5.81
Conscientiousness	234	70.02	1.79

Table 6: showed that the personality trait of conscientiousness had the highest mean score of 70.02, followed by agreeableness 66.73, openness to experience 65.42 and extraversion 63.17, while the personality trait of neuroticism had the lowest score of 56.5.

The result indicated that nurses with personality trait of conscientiousness are the most effective. The personality mean score was however subjected to statistical analysis of one-way analysis of variance (ANOVA).

Table 7: One-way Analysis of Variance (ANOVA) of the Effectiveness Mean Scores of Nurses by their Personality

Sources of variance sv	Sum of squares ss	df	Mean square ms	f	Sig.	Decision
Between Groups	15584.640	4	3896.160	85.070	.000	Significant
Within Groups	27250.720	595	45.800			
Total	42835.360	599				

Table 7: The absolute value of 85.070 was used for taking decision.

Decision: From the F-distribution table, the critical value of F with 4 and 595 degree of freedom at 0.05 level of significance is 3.38. Since the computed f-value of 85.070 is higher than the critical value of f (3.38), we reject the null hypothesis and conclude that

there is a significant difference in mean personality trait scores of nurses in respect to their effectiveness. That is to say that personality of nurses significantly influences their job effectiveness.

Since f-value is significant in ANOVA, in order to identify the direction or source of the significant difference, the mean score was subjected to multiple comparison, Post Hoc-Sheffe test.

In Sheffe test, all the means involved are compared pair by pair in order to identify pairs of mean that have and have not given rise to the significant difference represented by the f-value of ANOVA.

Table 8 compared grouping

Compared Groups	Computed f-values	Sig	Decision
Group 1 and 2	-6.75000 *	.000	Significant
3	-7.72000 *	.000	Significant
4	-8.05000 *	.000	Significant
5	14.74000 *	.000	Significant
Group 2 and 1	6.75000 *	.000	Significant
3	-.97000	.906	Not significant
4	-1.30000	.764	Not significant
5	-7.99000 *	.000	Significant
Group 3 and 1	-7.72000 *	.000	Significant
2	.97000	.906	Not significant
4	-.33000	.998	Not significant
5	7.02000*	.000	Significant
Group 4 and 1	8.05000 *	.000	Significant
2	1.30000	.764	Not significant
3	.33000	.998	Not significant
5	-6.69000 *	.000	Significant
Group 5 and 1	-14.74000 *	.000	Significant
2	7.99000 *	.000	Significant
3	7.02000 *	.000	Significant
4	6.69.000 *	.000	Significant

*Mean difference is significance at 0.05 level.

Table 8: showed that Group 1 & 2, 1 & 4 and 1 & 5 showed significant difference in their mean.

Significant difference also existed between Group 2 & 5, while Group 2 & 3 and 3 & 4, showed no significant difference in their mean.

Group 3 & 1 and 3 & 5 also showed significant difference, while Groups 3 & 2 and 3 & 4 showed no significance difference in their mean.

Significant difference also existed between the mean of Group 4 & 1 and 4 & 5, while Group 4 & 2 and 4 & 3 showed no significant difference in their mean.

Group 5 & 1, 5 & 2, 5 & 3 and 5 & 4 showed significant difference in their mean.

This result revealed that personality trait of the nurses significant influences their effectiveness.

Discussion

The personality traits of nurses significantly influence their job effectiveness. Table 6 shows job effectiveness mean scores 56.5, 63.17, 65.42, 66.73 and 70.02 respectively, for personality traits of neuroticism, extraversion, openness to experience, agreeableness and conscientiousness. The personality trait of conscientiousness is the most effective, followed by agreeableness, openness to experience, extraversion and neuroticism. This may be because individual

personality traits have a main effect on work behaviour, which in turn has a main effect on job performance.

Tett and Burnett (2003, p.103) clearly stated that job performance is the valued part of work behaviour, and this value is determined by the organizational goals. This indicates that the more the personality trait mean score of nurses increase the more their efficiency on the job and vice versa.

This is in line with Momberg (2005, p.31) who affirmed that there is a unique pattern of traits required for successful performance of a critical tasks of each occupation. Implicitly, units or department in a health institutions such as accident and emergency, labour ward, sick baby's intensive care unit (SCIBU), where neonates are hospitalized, and operating theatre, are to be manned by nurses who have the personality trait of conscientiousness. In support of this result, Goldbery (2004), concluded that those high in conscientiousness are well prepared, orderly, detail oriented, cautious, and dutifully; they achieve high level of success through purposeful planning and persistence. They aim for achievement.

McCrae & Costa (2003) in a recent study on a more universally recognized components of personality trait of agreeableness, quoted that they are more closely related to contextual performance, that performance improvement plan must be developed with detailed step to enhance their efficiency.

Implicitly, nurses that demonstrates traits like this, appreciates compromising their interests with others. They are marked by pronounced compassionate and cooperativeness on the job. Nwamadi (2002) affirmed that openness to experience individuals are marked by pronounced ambition and achievement oriented.

Micheal, et al. (2005), in their study on influence of personality traits on direct measures of person organization (P-O) fit, found out that openness to experience demonstrated stronger relationship with directly measured (P-O) fit (controlling for indirect fit components) when direct fit was operationalized as a general measure than fit was assessed on specific dimension. Implicitly, nurses who are intellectually curious, artistic, adventurous, more creative will passive themselves as being a match with the environment to a greater extent than the nurses low on this dimension. This means that they will be more aware of their patients problem, infact, they are problem oriented. On the contrary, they are emotionally exhausted because they are very often confronted with emotionally demanding relationship with recipients of their care, nevertheless they excel in quality nursing care.

Brain and Lauren (2005) reported that individual's high on extraversion, have a tendency to report greater fit than what exists as opposed individual low on extraversion. Extraverts tend to be enthusiastic, action oriented. They enjoy being with their patients and perceives as full of energy, social support seeking. They have higher frequency and intensity of establishing good rapport with their patients and

colleagues. On the contrary, a nurse with personality trait of neuroticism is associated to experience a negative distressing emotion and to possess associated behavioural and traits, such as inhibition of impulses, low self esteem. They show diminished ability to think clearly, ineffective coping strategies. All procedure entrusted to them are negative. They will be antagonistic with both their patient, colleagues and their job. They will not be able to establish good rapport with their patient. Such behavioural and cognitive trait may definitely affect his proficiency in meeting the health institution goal which are preventive, restorative, curative and rehabilitative.

Implication of the Result

The findings of this study have some implications for the nurse managers, nurse educators, administrators, education stakeholders, guidance and counselors, and the government. For the nurse managers, the result of this study point their attention to the fact that assigning nurses with personality traits of openness to experience, agreeableness and conscientiousness to critical task will promote quality assurance in practice, consistency and uniformity, and reduction in mortality and morbidity rate of the patients in the hospital setting. For guidance counselor, the findings are indicative of the fact that students need counseling on career choice especially the students with personality trait of neuroticism and extraversion.

For education stakeholders in nursing, age should be a prerequisite for admission to promote or inculcate a desirable behaviour which will enhance efficiency. For nurse administrators, years of experience, qualification, age should be considered to promote good interpersonal relationship in terms of nurse/patient relationship thereby promote optimum performance. They should also motivate the nurse by granting study leave, sponsorship to embark on educative programmes towards update their knowledge, thus promote job efficiency.

For the government, health is wealth, so increase funding is needed to maintain good health of individuals and community at large, to train nurses to update themselves on current trends in nursing skills.

Summary

Based on the findings of this study, the following conclusions were made.

There is significant difference in effectiveness of nurses based on their personality traits as revealed the result of the hypothesis and Post Hoc multiple comparison Sheffe.

Conclusion

This study was designed to determine the influence of demographic and personality traits on effectiveness of nurses: implication for nursing education.

The study was conducted in both general and teaching hospitals in Rivers State. The background of the study was written, followed by the statement of the problem. The purpose of the study and significant of the study were written. Ten research questions and null

hypothesis guided the study. Relevant literatures to the study were adequately reviewed. Correlation research design was adopted for the study. The population of the study was one thousand, six hundred and seventy-eight (1,678) duly employed nurses, (600) nurses was used using proportional stratified sampling method.

The study used standard instruments from personality inventory and job performance appraisal form, the instruments were validated and reliability was assured. The data collected were analyzed with correlation statistic (*r*) and Analysis of Variance (ANOVA) using (SPSS). Results obtained from data analysis were presented in tables in chapter four.

The results indicated that years of experiences as measured by the number of years in service, age of nurses, and status of nurses significantly influence their job effectiveness, while qualification of nurses does not significantly influence their job effectiveness.

Also, the personality trait of extraversion, openness to experience, agreeableness and conscientiousness correlated positively with work effectiveness of nurses. While the personality trait of neuroticism correlated negatively with work effectiveness of nurses.

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NURSING CHALLENGES, STRATEGIES TO OVERCOME THEM, AND LIKELY PROBLEMS TO BE ENCOUNTERED

Prof. Emmanuel E. Oyibo

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Niger Delta University
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Nigeria

Introduction:

I feel highly honoured and privileged to chair this occasion and to deliver this keynote address. And so, I say thank you Mr President and members of the International Organization for Nursing Research and Development, for this great honour.

Health is a universal need. Medical care is the cradle for health, and Nursing is the vital life force behind it. Health is a state of complete physical, mental, social and spiritual wellbeing of the individual and not merely the absence of disease or infirmity (WHO, 1954).

Everybody on earth wants to be at this level of wellbeing. Medical care is the place/source, where this state of wellbeing originates but, nursing is the vital life force behind it.

What is Vital Life Force? The Bible says God created man in His own image and breathed into his nostrils and he becomes a living being (Genesis 1 vs 27). That breathe of God which He gave to man and He becomes a living being is the vital life force. Therefore, the vital life force is the most important element on earth, it is the life giving element.

Comparatively, medical care is the cradle, the place where attainment of health begins; but nursing is the vital life force (the life giver). Or else, there can be no attainment of health.

Being a keynote address presented at the Nursing Summit, organized by International Organization for Nursing Research and Development at Uyo, Akwa-Ibom State. On 15th - 20th October, 2012

What is Nursing?

The most important function/definition of the Nurse, was given by Virginia Henderson:

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as soon as possible (Henderson, 1961).

This is the basic function or definition of the role of the nurse generally, Nursing in Nigeria, has attained professional status. What rights, and responsibilities does this professional status confer on Nursing?

When you are searching for the eye of a fish, you go to the head. Therefore, let us look at the characteristics of a profession.

Characteristics Of A Profession

A profession has:

- Broad based educational program and thus it possess a basic body of knowledge.
- Functions involve intellectual operations accompanied by individual responsibility and techniques of operations are based upon principles rather than rule-of-thumb procedures or simple routine skills.
- Functions are learned in nature, and members are constantly resorting to the laboratory and seminars for a fresh supply of facts.
- Functions are not merely academic and

theoretical, but are definitely practical in their aims.

- Emphasis is on service to be rendered than economic gain to practitioners.
- Members possess a technique capable of communication through a highly specialized educational discipline.
- Organization of members with activities, duties and responsibilities leading to the development of group consciousness.
- A controlled entry usually by a formal education and examination.
- Autonomy- freedom of the organization to govern itself independently with the ability to act and make decisions without being controlled by anyone else.
- A code of ethics, with discipline for those who break them.
- Oyibo E.E (1999)

These characteristics of the Nursing profession which are given above are reinforced by International Council of Nursing (ICN) Position Statement. The ICN position statement (1993) sets the standard for nursing education and practice internationally. Nigeria of course, is a member.

International Council of Nurses (ICN) Positions Statements

The International Council Of Nurses Position Statements (1993) set the standard for nursing education and practice internationally. International

- Council of Nurses believes that:
- I. Nursing profession must reaffirm the scope of

represents what can be described as best practice which in turn will yield an outcome of practice standards.

As a service profession, the application of research results is relevant and necessary in nursing for its practice. It can therefore be inferred that nursing practices based on research will involve;

- a) Techniques, methods and activities in clinical skills repeatable in various situations.
- b) Such activities are tried, tested and proven to produce desired outcomes.
- c) Process of assessment of clients conditions, making nursing diagnosis, planning care, implementing and evaluating care.
- d) Involves the process of coordinating care efficiently with positive ethical and professionally competent nurse-client negotiated relationships.
- e) Delivering effective outcomes (best results) with fewer problems or complications for the care receiver (Ojo A.A 2010).

Whenever or in whatever nursing care situation these components are present, standard of nursing care will be of high quality and client satisfaction with care will be assured.

On the whole, knowledge of research methodology and its application is a pre-requisite for nursing professionalism. And ofcourse research findings must be published so that humanity can gain from the knowledge.

What is the strategy to overcome this limitation? The answer is practice. Indulge in research, form partnership with co-nursing researchers or other health professional researchers. you will be surprised at the result.

4. Gender Marginalization and/or the name "Nursing"

In a published article "Revamping the Nursing profession. Need for a change of Name" published in West African Journal of Nursing Vol 10 (1),PP 55-57,I adequately addressed this problem facing the Nigerian Nursing profession and nursing the world-over. Nursing, I stated, may consider itself to be a profession without gender, but in actuality, it is not adjudged to be so by most persons.

Nursing connotes an aura of femininity. No wonder, most members are female, not only in Nigeria, but worldwide. For example, in USA, 1972, 98% of students who entered school of nursing were females, men were about 2% (Silver & McAfee, 1972).

Similarly, a comparative analysis of men and women who got admitted into diploma in Nursing Administration and Management (DNAM) programme in University of Benin, Benin city, supports this assertion. See table 1.

Table 1: Comparative Enrolment of Men and Women in DNAM programme of Uniben in 3 sessions

NURSING CHALLENGES, STRATEGIES TO OVERCOME THEM, AND LIKELY PROBLEMS TO BE ENCOUNTERED

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NURSING CHALLENGES,

Session	Men %	Women %	Total %
1994/95	4 8%	45 92%	49 100%
1995/96	7 11.47%	54 88.53%	61 100%
1996/97	4 7%	53 93%	57 100%
Grand total	15 9%	152 91%	169 100%

Source: Institute of Public Administration and Extension Services, Uniben Admission Records.

Let us come to our base;

Let us examine existing enrolment of men and women in faculty of Nursing Niger Delta University, Wilberforce Island, Bayelsa state.

Table 2: Enrolment of men and women in Faculty of Nursing, NDU, Bayelsa state. 100 – 500 levels 2012

Level	Men %	Women %	Total %
100	11 13%	73 87%	84 100%
200	9 12%	67 88%	76 100%
300	5 13.5%	32 86.5%	37 100%
400	7 18%	31 82%	38 100%
500	9 23%	30 77%	39 100%
Grand total	41 15%	233 85%	274 100%

Source: Faculty of Nursing, NDU, Student Record, 2011-2012 Session

These data again support the assertion.

There appears to be no overt or covert policy preventing the men from entering the profession now in Nigeria. Neither are the functions of nursing meant to be performed by the female sex alone. Admittedly, N&MCN in the past restricted male nurses from performing certain functions such as female catheterization and midwifery functions. But this has changed, I hope for good.

So what prevents males from joining the profession now? Potential male nurses have been kept out of the profession by social pressures. The concept "nursing" connotes femininity. This idea is imbibed by boys from infancy and is re-enforced by sociological and psychological inhibitions and barriers. Besides, the function of nursing pertains to provision of personal assistance, nurturing and caring for others, which is reminiscent of feminine role in society. Thus, Silver and McAfee (1972) opined that men hesitate to join the profession for two reasons;

➤ The connotation of femininity that is associated with the word "nursing" and

➤ The function of nursing.

It is therefore right to say that men are marginalized from the profession, overtly or covertly, and the name "nursing" prevents males from joining the profession.

The way forward;

To revamp the profession and make it acceptable to men and women generally. I suggested then and still stand by it now that the name of the

profession "nursing" and the practitioners "nurses" should be changed to "Health Care Practice" and "Health Care Practitioners" respectively. These names are free of any gender designation. Schools of nursing will be renamed schools or departments of "Health Care Practice", and the graduates "Health Care Practitioners".

The new nomenclature of the profession and professionals, will require an expanded scope and role of the profession and professionals, thus the practitioners should be prepared to give more evidence based, standard health care to their clients.

The nursing process which should now be known as the "Health Care Practitioner's process" will still be the corner stone of the professional's practice. This will be:

- Assessment of the client and his/her environment,- physical, social, mental, economic and spiritual.
- Possible Etiology- identifying the possible cause(s) of the problem.
- Diagnosis of the client's problem(s) that the health care practitioners will treat.
- Setting of goals and objectives.
- Planning for intervention.
- Intervention and
- Evaluation.

In summary, change is usually resisted because of the fear of the unknown. This suggested change will surely be resisted by leaders of the profession, but it is food for thought.

Fake (Quack) Nurses;

One of the characteristics of professionalism is a controlled entry, usually by a formal education and examination. The nursing profession in Nigeria headed by its professional organ, N&MCN, has tried to observe this tenet to the letter. But there are elements in the health industry who are out to rubbish this nursing professional principle and tarnish the image of the profession.

These are self employed medical doctors who establish their own hospitals, who sow white gowns and cap for primary six pupils and boys to work as nurses for them. They give them little or no training, and of course, doctors are not qualified to train nurses. And under their cover in the hospital, they carry out the duties of the nurse and sometimes midwives. They commit a lot of atrocities in the name of caring for their patients.

The Nigerian public do not know the difference between these fake nurses and the trained professional nurses. Consequently, all problems emanating from these fake nurses are attributed and heaped upon the Nigerian nurse and the nursing profession. Surely these doctors who always protect their own professional code of conduct are eroding and tarnishing our professional ethics and image.

What do we do to stop this deliberate act aimed at tarnishing the image of our profession and to get rich by all means? The N&MCN and NANNM as well as Nurse Scientists Union must do something, let us lobby members of the House of Assembly to enact a bill to stop doctors from employing untrained quacks who

fake as nurses to work in their hospitals. If they are rich enough to establish a hospital, they must employ qualified nurses to work in their hospitals.

These quacks who go in white nursing dress and cap with their employer, the doctors, have done enough damage to the profession and the Nigerian public, they must be stopped.

Nursing Autonomy;

One of the characteristics of professionalism is autonomy. Autonomy connotes freedom of an organization to govern itself independently; the ability to act and make decisions without being controlled by any one else (Oxford Advanced Dictionary).

Nursing from its inception, has been under the control of the medical profession. Even after it has achieved professional status, as it is at present in Nigeria, it has still not achieved full fledged autonomy.

The N&MCN, the organ that controls the profession in a bold attempt to raise the standard of nursing practice and address the issue of autonomy raised the level of entry into schools/departments of nursing to the same requirements for entry into medicine (five (5) credits in atmost two sittings (English, Mathematics, Physics, Biology and Chemistry). Medical students and nursing students now sit side by side in the same class and do the same subjects in the first year in the university.

While this enhances the image and status of the nursing profession, it has not brought complete independence to the nursing profession in Nigeria. Take for instance, the faculty of nursing in Niger Delta University, Bayelsa state. It is the only faculty of Nursing in Nigerian Universities. It is under the college of Health sciences. Consequently, all correspondence and actions must go through the Provost, College of Health sciences. Why? It is a faculty, is it not? Faculties in the university system are autonomous. Take for an example, the faculty of Pharmacy, it is autonomous. It is not under college of Health sciences.

For a full autonomy, the faculty of Nursing must be able to govern itself independently, and must have the ability to act and make decisions without being controlled by the Provost of the College of Health sciences.

Some of the reasons why the faculty of Nursing must be autonomous are:

i) No matter how knowledgeable and versatile a professor of Nursing is, he can never be a provost of the college of Health sciences. only a medical doctor can be a provost of the college.

ii) A professor of Nursing, for example, the Dean of the faculty of Nursing, can never be a representative of nursing in the Medical Council of Nigeria. Similarly, the Provost can never be a member or representative of medicine in the Nursing and Midwifery Council of Nigeria.

Medicine and Nursing are health professions, but they are different. Pharmacy is a health profession, Just as Nursing, it is a faculty and it is autonomous, not under the college.

It is therefore a big challenge to nurses in

academics in the universities to:

i) To establish faculties of nursing. Universities of Ibadan, Ibadan and Obafemi Awolowo University, Ile-Ife, should head other universities in this direction.

ii) Faculty of Nursing, Niger Delta University, Wilberforce Island, Bayelsa state, must free itself from the arm-string of the College of Health sciences, just as faculty of Pharmacy has freed itself.

iii) Nursing faculties and departments must endeavour to establish post-graduate programmes- M.Sc and Ph.D.

iv) Finally, nurses must embrace higher education and be assertive. Knowledge is the route of authority, power and independence.

Competency in Nursing Practice.

A major challenge to nurses and nursing is lack of competency in the application of the Nursing Care Process by nurses in their care of clients. Most nurses in Nigeria do not know the Nursing Care Process, and those who know it, do not put it into practice. The Nursing Process is the route of competency in nursing practice.

The nursing process is the nucleus of modern nursing practice. It has seven paradigms (Tura and Walsh (1978); Hegyvary,(1979).

1. Assessment or data collection.

Assessment by the nurse is a systematic, organized, deliberate act of reviewing the clients situation for the purpose of diagnosing his nursing care problems. The process is physical examination of the client with or without instruments, interviewing, collecting data, analyzing and interpreting the data collected.

2. Possible etiology- identifying the possible cause(s) of the clients problem.

3. Diagnosis of the clients problem(s) that the nurse will treat.

Nursing diagnosis is the end-product of nursing assessment. it is a statement of conclusion, either tentative or definitive, drawn by the nurse after having assessed the client's health status. it is not the goals set for the client nor is it nursing intervention. It forms the basis for setting goals and for planning nursing intervention.

4. Setting of goals and objectives.

Based on the diagnosis of the client's problem(s), the nurse now set the goals and objectives of the nursing intervention.

5. Planning for intervention.

This is usually known as the nursing care plan. At this stage the nurse determines what can be done to assist the client in over-coming his/her health problem(s).it involves judging priorities and designating methods to resolve the identified problem(s). This plan of action (Nursing Care Plan) is done at this stage.

6. Implementation of the plan.

This stage is generally referred to as nursing intervention. it encompass the execution by the nurse of the planned actions necessary to achieve the desired goals.

7. Evaluation of the Nurse Intervention

Effectiveness.

This is the appraisal of the effects of the nurse intervention. Here the changes experienced by the client as a result of the intervention by the nurse are appraised to determine their effectiveness.

In sum, the nursing process is the vital life force in nursing practice. Without its application in nursing practice, then nursing practice becomes a routinized, ritualized care, because all clients are not the same, and their problems even if they are similar, they have not the same etiology.

Nursing professionalism depends on true professional practice, not rhetoric. Application of nursing process, which is the vital life force of nursing, in nursing practice, enliven nursing care just as the entry of the vital life force into a new born baby at the first breath animates the baby.

8. Observation of Nurse Professional Ethics.

One of the pillars of nursing professionalism is observation of code of nursing ethics. Ethics is a set of rules of conduct or moral behavior; a body of principles which govern how people ought to behave either as a professional or a member of a social class.

Critics of health care services in Nigeria point an accusing finger at what they call "lousiness" of the health care providers- doctors and nurses. The Nigerian public is now more knowledgeable about their health service rights. Thus the observance of the nurse professional ethics is very important.

The ethics which the nurse is expected to observe range from his/her professional ethics to managerial ethics. This is because from the status of the nursing officer to the Director of nursing services, they are all managers.

They perform the function of management-planning, organizing, staffing, leading, and controlling. They guide, encourage and motivate their staff in order to get the organizational work done. Like all managers in corporate organizations, they manage their clients (patients), human resources (staff) in the organization, finance and equipment.

Ethics is influenced by the geo-socio-cultural values of the people and the professional code of conduct. Thus medico- nursing ethics determine the relationship of the medical and nursing professionals to health care consumers, their colleagues, and the society at large. It provides an essential basis for good medical and nursing practice. Similarly, management ethics determine the relationship of the manager to organizational clients, his colleagues and the society. Nurse managerial ethics is therefore a code of conduct for the nurse aimed at preventing him/her from dehumanizing his clients and subordinates, to maintain a basic concern for his/her organization, staff and clients, and to maintain an awareness for the nurse-manager's socio-political responsibilities.

Therefore the nurse, who is a de facto a manager, must be abreast with the ethics (principles) of management and strictly observe them. This is not a forum for discussing principles of management, however let me mention a few of them:

- Division of Labour.

The economist call it principle of specialization. Division of labour promotes efficiency because it permits the worker to work in a limited area and thus specializes. This is what is done in functional nursing.

- Authority and Responsibility.

Authority is the right to give orders, to control or do something, while responsibility is the obligation to do something. In organizations, "responsibility is the duty one has to perform organizational tasks, functions or assignments" (Hicks & Gullett, 1984). This principle must be adhered to strictly or else, there will be inefficiency and lack of accountability in the organization

- Unity of Command.

The principle states that a subordinate takes order from one superior. If this principle is violated, authority will be undermined, discipline will be in jeopardy, order disturbed, and the stability of the organization threatened.

- Subordinate of Individual Interest to General Interest.

The interest of the organization should come first before personal interest.

- Remuneration of Personnel.

Remuneration should be fair and should give maximal satisfaction to both the employees and the employer, it means the manager should not rob Peter to pay Paul.

- Hierarchy of Authority (Scalar Chain).

There is a chain of superiors in the organization from the highest to the lowest rank. Authority flows along this chain in the organization; it must not be bypassed.

These are few management ethics. They complement nurse professional ethics. Do nurses know them, if they do, are they observing them?. Nurses must know these ethics of management and observe them to avoid the consequences of their violation on their organization and themselves.

Coupled with the managerial ethics are the nurse professional ethics. The nightingale pledge (Nursing Oath) is an embodiment of ethics which the nurse must observe. These code of conduct include:

- Avoidance of Negligence.

Negligence is want of proper care or attention. It means negligence of some care which the professional is bound to exercise toward somebody or something. An act of omission is negligence. For example, failure to serve a medication to a patient.

- Avoidance of Malpractice.

Malpractice professionally means negligence or carelessness of a professional personnel in the performance of an activity or procedure. For example, failure to give attention: wrongful advice to a client about drugs or after operation.

- Incompetence.

Incompetence is not synonymous with negligence. Competence implies possession of a particular skill. Therefore incompetence means failure to exercise that expertise. A nurse who fails to exercise or display that reasonable degree of competence in the skill he/she claims to possess is incompetent.

- Improper conduct.

Improper conduct by the nurse constitute a breach of nurse-professional ethics as well as criminal offence. For example, committing adultery with a client; working under the influence of drugs/drink.

- False Imprisonment.

False imprisonment is the unlawful restraint of an individual's personal liberty or the unlawful detention of an individual. (Amechi Anumonye, 1982) defines it as "unjustifiable detention or preventing the movement of another person without proper consent and the indiscriminate and thoughtless use of restraints". For example, detaining a patient after discharge from the hospital because he/she could not pay his/her hospital bill.

- Invasion of Privacy.

The right of privacy as recognized by law is the right to be left alone, the right to be free from unwarranted publicity and exposure to public view, as well as the right to live one's life without having one's name, photograph or private affairs made public against one's will. (Cazalas, Mary W. 1978).

Any violation of these rights by the nurse is tantamount to invasion of privacy of the client.

In sum, the implications for the professional nurse violation of his/her ethics are numerous and grievous for him/her profession, his/her organization, and for him/her self. Consequently, nurses as professionals, nurses as managers, and nurses as leaders, have a great responsibility to their clients, their subordinates, the organization that employ them, and the society. They have an ethical code of conduct as a health professional, as a manager, and as a leader to uphold, the violation of which goes with high consequences

Conclusion

Finally, my dear fellow nurses, ladies and gentlemen, this discourse has been lengthy. I have not touched all the challenges facing nursing, they cannot all be discussed in one lecture. But I think I have discussed and proffer solution to a good number of them. Permit me to end this discourse with a note of advice. I therefore admonish you my fellow nursing professionals to note that:

He who is silent is forgotten; he who abstains is taken at his word; he who does not advance, falls back; he who stops is overwhelmed, distanced, crushed; he who ceases to grow greater, becomes smaller; he who leaves off, gives up; the stationary condition is the beginning of the end

(Henri Frederic, 1989).

Therefore the Nigerian Nursing Profession and the Nigerian Nurses cannot be silent; to abstain; not to advance; we can not afford to stop; we can not afford to cease to grow greater ; and we can not afford to leave off or give up; because there is no stationary condition in nature, it is the beginning of the end. Thank you.

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PREPARATION FOR HEALTHY LIVING AFTER RETIREMENT

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Introduction

Just like 'death' which majority of us do not like to hear of or talk about, whether we like it or not, if one lives longer, one cannot escape both retirement and death. Whatever has a beginning must have an end. This paper will focus more on socio-cultural aspects of pre-retirement planning towards a blissful retirement.

What is Retirement?

According to the 'Shorter Oxford English Dictionary' the word 'retirement' means, to withdraw from office or an official position; to give up to one's business or occupation in order to enjoy more leisure or freedom, especially after having made a competence or earned a pension. It could also be described as a period of time in our later years when we stop work and start enjoying life. These definitions summaries what retirement means; withdrawal, giving up, leisure, freedom, enjoyment of pensions, seclusion, shelter, security, returning home, returning to one's business or rest.

Causes Of Retirement

- a. Change of Job
- b. Personal feelings
- c. Desire to relocate
- d. Downsizing or forced retirement
- e. Health problems
- f. Grief
- g. Confusion
- h. Anxiety
- i. Insecurity or fear
- j. Adventure
- k. Euphoria
- l. Statutory period of time

Classification Of Retirement

- a. Semi retirement

These borders on change of job or stepping down into other jobs as one ages.

- b. Full retirement

In Nigeria full retirement starts at the age of 60 while in Britain 65, France 62 and the U.S.A. it is 67

Types Of Retirement

Retirement can be summarized in two; namely planned and unplanned

- a. Planned retirement

In this classification, the intending retiree planned for his retirement and look forward to it. Planned retirement could also sub-divided in two.

- (a) Voluntary

This is a situation where the employee voluntarily decide to withdraw from service after putting in some years.

- (ii) Statutory

This is where an employee is expected to retire after

serving for 35 years or specific age (depending on profession) irrespectively of numbers of years of service. It is as follows:

- * Private Sector Employees - 55 years of age
- * Civil Servants - 60 years of age or 35 years in service
- * University dons - 70 years of age
- * State High Court Judges - 65 years of age
- * Federal High Court Judges - 65 years of age
- * Supreme Court Judges - 70 years of age

(b) Unplanned Retirement

The intending retire did not plan for his retirement. It can be by his own making or circumstances beyond his control.

(ii) Compulsory retirement

It is a situation where an employee is made to retire against his own volition. The reasons could be as follows;

- On health ground
- As a form of punishment where the employee has committed a serious offence which can subsequently lead to dismissal or termination of appointment
- Declining or low productivity
- Personal vendetta
- Downsizing due to poor market returns or other economic, political and social factors
- Phasing out of one's office
- Government policy

6. The Decision To Retire And When To Retire

It has been proved by psychologists that an individual makes and takes an average of sixty decisions in a day. And sociologists too, have shown that only 5% of mankind thinks. Thinking leads to decision and planning. However some decisions are momentary, short term, intermediate and long term. Your decision to choose a fixed time for your retirement is yours. Is it early or late retirement?

The answer is; it depends on choice and circumstances. For example, a sportsman automatically retires at 35. But also, one must be prepared for life-long events like divorce, death of spouse, major illnesses or accidents, loss of benefactors or towers of strength which can affect one financially.

However when faced with retirement decision, the following should be considered

- a. Financial position
- b. Talent/Profession/Vocation/Hobbies
- c. Temperament

- d. Family Matters
- e. Lifestyle

rebuke hardens the mind.

- * Never reject a disabled child.
- * Don't expect your children to tell you everything about themselves.
- * Don't discriminate against female children
- * If you, as a father is suspicious of the paternity of a child, go for a DNA test and resolve the matter once and for all, while you are still alive.
- * Don't deny your children of love out of hatred for your spouse
- * Identify the powerful influence of peer-groups on your children.
- * Train your children the art of parenthood from childhood
- * A child born out of wedlock is a child
- * Don't display money in presence of your children. Children know the amount of money and not the value. Teach them to cultivate both savings and investment mentality.
- * Save a little loving from them. They are not your pals.
- * Don't breed the younger ones for the older ones to train
- * Prevent your children from hating each other from childhood
- * Don't train your children the habit of attacking people.

(d)

Your family or Relations

- All of us came into this world through a family. In fact, we were born into a family. And when we die, it is the same family that will arrange for our burial. United Nations was not foolish when it declared a day May 15th of each year as 'Family Day'. An Igbo proverb says that "you can choose your friends but you cannot choose members of family "Remember, for every family there is always a black sheep."
- Accept the positive and negative facts about your family and its members.
- Stand by them, they will stand by your children when you are no more.
- Always show sign of gratitude for any assistance rendered to you by a family member. Try and see to their well being. Build generals or giants among them.
- Arrange for periodic family re-union or meetings.

Time Management

- (I) A stitch in time saves nine' English Proverb
- (ii) Time and tide wait for no man' English Proverb
- (iii) Time is life, when wasted, life is wasted' German Proverb
- (iv) Time is money "Benjamin Franklin
- (v) Teach us to number our days – Psalm 90 vs 12
There are sixty seconds in one minute, sixty minutes in one hour, twenty four hours in one day, seven days make one week, four weeks make one month, twelve months make a year, ten years make a decade, while three decades make a generation. Ask yourself how you have been spending your time. We

must remember that we are only young but once. It is a one time in our life-time; there is no second chance.

Time wasting activities:- Watching TV and films, discussing irrelevances, attending one's time in service of others, idleness, telephoning, listening to the radio all the time. So also spending a lot of time reading the dailies.

To this end, I recommend the following:

- Get busy on your chosen career, learn a trade
- Find time for solitude to allow independent thinking
- Sleep less, talk less
- Reduce the number of friends you have: 'Eagles don't flock together'
- Identify daily specific goals – use the diary
- Establish deadlines
- Use the phone
- Take notes
- Don't do everything, delegate
- Plan in detail for tomorrow
- Remember, working daily for only eight hours can never make you rich.

(e) **Health Management**

As earlier stated, life expectancy of birth in Nigeria today is 47. Why are we dying young? To increase our longevity, I am to recommend the following:

- Find time to rest and sleep. Don't overwork yourself
- Drink plenty of clean water. Avoid alcohol, tobacco and dangerous drugs. Avoid drugs, drugs will avoid you.
- Prevent sexually transmitted diseases by sticking to only one sexual partner, HIV/AIDS is real.
- Take care of your health more than your look.
- Go for routine medical check-up to check your vision, hearing, heart, liver, spleen, kidneys, pancreas, blood, urine, teeth etc.
- Carry out by yourself simple checks on your breasts, testicles, virginal discharge and semen.
- Treat malaria attack promptly. Malaria is No. 2 killer in sub Saharan Africa, after hunger.
- Keep your health problem to yourself. Talk to your doctor only and it is better to keep on doctor who will know your medical history. Don't take your medicine in the dark
- Eat balanced diets with plenty of fruits.' An apple a day keeps the doctor away.
- Watch your health and learn FIRST AID to prevent stress
- When on the wheel, don't claim your right on the road.

(f) **Financial Management and Investment Decisions**

A penny saved is a penny saved. Take care of the pennies, the pound will take care of itself are English adages. Cut costs and become a supersaver. As an employee it's better to invest your idle cash in savings

especially in your co-operative Pension Scheme and shares. Money making is a gradual process.

- Search for your own field. Learn a trade or a vocation after the day's work. Buy books on your chosen field. Get yourself a good apprenticeship. We are in the age of first, second, third and fourth professions.
- Avoid wine, whiff and women
- Buy shares in viable Public Liability Companies
- Pay your debts. "Be just before you are generous"
- Turn your hobbies and your talents into money making
- Cultivate the habit of asking and seeking
- If you plan to retire, you need three things; liquid cash, a home and small enterprises.
- To the end, when proceeding on retirement, save half of your monthly salaries for a year to keep your family afloat financially for a year after. Secondly, set up your own small business.

Choosing A Place To Retire To

This borders on location and relocation. It should be noted that relocation is emotional. In choosing a place to retire to, the following factors should be considered.

- Cultural identity and primordial attachment
- Homey instincts
- Climatic and environmental factors
- Economic reasons and business consideration and employment
- Security consideration: burglary, dangerous animals and reptiles, pests and freedom from communal, political, ethnic and religious upheavals.
- Access to good medical care
- Rates and taxes
- Outdoor activities, religious, sporting etc
- Good transportation
- Cost of living indexes
- Access to information and communication facilities.

After the above factors. You then consider to retire into urban or rural area.

- a. Urban – Is it uptown, middletown or downtown?
- b. Rural – how far from the urban centre?

Home Ownership

This is the third most important decision to make life

Researchers have conclusively agreed that for a hitch-free retirement, one should own his home and pay all debts incurred on it at the age of 40. This gives a breathing space to prepare for the business future. Home ownership could be realized in these ways:

- (a) By gift
- (b) By inheritance
- (c) By direct purchase-either from a private mortgage company, individuals, families and governments.

- (d) By direct construction. This the most expensive and cumbersome option. You have the right of choosing your location and the home of your choice and taste. In building a home for retirement you must consider the following:
- Keep your eyes open when acquiring land. It is better to go through a qualified and reputed estate agent or a surveyor
 - Consider the access-ability of the land to water supply, road networks security consideration, social, ethnic cultural and political background of the neighborhood
 - Build a bungalow with few rooms (2-3) with a separate guest area, a garden and walking space. Let the rooms be three meters from the floor to the ceiling.
 - Install toilets (water closets) with high seats only
 - Provide bright lights to make vision clearer to save one from failing
 - Provide rough surfaced rugs and carpets
 - Maintain security around the house

Enemies Of Pre-Retirement Planning

- (a) Financial recklessness
- (b) Loss of health or any form of disability
- (c) Prolonged litigation or jail term
- (d) Debts
- (e) Keeping bad company
- (f) Loss of spouse, children and benefactors.
- (g) Prepare for a shock
- (h) Loss of income/wages
- (i) Inflation
- (j) Working under a harsh condition or a bad boss.
- (k) Political upheavals or prolonged wars
- (l) Periodic postings/transfers/migration

People belief that retirement is an impossible dream or will not come on time. They work hardest to make money and save little for the raining day., it is saddening to note that some people are still indebt at after 60.

Retirement and Old Age

Retirement: At this stage it is usually 55 or 60 and as one retires, these are the questions one ask his or herself. Am I leaving with pride or honour? What impression am I leaving behind? Am I leaving as a happy or unhappy person? What are my gains or points of all those years of work? Have I enough to live on for the rest of my life? Am I retiring into penury, loneliness, new interest, challenges, children and grandchildren, good health or ill-health? Better opportunity to make money? Where and how do I spend the rest of my life?

One of the omissions of our grand parents was that they think less of their grandchildren. They have no plan for them. Are we not making the same mistake today?

Old Age: Old age is the summary of the whole of our life. Ageing starts from the first year of life. It should be the age of reflection correction and adjustment. People should be wise enough to realize that when we get older our ability to maintain our income declines. And at the same time, the money you need. This is also the time to do less physical work. Time flies, time changes. Welcome grey hairs, wrinkling skin, blurred vision, loss of memory and aching joints. The first part of old-age is the struggle for power. The second part is the naked awareness that the battle is lost or shall be lost. One's children now direct one's affairs. Another problem is isolation or abandonment or loneliness, conflict of balancing value of three generations. There is also an emergence of physical, intellectual, economic and social inferiority.

There is steady loss of friends and relations, coupled with these are anxiety, depression, jealousy, insecurity, adherence to what may be left of life. In addition, there is suspicion of the younger ones. Some behave embittered that they fight their relations, children, sons and daughters-in-laws, and neighbours. They unconsciously destroy what they built over the years'

What To Do To Make Old Age More Acceptable

- Turn your spouse, and children into great friends. In old, it is better to live near ones children
- Love your children's children. Remember grand-children from your daughters are your children's children too
- Have a reasonable source of livelihood. Avoid debts
- Have capacity to make friends of all ages. Adapt to changes
- Don't run the homes of your children for them. Let them make their mistakes
- Handover the baton of leadership to the younger one's
- Forgive those who wronged you and seek forgiveness from those you have wronged.
- Be prepared to shift ground
- Write books
- Take a part-time job
- Take and keep photographs they are good for record purposes and in judicial proceedings
- Keep your health. Retain balance. Be close to humorous people
- Find time to rest and sleep
- Keep pets
- Save money for your funeral ceremony
- Arrange for periodic family re-union
- Be close to your Creator
- Write your own will

Those Who Can Not Retire Blissfully

- a. Traditional rulers
- b. Opinion leaders
- c. Unrepentant political godfathers
- r. Experienced Professionals
- s. Quarrelsome Personalities
- t. Those under curses

- d. Chronic debtors
- u. The Indolents
- e. Those without retirement savings
- v. Lack of home ownership
- f. Those who lack income
- g. People with divorce repercussions
- h. Those who are ill (i.e terminal ailments)
- i. Those with lack of credible successors
- j. Those who raised their children late
- k. Fastidious personalities
- l. Greedy personalities with acquisitive instincts
- m. Workaholics
- n. Brutes
- o. Prophets/seers
- p. Pathologically stingy and selfish people
- q. sex workers

Write your own will what is a will?

A will it is a testamentary document voluntarily made and execute in accordance with the law by a person called testor with a sound disposing mind in which document he disposes of his properties and gives other directives as he may deem fit"

This implies that:

A will is testamentary. That is, it takes effect only from the death of the testor. A Will speaks from the grave or after death. It also implies that once a person is alive, he can make or revoke a will

- b. A Will must be made voluntarily
- c. A Will must be executed in accordance with the existing laws regulating the making of Will
- d. The maker of Will must be of a sound mind as at the time he is making the Will.

Where a Will is not made (to die intestate), it is difficult and more expensive to have grant of administration issued Granting letters of administration, there has to be a bond and additional provision of sureties to ensure that the estate is properly administered.

Laws Regulating Wills

The English Will Act 1839 and Will Amendment Act 1858. These are formally applicable in the Statute Books in Nigeria except the defunct Western Region which enacted its own law in 1959. As today, there are various laws on inheritance in Statute Books of different states which are tailored in line with the religious and cultural settings of the states.

Why Should You Write a Will

Planning for dependants or Loved Ones

It is also referred to as planning for dependents or planning ahead for our loved ones. All of us must take cognizance of one thing of our existence on this planet, that we may die unexpectedly and at times one does not need to be sick before he or she dies. In this wise, a wise person should make an advance provisions for his surviving loved ones, after his exit from this planet.

One of the problems of our society is that most of us do not like to think about the possibility that we might die, at any time, much less plan for death. To be frank, we cannot foresee the day of our death.

Planning for the possibility of death should be practical. It should show loving concern for our survivors.

Prevention of Properties Grabbing

Human beings are dangerous. Widows in many societies suffers most when their husband dies.

Who Can Make a Will?

Virtually everyone who is over 18 years of age can and should make a will. I am to explain to you here, that it should be that noted atimes you don't need a lawyer to prepare your will for you. You can make a do-it-yourself will. But it is better to consult a lawyer who is in a better position to explain the legal stand of the possessions to be incorporated in the will. However, it is good to make a simple will. The will should not be alien to the cultural values of your ethnic group.

Those Who Cannot Make a Will

1. Minor: A minor is a child under the age of 18. A will made by a minor is not valid unless he is a serviceman
2. Persons of unsound mind
3. The blind: He can not attest to Will because he can not be a witness to what he cannot see.

Who Can Benefit From a Will?

During preparation on the beneficiary of a Will, one must consider the facts that the beneficiaries can die or get missing or becoming of unsound mind before one's death. So it is always good to think of any eventuality.

Children: This include children fathered outside marriage; bring them home before your death and admit your mistakes. So also an adopted child, is entitled.

Spouse: If you have more than one husband or wife you can share your properties among them

Animals: This is in form of funds for the upkeep of the animals

Extended: Family members – Cousins, Nephews, Aunties, Uncles, In-laws etc

Charities or Gifts: i.e old peoples homes,, libraries; poor, maintenance of sick and maimed soldiers, advancement of education, repair of bridges, orphans, disabled, advancement of religion, foreigners Trade Unions, Federal, States or Local Governments.

Domestic: Staff : Cooks, Gardeners, Security Guards, Drivers, House-helps, Personal Assistants etc.

What Property Can Be Dealt With In A Will?

1. Your Body

Disposal of one's body after death whether by burial or cremation, funeral arrangements, maintenance of grave; what gravestone or monument should be set up or epitaph on one's tomb. One can will his body or part of his body for the purposes of medical science or for spare part surgery. (i.e eyes, heart kidneys) or medical researches, for the case of spare parts. It must be removed by surgery immediately (few hours) after death. The

in the presence of next of kin.

2. Lands & Buildings

It is a common scenery these days to observe in our towns and cities the inscription: "This house is not for sale" and This land is not for sale Beware of 419s". This is a clear indication that many people who have gone to the world beyond did not prepare a Will. That is, they died intestate (without a will). A person may dispose in his will of any freehold land or houses of which he is the sole owner. He cannot will a property that is jointly owned like those in business partnership and properties owned by both husband and wife.

3. Insurance policies

This depends on the terms of the insurance policy

4. Shares in Companies

5. Money

Gift of money in a will are usually referred to pecuniary legacies

6. Specific items

7. Property abroad

Step to be taken when Making a Will

- 1.** List all the properties (both movable and immovable) you have and assemble all documents of your entitlement to them. This also include cash that will be flowing into one's estate
- 2.** Make a list of the beneficiaries including charities and other organizations
- 3.** Select your executors. (members of family, friends, solicitors or a bank). Ask for their charges and incorporate them in your will.
- 4.** Write your will in your own clear and legible handwriting (holographic). It is better than typed one, because a hand-written will is very difficult to be tampered with. But use a clean sheet of paper. If you are producing several copies, copy all of them in your own handwriting.
- 5.** When you sign your will, make sure that you have two (2) strategic witnesses who actually see you sign. And also make sure that they too sign the document in the presence of each other. When you all sign, you can thumb-print. Remember, you cannot leave any inheritance to the two witnesses. Make sure that your signature is your usual one
- 6.** Make sure that all is dated the day you sign
- 7.** Incorporate your current address and your profession
2, Church Street
(foreman, WAPCO Ewekoro)
Daniel Bakare
8, Ibogun Road
Ifo, Ogun State
(Class Teacher)

Fold up your Will and place a copy each in different envelopes and clearly mark it "The last Testament of Ajayi James (Your name) if the person

making the will is a married woman she inscribe her maiden name: Mrs. Mary Ajayi (Nee Chukwu).

Custody of a Will

Put copies of your Will in safe place where it will not be lost or destroyed.

The places can as follows depending on your choice.

1. Lodge it at the High Court of Justice Registry
2. Deposit it in your Bank
3. You can keep it with your club or society or social group you belong
4. Your lawyer
5. Priest or Imam that is well known to you
6. Your trusted friend

Revocation of a will

A Will can be revoked or cancelled in three major ways

- (a) By another fresh will
- (b) By subsequent marriage under the marriage act and
- (c) By destruction in doing this there must be intention to revoke the will

Note that a will is not revoked if

- (a) It is destroyed in a fit of madness
- (b) It is destroyed by mistake
- (c) It is destroyed as a result of intoxication or,
- (d) It is lost

In case you want to write a will, consult your solicitor. Remember, it is better for your children to inherit business enterprise than to inherit houses. Inheriting mortgage properties always end them becoming loafers and indolents.

At the same time one should ask himself, where is Solomon's wealth?

Conclusion

Yesteryears will continue to look like yesterday the journey from cradle to grave start from birth. As we count our days on this planet, death is the ultimate. And as we take all life has to give, we will give all we have back to life. Retirement and death real Treasure these words, they are yours to keep.

I am thanking you for listening to the lecture.

God bless.

Being an address presented at FOLGONM 2012 National Conference @ Abeokuta, Ogun State.

PREPARATION FOR HEALTHY LIVING AFTER RETIREMENT

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Introduction

Just like 'death' which majority of us do not like to hear of or talk about, whether we like it or not, if one lives longer, one cannot escape both retirement and death. Whatever has a beginning must have an end. This paper will focus more on socio-cultural aspects of pre-retirement planning towards a blissful retirement.

What is Retirement?

According to the 'Shorter Oxford English Dictionary' the word 'retirement' means, to withdraw from office or an official position; to give up to one's business or occupation in order to enjoy more leisure or freedom, especially after having made a competence or earned a pension. It could also be described as a period of time in our later years when we stop work and start enjoying life. These definitions summaries what retirement means; withdrawal, giving up, leisure, freedom, enjoyment of pensions, seclusion, shelter, security, returning home, returning to one's business or rest.

Causes Of Retirement

- a. Change of Job
- b. Personal feelings
- c. Desire to relocate
- d. Downsizing or forced retirement
- e. Health problems
- f. Grief
- g. Confusion
- h. Anxiety
- i. Insecurity or fear
- j. Adventure
- k. Euphoria
- l. Statutory period of time

Classification Of Retirement

- a. Semiretirement

These borders on change of job or stepping down into other jobs as one ages.

- b. Full retirement

In Nigeria full retirement starts at the age of 60 while in Britain 65, France 62 and the U.S.A. it is 67

Types Of Retirement

Retirement can be summarized in two; namely planned and unplanned

- a. Planned retirement

In this classification, the intending retiree planned for his retirement and look forward to it. Planned retirement could also sub-divided in two.

- (a) Voluntary

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CARING NEEDS OF A PATIENT WITH ASTHMA

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Abstract

Many physical social and emotional disabilities associated with asthma result in social dependent on the spouses and significant other. Little is known about the dependency needs of a person with asthma in the management of every day to day activities. There is need that the caring needs of the asthmatic be known to the public and especially to the family so as to reduce the suffering of the asthmatic patient. The sign and symptoms should also be known to enable them go for medical treatment on time. Prevention of trigger factors or minimizing them as much as possible will also reduce the incidence of asthmatic attacks and hospitalization which could be financially and emotionally draining to the patient and the family.

In this paper we have discussed the caring needs of a patient with asthma.

Introduction:

Asthma is a chronic inflammatory disease affecting the lower airway of which manifests as reversible airway obstruction and mucosal inflammation resulting in airway narrowing (bronchi constriction).

In many countries, the prevalence and death from asthma is increasing particularly in the second decade of life where this disease affects 10–15% of the population.

For most patients, asthma is disruptive, affecting schools, work, occupational choices, general activities and quality of life. Little is known about the caring strategies used in responding to the dependency needs of persons with asthma in the management of daily activities, knowledge about such caring needs would be useful to healthcare providers in helping families deal with the changing and long term demands required when living with an asthmatic patient.

Caring is defined by chambers universal Learner's Dictionary, international students' edition as close attention. Caring is to feel concerned for the safety and well being of another, to have regard (Esteem) for and be interested in the situation of another ("Webster Third New International Dictionary, Unbridged", 1971).

Caring is directed at regulating physical, psychological and emotional response to the offending organism that results to asthmatic attacks (Barbar M. J, 1977).

Needs are defined generally in terms of lack, that is, something which is missing and by its absence leads to tension in the organism. When the thing lacking is supplied, tension abates. Reasons for providing the asthmatic with the needs are to enable him cope with his activities of daily living and be less burdensome to the family and the significant others. The presence of dependency needs among persons with chronic asthma can have an adverse effect on the health of spouses and significant others then solution to such should be provided.

Objective

At the end of the presentation, the participants will be able to:-

1. Explain the concept of Asthma
2. Demonstrate adequate knowledge, pathophysiology of asthma clinical manifestations of Asthma, and management of a patient with Asthma and related problems.
3. Identify caring needs of a patient with asthma through Assessment and diagnostic findings.
4. Explain ways of meeting the identified caring needs of an asthmatic patient using nursing process.

Concept Of Asthma

Asthma is a condition associated with increased excitability affecting the airways (bronchi of the lungs) doctors often refer to this as increased "twitchiness" of the airways (Dr. Brown M.N. 1990).

Asthma has been classified as an allergic disease despite the fact that it is not always caused by hypersensitivity to an allergen. Hypersensitivity is found to be a predominant cause in only one third of cases and a contributing factor in another third (Beland I.L 1975). Allergic factors in urticaria sometimes precede development of asthma or may occur at the same time. Inhaled pollens, mold and dust are associated with both asthma and allergic rhinitis. Asthma has been divided into extrinsic and intrinsic forms.

Extrinsic asthma occurs when the allergy is due to substances originating extrinsic to the body. Those persons who inherit the tendency for certain anaphylactic responses are termed atopics and the responses are called atopic disease. They typically have history of infantile eczema, allergic rhinitis or gastrointestinal food intolerance. Symptoms usually start in childhood. There are immediate skin allergies and the results correspond to provoking factors described in the history. Asthma may be completely stopped in the extrinsic group of patients when

exposure to the offending allergen is stopped.

Intrinsic asthma is not usually preceded by history of certain anaphylactic responses symptoms usually begins in adult life. Perennial non allergic rhinitis and nasal polyps may be present. There is no relationship between wheezing and exposure to common allergens. This type of asthma usually begins with an illness suggesting, infection from time to time but this is not the cause of the persisting symptoms.

Asthma is frequently mild but can also be disastrously severe and quite unpredictable or so fluctuant that patients are mistaken for neurotic or malingeringers. Death is unusual but can occur unexpectedly with overwhelming suddenness, so it can be dangerous to underestimate asthma.

(According to Dr. Brown, 1990) about one in ten children suffer from asthma. Symptoms usually presents before five years of age. The diagnosis is very difficult in the very young but recurrent cough, wheeze or chest infection should make one suspect the condition. The disorder appears to be more common in urban communities than rural population and occur throughout the world with varying incidence depending on genetic and local environmental factors.

Pathophysiology

Knowledge of pathophysiology of asthma will help to know how the drugs work. In allergic asthma, the basic lesions occur in the bronchial tubes.

Asthma is characterized by specific pattern of inflammation that is largely driven via immunoglobulin (Ig) E dependent mechanisms. Genetic factors have an important influence on whether atopy develops and several genes have now been identified. Most of the genetic linkages reported for asthma are common to all allergic disease. However environmental factors appear to be more important in determining whether an atopic individual develops asthma although genetic factors may exert an influence on how severely the disease is expressed and the complication of the inflammatory response. Foreign materials that provoke IgE production are described as "allergens" the most common are proteins from house dust mite, cockroach, cat dander, molds and pollens.

The tendency to produce IgE antibodies is genetically determined. IgE antibodies bind to mast cells in the airway mucosa.

On reexposure to a specific allergen antigen antibody interaction on the surface of the mast cells triggers both the release of mediators stored in the cells, granules and the synthesis and release of other mediators primarily by decreasing the cAMP, which inhibits the release of chemical mediators and causes bronchi constriction.

The histamine, typtase, leukotrienes C4 and D4 and prostaglandin D4 when released, diffuse through the airways mucosa triggering the muscle contraction and vascular leakage responsible for the acute broncho constriction, the "late asthmatic response" which is associated with an influx of inflammatory cells into the bronchial mucosa and with an increase in bronchial responsiveness that may last for several

weeks after a single inhalation of allergen.

The mediators responsible for this late response are thought to be cytokines characteristically produced by TH2 lymphocytes, especially interleukins 5, 9 and 13. Some adults with asthma have no evidence of allergic sensitivity to allergen, and even in people with allergic sensitivity the severity of symptoms correlated poorly with levels of allergen in the atmosphere.

Bronchospasms can be provoked by non allergic stimuli such as distilled water, exercise, cold air, sulfur dioxide and rapid respiratory maneuvers.

This tendency to develop bronchospasm on encountering stimuli that do not affect healthy nonasthmatic airway is characteristic of asthma and is sometimes called "nonspecific bronchial hyper reactivity to distinguish it from bronchial responsiveness to specific antigen"

Clinical Manifestation

All these changes described in the pathophysiology of asthma contribute to the interference with breathing which is the major manifestation in asthma. At the onset of the attack the patient is likely to feel he is about to suffocate and this behavior may suggest that he is in a state of panic or acute anxiety. The feeling of suffocation accompanying an attack of asthma probably always engenders feelings of fear and anxiety and may prolong the attack after it is underway. Because the bronchi dilate with inspiration air is trapped in the lung, causing them to be distended and chest to be in a continuous state of expansion. Therefore the efforts of the patients are directed towards forcing air out of the lung during expiration. Respiration is accompanied by a wheeze that is audible, coughing stimulated by an increase in the secretion of mucus.

The other signs and symptoms include tightness of chest, dyspnoea, tachycardia, hypoxemia, Diaphoresis and central cyanosis.

Caring Needs Of A Patient

1. The management of a patient with asthmatic attack is directed at meeting the basic physical and psychological needs.
2. Reducing the allergic response, dilating the bronchi, decreasing the anxiety of the patient and correcting the conditions predisposing to asthma.
3. Meeting needs in a consistent, dependable way is necessary for fostering physical growth and psychological security. Man constantly strives to maintain equilibrium to his environment through meeting basic needs.
4. An asthmatic is most often confronted with many urgent attention from care providers. The caring needs are hereby enumerated as below:
 - i. Adequate supply of oxygen to the lungs
 - ii. Facilitation of Airway patency
 - iii. Relief of Apprehension and fear
 - iv. Reduction of metabolic demands

- v. Maintenance of rest and Activity
- vi. Decrease effort of breathing
- vii. Maintenance of Nutrition and hydration
- viii. Maintenance of elimination
- ix. Prevention of infection
- x. Maintenance of other activities of daily living.



reversal of airway constriction.

Long term control is most effectively achieved with anti-inflammatory agents such as inhaled glucocorticoids. It can also be achieved with leukotriene pathway antagonists or inhibitors of mast cell granulation or an inhibitor of mast cell degranulation, such as cromolyn or nedocromil. Clinical trials have established the efficacy of treatment for asthma with a humanized monoclonal antibody, omalizumab, which is specifically targeted against IgE, the antibody responsible for allergic sensitization.

Other management of care include:-

Management of exacerbations

In addition to the use of drug oxygen supplementation may be required to relieve hypoxemia associated with moderate to severe exacerbations. (Expert panel Report, 2003). In addition response to treatment may be monitored by serial measurement of lung functions etc peak flow monitoring. Monitoring of the peak expiratory flow using the peak flow meters, a handheld device allowing the person to determine the airflow in the lungs. It measures the highest airflow during a forced expiration. Daily peak flow monitoring is recommended for all patients with moderate or severe asthma because it helps measure asthma severity. And when added to symptom monitoring, indicates the current degree of Asthma control.

The 2003 expert Panel Report recommends that peak flow monitoring should be considered as an adjunct to asthma management for patients with moderate to severe persistent asthma among others.

Peak flow expiratory flow rate (PEFR) measures how fast air is moving out of the lungs. As asthma worsens PEFR decreases.

Nursing Management

Specific nursing management

The immediate caring needs of patient with asthma depends on the severity of symptoms. The patients may be treated successfully as an only patient if asthma symptoms are relatively mild or may require hospitalization and intensive care if symptoms are acute and severe. The patient and family are often frightened and anxious because of patient's dyspnoea. Therefore, a calm approach is an important aspect of care.

- The nurse generally performs the following tasks apart from obtaining a history of allergic reaction to medications before administering medications.
- Identifies medications the patient is currently taking.
- Administer medications as prescribed and

Medical management

Immediate intervention is necessary, because the continuing and progressive dyspnea leads to increased anxiety, aggravating the situation.

Pharmacologic therapy

There are two general causes of asthma medications: Quick relief medications for immediate treatment and asthma symptoms and exacerbations and long – acting medications to achieve and maintain control of persistent asthma

- Short term relief is the most effectively achieved agents that relax airways smooth muscles, of which β -adrenoceptors are the most effective and most ideally used. Theophylline, a methylxanthine drug and antimuscarinic agents are also used for

monitor the patients response to those medications. An antibiotics may be present if the patient has an underlying respiratory infection.

- Administer oxygen if prescribed
- If the patient requires intubation because of acute respiratory failure, the nurse will assist with the intubation procedure, continuous close monitoring of the patient and keep the patient and family informed about procedures.

Identifying the caring needs of a patient with asthma by nursing assessment using gordon's function typology

Health perception and health management pattern

- Get history of illness and find out patients understanding of illness and medical diagnosis, procedures, treatment and prognosis. Can he/she give a thorough history of his/her illness, previous treatment, progression in illness etc.
- Take history of habits, allergies, risk factors, respiratory difficulty, wheezing, coughing Appreciation of need for education.
- Assess for use of home and/or community based care and compliance with care.

Nutritional/metabolic

- Find out previous body weight, current body weight
- Assess for usual eating, appetite, food preferences, skin turgor etc (state of hydration,

list of common foods).

Elimination pattern. How many times he or she moves bowel or micturates in a day
Activity – exercise pattern can she/he walk a little distance.

Sleep – rest pattern: Whether he or she sleeps well at night without being disturbed by asthmatic attack or anything.

Cognitive perceptual pattern
Self-perception/self-concept pattern
Role relationship pattern
Sensuality/reproductive pattern
Coping/stress-tolerance pattern
Values/belief patterns

Following the assessment of patient, the identified nursing Diagnosis (caring needs) include the following:

- Impaired gas exchange related to broncho constriction by wheezing, dysnoea and cough.
- Anxiety related to unknown outcome of disease condition evidenced by apprehensive and asking too many questions
- Ineffective airway clearance related to increased mucus production, evidenced by persistent cough.
- Activity intolerance related to hypoxemia and breathlessness as evidenced by fatigue.
- Ineffective coping related to anxiety as evidenced by reduced socialization.
- Deficient knowledge regarding home self management evidenced by patients verbalization of deficiency in knowledge.
- Imbalanced nutrition, less than body requirement related to exhaustion.

Nursing Care Plan Of A Patients With Asthma

s/n	Nursing Diagnosis	Nursing objectives	Nursing orders	Scientific Rationale	Evaluation
1.	Impaired gas exchange related to broncho-constriction and broncho secretion evidenced by wheezing dysnoea and cough	Patient will breath with ease by breathing at the rate of 18 -24 cycles per minute within 45 minutes of nursing intervention	1. Adequately hydrate patient 2. Place patient in an orthopneic position 3. Teach and encourage the use of diaphragmatic breathing and coughing techniques 4. Administer prescribed broncho dilators/Assist in administering nebulizer or MDI 5. Monitor pulse oximetry and arterial blood gases. 6. Administer prescribed supplementation of oxygen and assist intubation of patient if need be.	1. Systematic hydration keeps secretions moist and easier to expectorate. 2. Orthopneic position ensures adequate expansion. 3. These technique helps improve ventilation and mobilize secretions without causing breathlessness and fatigue. 4. Bronchodilators dilate the airway this ensures adequate delivery of medications to the airways. 5. Recognition of changes in oxygenation and balance will guide in correcting and preventing hypoxemia 6. Administration of oxygen and provision of mechanical ventilation are critical to survival if indicated.	Patient was able to breath freely at the rate of 24 cycles per minute after 40 minutes of nursing intervention.
2.	Anxiety related to known outcome of disease condition evidenced by apprehension and asking too many questions	Patient will be less apprehensive and verbalize concern within 24 hours of interventions.	Establish rapport with the patient, explain the cause and course of illness to him. Introduce patient to other patients on the ward with the same condition. Give diversional therapy, such as watching TV, playing games, serve prescribed anxiolytic e.g. Tab. Lexotan 1.5mg	Make patient to have confidence in the nurse and co-operate with him or her. Enable him know that the condition is manageable help patient know that the outcome of the disease is favourable with treatment. Helps take away patients attention from his condition. Relaxed the patient and takes away his mind from the condition	Patient was less apprehensive and communicated freely after 18 hours of nursing intervention.

3.	Self-care deficit related to insufficient ventilation and oxygenation evidenced by fatigue	Patient will be kept and will gradually participate in his activities of daily living within 48 hours of nursing intervention.	Teach patient Diaphragmatic and pursed lip breathing Assist patient with activities of daily living Encourage alternative activity with rest periods. Allow patient to make some decisions (bath, shaving) about care based on tolerance level.	Help patient to prolong expiration time and decrease air trapping with these techniques, patient will breath more efficiently and effectively. Activities of daily living (ADL) ensures that personal hygiene is maintained. Spacing activities permit patients to perform without excessive distress	Patients self care was maintained and patient participated actively in his care after 36 hours of nursing intervention.
4.	Activity intolerance related to the disease process evidenced by tiredness	Patient will exhibit calmness and conserve energy by remaining in bed while symptoms persists and slowly increase his activities within 48 hours of nursing intervention.	Patient will exhibit calmness and conserve energy by remaining in bed while symptoms persists and slowly increase his activities within 48 hours of nursing intervention	Promote rest and enhances breathing aids energy conservation . Helps conserve patients energy. Ensures that these activities are well taken care of with less energy expended by the patient.	Patient was able to exhibit calmness on the bed and participated in some activities he was comfortable with after 48 hours of nursing intervention
5.	Deficient knowledge regarding home . Self management evidenced by patients verbalization of deficiency in knowledge	Patient will have good knowledge of the cause/course and treatment in regimen about the disease condition within 72 hours of nursing intervention.	Teach the patient about disease, medications, procedures and how and when to seek help Give strong message to stop smoking and exposure to known irritants, discuss smoking cessation strategies , provide information about resource groups e.g. (smokenders)	Patient needs to be a partner in developing the plan of care and needs to know what to expect. Teaching about the condition is one of the most important aspect of care; it will prepare the patient to live and improve quality life. Smoking and other irritants cause over stimulation of the airway. Air flow is obstructed and lung capacity is reduced. Smoking increases mortality and is also a risk factor for lung cancer.	Patient demonstrate understanding of his condition on management after 48 hours of nursing intervention.

Complications

Complications of asthma may include respiratory failure, status asthmaticus, respiratory failure, pneumonia and atelectasis. Airway obstruction, particularly during acute asthmatic episodes, often results in hypoxemia.

Status Asthmaticus

This is a severe and persistent asthma that does not respond to conventional therapy. The attacks can occur with little or no warning and can progress rapidly to asphyxiation. Infection, anxiety, nebulizer abuse, dehydration, increased adrenergic blockage and non specific irritants may contribute to these episodes. An acute episode may be precipitated by hypersensitivity to aspirin.

The most common scenario is severe bronchospasm, with mucus plugging leading to asphyxia. There is a reduced PaCO_2 and initial respiratory alkalosis, with a decreased PaCO_2 and increased pH. As status asthmaticus worsens, the PaCO_2 increases and the pH decreases, reflecting respiratory acidosis.

An MDI with or without a spacer may be used for nebulization of the drugs. The patient usually requires supplemental oxygen and intravenous fluid for hydration. Oxygen therapy is initiated to treat dyspnea central cyanosis and hypoxemia. Sedative medications are contraindicated. Magnesium sulphate, a calcium antagonist may be administered to induce smooth muscle relaxation. Adverse effects of magnesium sulphate may include facial warmth, flushing, tingling, nausea, central nervous system depression, respiratory depression and hypotension.

Preparation available

Sympathomimetics (β agonists) used in

Asthma

- Albuterol (generic, proventil, ventolin)

- Inhalant: 90mcg/puff aerosol;0.083, 0.5, 0.63% solution for nebulization.
- Oral: 2, 4mg tablets; 2mg/5ml syrup
- Oral sustained-release: 4mg, 8mg tablets

Aerosol corticosteroids

- Bedomeetasone (OVAR)
- Aerosol:40, 80mcg/puff in 100 dose container
- Budesonide (pulmicort)

Leukotriene inhibitors

- Montelukast (singulair)
- Oral; 10mg tablets; 4, 5mg chewable tablets, 4mg packet granules.
- Zafirlukast (Accolate)
- Oral: 10mg, 20mg tablets

Cromolyn sodium & nedcromil sodium

Cromolyn Sodium

- Pulmonary aerosol (generic, intal): 800mcg/puff in 200 dose container, 20mg/2ml for nebulization (for Asthma)
- Nasal aerosol (nasalcrom): 5.2mg/puff (for hay fever)
- Oral (gastrocrom): 100mg/5ml/concentrate (for gastrointestinal allergy).

Summary

Respiratory disorders such as asthma are anxiety provoking for the client because they threaten the ability to breathe comfortably. The caregivers at all times should recognize this and establish a climate of trust with the client in order to help allay this anxiety, foster co-operative participation and health directed interactions. The caring needs of a client with asthma depends solely on recognizing the needs and attending to them in their order of priority.

Conclusion

In conclusion, I have succeeded in explaining

the concept of Asthma, demonstrated adequate knowledge of the causes, pathophysiology, clinical manifestation management of a patient with asthma and related problems. I have also succeeded in identifying the caring needs of a patient with Asthma through the assessment and diagnostic findings.

Explain ways of meeting the identified caring needs of an asthmatic patient using nursing process.

Recommendation

Asthma restricts the activities of the patient and disrupts family and social life. The cost and stress of emergencies room visits and hospitalization can be financially and emotionally draining to the client and family. Care givers should be cognizant of these factors and refer patients to the appropriate social services/agencies for help. During convalescence of the client, the family members should be involved in all aspect of care in order to assist the patient when the illness becomes more severe and provide emotional support.

Psychological support of both patient and family is essential. Verbal reassurance, explanation of therapies used and non verbal communication such as touch and time spent with the client are supportive. Health education and counseling is an important aspect of this caring needs because it will help client avoid those trigger factors that predispose them to asthmatic attack.

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CREATIVITY IN NURSING: IMPLICATION FOR QUALITY NURSING CARE

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Abstract

Today's health care delivery system is witnessing lots of challenges emanating from advance technology and knowledge explosion to meet this demand of these challenges, this paper looked at how nurses who are expected to acquire and apply current knowledge and skills in the provision of care that meets the needs of the health care consumers through creativity. It is universally accepted that high quality care is the right of all patient and the responsibility of all nurses to give it. To achieve this, shift must be made from the traditional nature of care which utilizes simple problem solving to more complex thinking – creative thinking and this has led to the development of strategies and guidelines in helping nurses to be creative which will help them in finding unique (one of a kind) solution to unique (one of a kind) problem. Based on the conclusion, recommendation were made to ensure that nurses become creative in thinking in order to give a quality nursing care to the teaming consumers.

Introduction

Today's health care delivery is witnessing lots of challenges emanating from advanced technology and knowledge explosion. Nursing practices and quality care have been the major focus of most discussion in recent times, the reason being the need to strengthen strategies whereby the practice would benefit the client served and most practitioners.

It is universally accepted that high quality care is the right of all patient and the responsibility of all nurses to give it.

To meet the demands of the challenges of quality care, nurses are expected to acquire and apply current knowledge and skills in the provision of care that meets the need of the health care consumers.

To achieve this, a shift must be made from the traditional nature of care which utilizes simple problem solving to more complex thinking – creative thinking.

To adoption of an ethic of creativity will allow nursing practice to stretch the limits of the nurse and collective knowledge skill and ability to meet complex health consumer's needs.

Creativity is needed in all aspect of nursing because it finds unique solution to unique problems and further establish and reinforce practice; a level that appropriately sees the nurse as a creative member of the care team.

This paper will try to explain creativity, the concept of quality nursing care models of creativity stages in creativity, characteristics of a creative thinker, attitudes that foster creativity in nursing, impact of creativity in Nursing and there after discuss creativity a strategy for quality nursing care.

Concept Of Creativity

Creativity comes from the Latin work "creare" (to cause, to exists) the ability to make something exist. It is however more of an internal word, subjective, for harder to measures and simply means getting good ideas.

Creativity in thinking is defined by Reilly and

Qermann (1992, p 217) as thinking that results in the development of new ideas and products.

Strader (1992) defined creativity as the ability to develop and implement new and better solutions. Creativity can then be said to be introduction of a new concept idea, service, process or product aimed at improving treatment diagnosis, education, outreach prevention and research and with the long term goals of improving quality, safely, outcomes, efficiency and cost.

Concept Of Creativity

- ❖ Creativity is a major component of critical thinking
- ❖ Creativity helps in finding unique (one-of-a-kind) solution to unique (one-of-a-kind) problems.
- ❖ Creativity is required when a nurse is faced with a challenging situation where traditional interventions are not effective.
- ❖ Creativity thinkers ask questions such as what if? Or why don't we try something different?
- ❖ Creative thinkers use brain storming for eliciting ideas, decisions or solution to problem.
- ❖ Creative thinkers must have knowledge of the problem, assess the problem and be knowledgeable about the underlying facts and principles that apply.
- ❖ Creative thinking involves the nurse applying multidimensional skills, cognitive or mental process or set of procedures in the provision of care.

Concept Of Quality Nursing Care

Hornby (2001) saw quality as high standard or Feature of something especially one that makes different from something else.

Ugochukwu (2006), asserts that quality like nursing is difficult to define but in line with some author's opinion. It could be equated to excellence and belief that the best service is being rendered and received.

Quality nursing care is the care rendered by nurses to their numerous care consumers that can be said to be of high standard, or satisfies the recipients which must be timely, cost effective and evidence based. Quality makes our health care services to function as per expectation (Ugochukwu 2006). In quality nursing care, the nurse degree of proficiency by Okoronkwo (2004) affirmed that for one to be quality oriented, adequate training is needed to enhance efficiency and this can be achieved when employers (including nurses) are adequately trained and are provided with relevant information, given the best possible tools and are adequately rewarded.

Models Of Creativity

Few models are explained for want of space and to enable us have a better grasp of the ways we can initiate creativity and its implementation for quality client care and nurse satisfaction.

- ❖ **Creative model of waiting Programme**

The waiting programme utilizes a unique partnership between health professionals and the arts and cultural sector to ensure that health and wellbeing is at the heart of our health services.

We already know that our surroundings, our relations and how we spend our time can have a massive being on both our emotional and physical well being. Waiting builds on this established wisdom by injecting creativity into traditional care solutions and settings, to expand our ideas about what keeps us healthy and create new opportunities for improving the patient experience. For example, it is well known that being in the natural world can be very healing, so by bringing bird song into waiting rooms, we are able to experience some of the benefits of the outdoors in an environment where we are seeking care. Similarly, there is now considerable research about the positive effects of laughter on our physical health and emotional well being, so perhaps a good dose of giggles can enhance our work and help us deal with aches and pains. Finally, imagine how the stress and anxiety of an out patient appointment could be lessened by inspirational films in the waiting room. These are just some of the experiences that are part of the waiting programme which could be expanded to include more.

The Transformational Model For Professional Practice In Health Care

It is a descriptive picture of the factors necessary to support professional practice and patient care, the processes to meet the challenges of tomorrow's health care systems and the outcomes that can be anticipated.

It is divided into four components:

- **The professional practice components;**

This is core of the model which reflects the unique contribution each clinical discipline brings in caring for a patient. In times of

transformation and limited resources, it is critical that each clinical discipline carefully analyse its practice to eliminate elements that do not add demonstrated value to patient outcomes.

The process components

This is intended to reflect the processes used by professionals in caring for patients. In a transformed health care environment, "routines" of care that do not add value to patient care need to be abandoned. Care requirements will be negotiated between the patient and care givers resulting in highly individualized goals. Once these goals are determined, the mutually established plan of care will be purposeful, reflect the uniqueness of the patient, be sensitive to the availability of resources and be targeted directly to the desired outcomes.

The primary outcome component

The primary outcomes related to the patient includes the level of

- * Satisfaction with the quality of care received and accessibility of care
- * Congruence between patient and caregiver in determining health care needs and prioritizing health care services and activities.
- * Responsiveness to patient's needs, (as perceived by the patient)
- * Participation in planning and executing care.

The primary outcomes related to the health care team include:

- * A dynamic work environment that is supportive of higher performance behaviors
- * The transformational quality of professional relationship
- * The voice and power of caregivers to contribute to goals of the organization.
- * The support available for personal and professional growth.

The strategic outcome component

The strategic outcomes related to consumers includes:

- * The willingness to consumers (patients, caregivers, third party payers to promote and/or engage in future relationships with the organization.

The strategic outcomes related to the organization include:

- * The increased ability to respond flexibly to the dynamic changes in health care.
- * The increased ability to position itself to compete financially in the health care market.
- * An enhanced reputation for the provision of quality care.

The strategic outcomes related to the profession include:

- * The ability of the members of the organization to influence the direction and growth of individual members of the organization as well as the professional organizations to which they belong.
- * The ability of the members of the organization to influence the direction and growth of the professional disciplines (nursing, medicine, social services etc) through educational offerings, professional publication and research contributions.
- * The willingness of the organization to invest in the future direction of the professional discipline.

Transforming Care At The Bedside Model

Transforming care at the bedside (TCAB) (Robert Wood Johnson, 2009) is consistent with the principles of user-driven innovation. It draws on several tools to focus creative ideas and test them quickly and effectively. The use of rapid cycle improvement "snorkels" which address what is getting in the way of the nurse's patient care and "deep dives" which address what the nurse might do to fix the problem, help bedside nurses identify problems and inefficiencies and design possible improvements. In using this model, nurses identify the issue, suggest multiple possible solutions and determine which of the ideas to test. A simple pre and post metric is determined and implanted. For example, a test of change to conduct hourly rounds might include a pre and post measure of the incidence of falls. An initial implementation process such as observing the outcome for "once nurse, with one patient, for one shift" is applied. At the end of the shift, the process is quickly evaluated and adapted if necessary; it is then expanded to include other nurses with other patients.

Subsequently, the testing process is expanded and constantly adapted as needed until the determination is made to either adopt or abandon the solution being tested. This process is known as the "test of change", it is designed to be quick, unit – based and staff driven.

- **Stages In Creating**

Strader (1992) describes four stages in the creative process, viz; preparation, incubation, insight and verification.

Preparation Stage

During this stage, the creative thinker gathers information related to the problem or concern.

Incubation Stage

During the incubation phase, the creative unconsciously considers and works on possible solutions or decision. All possibilities that both old and new are considered may be included a creative application of an effective solution that was similar in nature to the present situation.

Insight Stage

During the insight stage, appropriate solution energy and are development and are developed and the solution believed to be most appropriate is implemented.

Verification Stage

The verification stage is the stage of evaluation for the effectiveness of the implemented solution. During the first three stages, there is occurrence of unconscious, intuitive and creative thinking that result in a unique solution to the problem at hand.

Characteristics Of Creativity Thinkers

- ❖ Creative thinker generates ideas rapidly
- ❖ They are flexible and spontaneous. That is they have the ability to discard one viewpoint for another or change pattern of thinking rapidly easily.
- ❖ They are able to provide original solution to problems.
- ❖ They prefer complex thought process to simple and easily understood ones.
- ❖ They are independent and self confident even when under pressure
- ❖ They exhibit distinct individualism.

Developing Attitudes And Skills That Foster Creativity In Nursing Practice

Creativity is one of the major components of critical thinking. Smith Tennyson 2010 highlights some attitudes a creative thinking and a critical thinking nurse should possess that will enhance a quality nursing care she renders to the teaming service consumers. They are;

- * **Independent of thought**

Creativity requires individual nurses thinking for themselves; and not at as robots always. Consider a wide range of ideas about a particular situation or condition and learn from them and make covert judgment about them.

- * **Fair Mindedness**

This entails assessment of viewpoints about a situation or problems based on some standards.

Avoid being judgmental or personal or group bias or prejudice to consider opposing points of view and try to understand new ideas fully before rejecting or suspecting it, try to be open to the possibility that new data or evidence could change your initial opinion or view point about a situation or problem.

Never rely solely on subjective data when assessing a client, consult and consider data from people and records to survive at an accurate nursing diagnosis.

* **Insight into Egocentricity and Ethnocentricity**

Creativity thinking nurse should be open to the possibility that her personal biases or cultural pressures and customs could widely affect her thinking or creativity.

She should activity try to examine her own bias and bring them to awareness each time she thinks or takes clients /patients take part in decisions relating to their care, as clients involvement aids assess to information that makes for compliance/co-operation in care.

* **Intellectual Humanity and Suspension of Judgment**

This implies having awareness of the limits of one's own knowledge.

A creative thinker should be willing to admit what she does not know, and be willing to seek new information and rethink her conclusion in the light of new knowledge she should never assume that everybody believes to be right will always be right because new evidence may emerge.

The creative nurse should be concerned with giving care that is evidence-based that is get involved in research and utilized findings to provide quality nursing care services, and should never base decision for care on trial and error or intuition, but on scientific evidence.

• **Intellectual Courage**

This hinges on an individual's willingness to fairly consider and examine his/her ideas or views especially those that may evoke negative reaction.

The creative nurse should endeavour to consider other people's beliefs and values when providing care, even if laden with inconveniences as a result of the change.

She should appreciate need to conform with innovations which may have clinical, educational or researcher based implications

• **Integrity**

This requires that individual nurse apply some rigorous standards to their own knowledge and beliefs as they apply to those of others.

They should learn to question their own knowledge and beliefs as quickly and thoroughly as they challenge those of other, and should be ready to challenge inconsistencies within their own beliefs and those of others.

• **Perseverance**

This is to be determined and make concerted efforts to find effective solutions to nursing

problems.

She should clarify concepts and sort out related issues inspite of difficulties and frustration which are uncomfortable. She should resist the temptation of finding quick and easy answer as solutions to problems.

She should endeavour to use great deal of thought and researcher to arrive at answers to questions or solution to problems and she should stick to contending issues until resolved, remain resolute and focused until self goals are achieved.

Confidence In Reason

This focused on belief that well reasoned creative thinking will lead to trustworthy conclusions, and therefore cultivates attitude of confidence in the reasoning process.

She should examine emotion-Laden arguments by using the standard of evaluating thought by asking questions, "if the argument put up is fair and based on sufficient evidence"

She should consider the best ways to avail interested staff of opportunity for formal educational update in the fall of man power shortage for examples, on basis of dates of application that is "first come first serve", seniority etc.

She should bear in mind that education, is needed by majority of nurses to ensure qualitative nursing practice.

She should developed skills both educative and deductive reasoning as to gain greater awareness and experience in creative thinking process, promoting confidence.

A confident and creative thinking nurse will not be afraid of disagreement and will indeed be concerned when others agree quickly; and so serve as a role model to colleagues in spurring and encouraging them to think creativity as well.

Interest In Exploring Both Thought And Feelings

This recognizes that emotion can influence thinking and that feeling underline thought. A creative nurse should adopt the attitudes that feelings are real and need to be acknowledged; never treat client's complaints with a wave of have even when it appears unreal or foolish.

She should explore feelings expressed to determine if based on reality or interpretations memories or fears. She should identify examine and controls or modify client's feelings that may interfere with clear creative thinking while rendering care.

Curiosity

This requires a thoughtful consideration of many questions and contending issues affecting quality of care client receive.

- **The Impact Of Creativity In Nursing**
When nurses imbibe the right attitude to creativity in nursing practice, the following benefits will be harvested;
 - * Fostering integration at all levels
 - * Good quality client care
 - * Job satisfaction
 - * Career advancement
 - * Better public image and respect
 - * Better remuneration
 - * Reduced hospital stay for patients
 - * Cost-effective care
 - * Improve health of staff
 - * Better nurse/ client relationship.
- **Creativity In Nursing Implication For Quality Nursing Care**

Education and research are indispensable to creativity and practice of quality nursing care. We have to accept that for quality assurance to be meaningful in nursing care, there is need for creativity and innovations, standard setting, comparison of standards to actual practice selection and implementation of action to change practice through creativity; and feed back on the result of action. These require knowledge and necessitate the creativity process.

Change is inevitable and nurse experience change daily, and observe change in the society. This is the time to make creativity a nursing priority in every health institution.

Creativity and competent nursing care is critical to the financial integrity of hospital and health care delivery system (primary, secondary or tertiary). Every nurse, in whatever field should be able to use creative thinking and modify practice as the light of new findings.

Nursing educators, administrators, practitioners/ clinicians, have the collective responsibility to ensure that creative thinking is activated in our health institution and country.

Opportunity that encourages creativity should be provided for nurses at all levels of the health care system.

Conclusion

This paper has highlighted the contribution of creativity to patient care. There is general agreement that the acceptance creativity and imbibing creative thinking into practice are "sine qua non" to quality nursing care there are therefore new demands for staff development, and need for research based practice as opposed to care base on tradition or outdated information. We have come to the realization and recognition that every nurse, ideally is educated for practice anywhere in the world.

That nurse's ability to function will depend on how creative and dynamic and up to date he/she is with current practice.

Creative thinking scientific enquiry and investigation is what nursing requires in this modern age

to ensure a cost effective and quality patient care.

If by this presentation you interest have been stimulated and the desire for creativity aroused into providing quality nursing care through thinking, then the objective of this paper has been achieved.

Recommendation

Having seen the need for nurses to render quality nursing, actualize the goals of health sector reform, it is therefore recommended that;

- Nurse educators should intensify efforts in producing graduates who are creative.
- Curriculum and methods of teaching in our universities should be the type that will help in producing nurses that have:
 - * Information and experience in the creative process
 - * Creative thinking in solving nursing problems
 - * Further establish and reinforce a new higher level of Nursing practice, a level that appropriately sees the nurse as a creative member of the health care team.
 - * Nurses should update their knowledge on creative process either through continuing education or in-service training.

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BREAST CANCER SURGERY: THE REHABILITATIVE ROLE OF THE NURSE

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Introduction.

Breast cancer is a common cause of cancer morbidity and mortality in women. It is the most common cancer in women in the United States, and the second leading cause of cancer death in women after lung cancer. In 2008, about 182,460 women were expected to be diagnosed with either invasive or noninvasive breast cancer (Weaver, 2009). A world cancer report by International Agency for Research on Cancer (IARC), (2012) state that breast cancer is the most common cancer in women in many countries, including developing countries, with an estimated 999,000 new cases and 375,000 deaths in the year 2000. Breast cancer incidence and mortality rates are increasing in most countries of Africa and Asia.

Because most breast cancers are diagnosed at an early stage, with credit to mammography screening, many women have several treatment options; breast conserving surgery (a lumpectomy or partial mastectomy followed by radiation therapy or chemotherapy) is the most common local treatment for breast cancer (Weaver, 2009). However, mastectomy, which involves removal of all the breast tissue, is still performed in some situations; for example, if the tumor is 5 cm or larger, if the tumor is large compared with breast size and a lumpectomy would result in a poor cosmetic outcome, if clear margins couldn't be obtained with a re-excision of a lumpectomy site, or if the procedure is being done for breast cancer risk reduction. The American Cancer Society (2011) estimates that almost every form of breast cancer will involve some type of surgery ranging from lumpectomy to mastectomy. A woman undergoing mastectomy will need more nursing care than one undergoing lumpectomy, as well as extra emotional support and extensive patient education about postoperative care.

Cancer surgery often mutilates and produces a change in the body image. It is often difficult for the patient to cope with this while attempting to maintain usual lifestyle patterns. As the treatment for certain cancers becomes more effective, the length of time the patient must live with an alteration created by surgery will be increased. If quality of life is to be maintained, the body image must be one that the patient is able to accept and cope with on a daily basis (Bender, Yasko and Strohl, 2006).

Therefore a greater emphasis has been placed on the rehabilitative care in cancer management to increase quality of life. Therefore, a nursing challenge is to assist the patients to think of cancer as a chronic rather than a terminal illness. Many people with chronic illness and loss of body part learn to cope with their disease and losses and thus have a high quality of life. This is also the goal for the women with breast cancer after a mastectomy.

Objectives

This paper seeks to:

1. Discuss the overview of mastectomy.
2. Explain the Rehabilitative therapies after mastectomy.
3. Discuss the Roles of Nurses in post mastectomy Rehabilitation.
4. Out line the importance of Post mastectomy Rehabilitation.

Overview Of Mastectomy

Mastectomy is the surgical removal of breast

and is the most common treatment for breast cancer. There are several types of mastectomy, which are distinguished by the amount of breast tissue and other tissues that are removed, tumour size and type, cancer stage, and lymph node involvement are factors that are commonly considered to determine which procedure is most appropriate. The age and overall health of the patient also are taken into account (Stanley, 2007).

Types

Several surgical procedures are used to treat breast cancer;

- Simple (total) Mastectomy
- Modified radical Mastectomy
- Radical Mastectomy
- Skin-sparing Mastectomy
- Subcutaneous Mastectomy
- Partial Mastectomy and
- Lumpectomy

➤ **Simple Mastectomy**

In this procedure entire breast is removed, but the lymph nodes and surrounding muscle are left intact.

➤ **Modified Radical Mastectomy**

This is the most common surgical procedure performed for breast cancer. The entire breast, the lymph nodes under the arm, and the lining, over the chest muscles are removed. The muscles remain intact.

➤ **Radical Mastectomy**

The breast, lymph, nodes, muscles under the breast and some of the surrounding fatty tissue are removed. This procedure is rarely performed. It is used in cases where cancer cells have invaded the chest wall.

➤ **Skin Sparing Mastectomy**

A relatively new surgical technique, it may be an option for some patients. During this procedure, the surgeon make a much smaller incision, sometimes called a "key hole" incision circling the areola, though the opening is small, the same amount of breast tissue is removed. Scarring is negligible and 90% of the skin is preserved. Reconstruction is performed at the same time as the procedure by a plastic surgeon using tissue from the patient's abdomen or latissimus dorsi, a muscle in the back.

➤ **Sub Cutaneous Mastectomy**

The tumour and breast tissue are removed, but the nipple and the overlying skin are left intact. Reconstruction surgery is easier, but some cancer cells may remain.

➤ **Partial Mastectomy**

Here, a larger amount of breast tissue and some skin are removed with the tumour. It includes removal of the lining over chest muscles below the tumour and usually some lymph nodes usually done for stage 1 and 2 tumors.

➤ **Lumpectomy**

The tumour and a small amount of surrounding tissue are removed. Several lymph nodes may also be removed.

Procedure

Mastectomy is performed under general anesthesia. The incision includes the nipple, areola and the biopsy scar. The tumour and all of the breast tissue, including the nipple and areola are removed. Initially the incision may extend to the armpit to allow for removal of the lymph nodes, if radical, the muscle beneath the breast is removed. At the end, one or two drains may be inserted to drain excess fluid that may collect under the skin. Every effort is made to leave as

much healthy skin intact as possible, but sometimes a substantial amount of skin is removed resulting in a large possibly disfiguring scar and making breast reconstruction difficult (Stanley, 2007).

Effects Of Mastectomy

Any of the surgical procedures mentioned above may affect nerves tissue and muscles in the breast area. Muscle and skin may feel tough and stiff post-surgery and movement in the arm and shoulder may be limited for a short time after the procedure. Removal of lymph nodes slows the flow of lymph, which can cause swelling and some exercise can help reduce this symptom. The major effects include:

- Reducing muscle strength of the upper limb on the operated side.
- Limitation of shoulder joint motion.
- Lymph circulation disorder.
- Pains and discomfort, tightness in the breast area.
- Loss of female identity, scaring,
- Throbbing pains.
- Pins and needles sensation
- Emotional disturbance.
- Uncertainty and depression, etc.

The Rehabilitation Therapies

Rehabilitation nursing is a branch of the nursing field which is focused on providing care to the patients who have been incapacitated by injury or illness. The goal of the nurse is to participate in a treatment programme which will allow the patient to regain as much normal function as possible, thereby improving the quality of life for the patient. Hryniec, (2006) confirmed that proper rehabilitation programme is a key factor which influences life quality of women after mastectomy. Rehabilitation starts with psychological and physical preparation for surgery, which means learning gymnastic exercise for upper limbs and helping patient accept the ensuing situation.

Rehabilitation begins on the second day after surgery in order to avoid adverse effects of surgery such as reducing muscle strength, limitation of shoulder joint motion on the operated side and lymph circulation disorder (Hryniec, 2006). Rehabilitation medicine can play an important role in the postoperative management of those who have had breast surgeries. Some of the rehabilitation specialists that might become involved include doctors who specialized in rehabilitation medicine, physical therapists, occupational therapies, psychologist and social workers.

When one is diagnosed with cancer a life threatening illness, this affects many aspects of the person's life. Hence rehabilitation following any type of surgery on the breast involves emotional, psychological and physical healing. Physical therapy deals with the physical component of this disease but can indirectly affect the emotional and psychological well being also (ACS, 2010).

Physical Therapy

Physical therapy is one discipline in the field of

rehabilitation medicine that can offer many services to one who has had breast surgery as a result of cancer. The therapist will utilize all the necessary information to develop a comprehensive yet individualized treatment plan that is within the guidelines of the doctors' prescription. Some patients will require only a few sessions of the therapy, whereas some may require up to six weeks, before being discharged from the physical therapy. Thereafter patients are given a complete home exercise programme designed specifically to be done on a regular basis (Board Certified Doctors (BCD), 2007).

The following will discuss the role of physical therapy after a breast surgery as a result of cancer. The specific problem that can occur as a result of surgery and subsequent radiation include but are not limited to pain lymphedema; decrease range of motion and strength in the arm, and decrease soft tissue mobility, secondary to scarring at the incision site. It is important to note that not everyone will develop complications post-operatively, if they do occur, symptoms may range from very minimal to severe. Ideally a physical therapist should evaluate the patient early in the hospital setting to try to reduce the incidence of these clinical problems, should these problems persist, physical therapy is often recommended on an outpatient basis to establish a long-term plan of care. It will help to decrease adhesions and restore soft tissue mobility and muscular balance between the anterior and posterior chest musculature. It will also help to reinforce good postural habits for activities of daily living (Hyniec, 2006).

Pain Management

BCD, (2007) stated that people experience different type and amount of pain or discomfort after breast surgery. The goal of pain management is to assess the level of discomfort and to take medication as needed. There will be a better result of controlling the pain if medication is taken before the pain becomes severe. Everyone is different and if one plan to decrease the pain is not working, it should be changed. Healing and recovery improve with good pain control. Pain relief measures include:

- o Use of icepack which is helpful to decrease discomfort and swelling particularly to the armpit after a lymph node dissection.
- o A small pillow positioned in the armpit.
- o Prescribed narcotic such as vicodin for moderate pain.
- o Ibuprofen or Tylenol can be added to or replace the vicodin.

Physical therapy can help to decrease muscle guarding and pain early on to restore normal flexibility and use of the shoulder.

Hand and Arm Care

It is important to prevent infection or injury to the hand and arm, as it is believed that infection can contribute to the development of lymphedema or exacerbate an existing problem. Signs of infection in the arm can include redness, pain, swelling and

warmth and should be reported to the surgeon if it persist. Trauma such as having blood pressure taken on the involved hand should be avoided. Other precautions include:

- Avoid cutting cuticles,
- Wear gloves while gardening,
- Avoid underarm shaving with a razor blade
- Use an electric shaver if the doctor permits.
- Avoid heavy lifting or pushing avoids excessive sun exposure, as it can be dangerous on the irradiated skin and cause excessive swelling (BCD, 2007).

Exercise

After any of the surgical procedures for the first week there are some minor exercises that can be done. One of these exercises involves: lying down and raising the arm on the side of the surgery above the heart for 45 minutes. This can be done by using pillows to ensure that the hand is elevated above the wrist and the elbow is elevated above the shoulder. This helps reduce swelling while in this position the patient can open and close the hands 15 to 25 times and also bends and straighten the elbow. This also helps reduce the swelling. These exercises can be done two to three times a day. The nurse instructs the patient not to sleep on the side that was on and try to use the affected arm normally during daily routine like combing hair, eating, and putting on cloths.

Deep breathing exercises can help maintain normal movement of the chest and help make it easier to breath. The nurse instruct patient to lie down the back and breathe deeply and slowly. Try to breath in as much air as she can and then breathe out. This is done four or five time.

These include:

Axial extension where patient sit or stands with good posture, with tucked chin and head pulled straight backward. Hold this for some seconds and repeat 2 times per day.

Shoulder pendulum

- Patient assumes a standing position and leans over a chair with one hand allowing one hand to hang down relaxed.
- Sway whole body slowly to more arms forward and backward. Do not lift the arm tense up; use only body movement to begin the motion. Repeat with the arm moving side to side, circular patterns, clockwise and counter clockwise.

Shoulder flexion:

This involves Standing near a wall, slowly walking the fingers up the wall so that one feels the stretch. Hold position for some seconds and repeat.

Shoulder abduction:

Stand near a wall, slowly walk fingers up the wall so that you feel a stretch, hold position and repeat.

Shoulder external rotation /Abduction:

- Lie on back keeping elbows on floor, holding a stick above head.
- Lower the stick down behind your head letting your shoulders rotate backward, hold for

seconds and repeat.

Shoulder Internal Rotation

- Reach behind back with the arm.
- Grasp the arm with your other hand.
- Try to pull the arm upward so that you feel a stretch. Hold for seconds and repeat (BCD, 2007).

Phases Of Exercise Programmes

Phase 1: Immediately post surgery, exercise designed to be performed as soon as possible after surgery in the hospital or at home. These prevent swelling and tightness, frozen shoulder, scar tissues, relieving muscle and tension and to promote healing.

PHASE II: Up to 6 weeks post surgery, exercise designed to continue to prevent weakness and loss of flexibility, relieve stiffness, prevent muscle atrophy, increase physical endurance and improves ones' sense of wellbeing.

Phase III: 6 – 10 weeks post surgery, exercises are designed to progress toward more challenging upper body technique. Aerobic activities, flexibility training and mild strength training can be initiated.

Phase IV: 10 weeks post surgery. Here exercises are designed at an advanced level progressing stretching technique, accelerated walking and aerobic endurance (BDC, 2007).

Diet

The patient may resume diet as soon as she can take fluids after recovering from anesthesia. Eight to ten glasses of water and non caffeinated beverages per day, plenty of fruits and vegetables as well as lower fat foods.

A nutritionist is available for consultation in the breast care center for recommendations for healthy eating (University of California San Francisco (UCSF), 2007).

Incision and Dressing Care

Dressing is removed in seven to ten days, while the sutures will be removed in one to two weeks unless they absorb on their own. No attempt should be made to replace any dressing or skin-strips fall off (UCSF, 2002).

Prostheses

Wearing prosthesis is a very significant part of rehabilitation, which is connected not only to aesthetic qualities, but also with healthful properties. After bigger breast muscle removal, a body asymmetry occurs. It can lead to posture disorder such as:

- Lowering or raising of shoulder on the operated side
- Shoulder protruding
- Stoop
- Curvature of the spine.

In order to keep a good physical and mental state of the patient in the first postoperative period, the loss of breast is made up by a light and soft thing (i.e. cotton wool or sponge), which allows to heal injury. After injury is healed and sensitivity of the site to touch is lessen, a regular prosthesis should be worn. This is selected according to the shape, weight, size of a remaining breast. Each patient gets a prescription of breast prosthesis after mastectomy from her oncologist or

surgeon. This can be dispensed in specialist shops or in supply points with orthopedic equipment (Hryniec, 2006).

A breast prosthesis according to Smeltzer, Bare, Hinkle and Cheever (2010) can provide a psychological benefit and assist the woman in resuming proper posture because it helps balance the weight of the remaining breast.

Occupation Therapy

Most people return to work within three to six weeks. Return to work varies with the patient type of work, her overall health and personal preferences. The patient can do some work using her hand on the operated side as long as the weight does not exceed 2 kilograms. Any problem concerning the occupation of the patient should be discussed with the surgeon who after a thorough assessment of the patient will decide when she can resume work or refer her to an occupational therapist if she needs to change her job (UCSF, 2002).

Psychosocial Care

The diagnoses of cancer still bring the fear of death, financial depletion, chronic suffering/pain, disfigurement etc. Coping with this fear is facilitated by good network of support persons of which the nurse is a very important person (Bender, et al, 2006). The American Society of Cancer (2010) reports that women who lose a part of their body to cancer especially if it is a breast or part of the sexual organs sometimes miss the pleasure they felt from having that area stroked during sex. They may or are usually embarrassed with this new situation. The nurse therefore has a responsibility of helping the patients cope with the loss of the body part while also maintaining a healthy sexual life.

If given proper rehabilitation a woman can recover from a mastectomy fast, and can live life normally again. With the support of her family, husband and friends plus the quality of rehabilitation she will get, will determine how she will cope with the loss of her breast.

Royle & Walsh (2006) in their contribution said that nurses are not only responsible for the patient but also for identifying and alleviating the health needs of the husband and family. Family education and their involvement in care will help patients cope with the altered body image and family coping. They suggested contacting the social worker for any financial problem.

Berman, Snyder, Kozier and Erb (2008), added that assessing client coping status, using active listening, providing a non threatening environment, determining support people and assessing their response and available resources as well as being supportive of client's effective coping behaviors can help promote the psychosocial health of post mastectomy patients.

Breast Reconstruction

According to ACS (2009), breast reconstruction is a type of surgery for women who have had a breast removed (mastectomy). The surgery

rebuids the breast so that it is about the same size and shape as it was before. The nipples and the darker areas around the nipple (areola) can also be added. Most women who have had a mastectomy can have reconstruction. Women who have had only the part of the breast around the cancer removed (lumpectomy), may not need reconstruction. Breast reconstruction is done by a plastic surgeon. The nurse may assist during the procedure and thereafter takes care of the patient till recovery.

Types of Breast Reconstruction

Several types of operation can be done to reconstruct your breast. One can have a newly shaped breast with the use of a breast implant patient's own tissue flap or a combination of the two. ACS (2009) stated that after the general surgeon removes the breast tissues, a plastic surgeon places a breast implant where the breast tissue was removed to form the breast contour. It involves either a one-stage immediate breast construction or a two-stage delayed reconstruction. The ACS (2009) explained that implants may not last a lifetime and patient may need more surgery to replace them later. And that the patient can have problems with the breast implant which include rupture, infection / pain, scare tissue formation and capsular contracture. Also, the operations leave two surgical sites and scars, one where the tissue was taken and one of the reconstructed breasts.

Women who have reconstruction may go through a period of emotional readjustment, may feel tired and sore, anxious and confused. Hence the nurse will help serve her with prescribed medications, wound and drain care, advice on activities to avoid example overhead lifting, strenuous sports and sex for a 4-weeks after reconstruction and to follow surgeon's advice on when to begin exercises.

Follow up

Follow up appointments are generally made before surgery with the physician and the nurse. It is necessary that the patient keeps remembering this date or calls the breast care center or the surgeon or nurse if she forgets. In most cases, dressing is changed or removed at a postoperative visit or follow up visit. The nurse should get the phone number of patient and prepares for patient at the time of visit.

Importantly, the nurse advise the patient to report promptly any pain that is not relieved by medication, fever more than 100 degrees Fahrenheit or chills, excessive bleeding example a bloody dressing, excessive swelling, redness outside the dressing, discharge or bad odour from the wound. Allergic or other reactions to medications, constipation, anxiety, depression, trouble sleeping or when she needs more support (UCSF, 2002).

UCSF, (2002) suggest that the pathology results from the patient surgery should be intact in patient case note for easy contact and references. Also communication plays an important role in the follow-up care, hence telephone number should be available at the center and the patient should be encouraged to

keep every appointment.

Clinical Trial On Postmastectomy Patients

A prospective clinical trial by Na, et al (2009) on post-mastectomy patients was to determine the effect of rehabilitation on their response and recovery. The patients were assigned to three groups and each group introduced to rehabilitation programme at specific period. Group one was introduced to rehabilitation programme three days after operation, group two at discharge and group three one month post discharge. Using parameters such as range of motion of the ipsilateral shoulder joint, upper extremity, circumferential measurements as well as ten elements of shoulder function.

The result of the study revealed that the group of patient who received an early post mastectomy rehabilitation treatment programme had a better range of shoulder motion and functional activities than the other groups. They also showed less difficulty in five items for functional assessment.

In conclusion, the findings showed that an early rehabilitation programme did not increase post-operative complications but rather was beneficial to post mastectomy patients in regaining the functions and range of shoulder motion (Na, et al, 2009).

Nurses Role In Rehabilitation Of Post Mastectomy Patients

Mamede, Clapis, Panobianco, Biffi and Bueno (2000), stated that the rehabilitation of the women submitted to a breast cancer surgery require a multi-professional care in which the nurse plays an important role.

- ❖ The nurse prepares the patient for the surgery.
- ❖ During the process the nurse provides information on the care after surgery, orientation and information about the different stages of the recovery process,
- ❖ Care of the limb, exercises to recover the functional capacity of the arm and shoulder as well as other treatments.
- ❖ The nurse bearing in mind that healing and recovery improve with good pain control, adopts effective pain relief measures to ensure that the patient remain pain free.
- ❖ Nurses are also involved in the orientation on self-care, personal hygiene, nutrition, weight control, use of prosthesis and clothing information.
- ❖ The nurse stresses the need for compliance with prescribed drugs and therapies and advice the patient accordingly.
- ❖ The nurse arranges and contacts individuals and groups for social support and gives adequate education concerning sexual issues.
- ❖ Nurses are responsible for thorough family education and timely referral. She refers patients and family members to enroll in support groups where they will have the opportunity to talk with other caregivers and loved ones who are supporting family and

- ❖ friends journeying through cancer.
- ❖ The nurse advises the patient to keep her follow-up appointment and report promptly any abnormal observations or side effects of drugs.
- ❖ The rehabilitation nurse provides general nursing care which includes physical care and psychological care.
- ❖ She interrelates with other team members to ensure patient recovery (Mamede et al, 2000).
- ❖ Being the closest person, the nurse frequently answers questions from the patients that relates the her condition and general wellbeing

Importance Of Rehabilitation

Rehabilitation is an important part of cancer care; the health care team makes every effort to help patients return to normal activities as soon as possible through the following:

- Extensive education and training concerning physical care and medical precautions.
- Patients learn exercises to increase motility and strength thus preventing stiffness and formation of scar.
- It ensures promoting of progress of post surgery healing.
- Alleviate pain and swelling after surgery.
- Increases strength and flexibility post surgery.
- Assist in restoring an upright posture.
- Increase or restore physical stamina after surgery and treatment.
- Assist in preventing lymphedema by promoting drainage of lymphatic fluids.
- Provides information about resources and support groups.
- Provides adequate information to help patient cope with lifestyle issues including emotional, physical and sexual concerns.
- Helps patients successfully complete their recovery after surgery and resume their former work and recreational activities (Atwell, 2010).

Summary/Conclusion

Proper rehabilitation is what a patient who has undergone a mastectomy needs. The kind of rehabilitation she will receive will contribute to the quality of life she will have after the operation. The need for rehabilitation and psychosocial support for a patient diagnosed with breast cancer and who has undergone mastectomy cannot be over-emphasized. Nurses must rise up to the challenges, develop more interest in rehabilitation nursing so as to be able to help the patient's family and caregivers have a positive attitude toward cancer and cancer treatment as this has a significant positive impact on the quality of life the patients experience.

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YOU AND YOUR HEALTH

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Introduction

Good Health is an integral part of existence on planet Earth. One has to be in good health to understand who he or she is, be able to accomplish personal and expected goals as well as live a socially and economic independent life (Yemi, 2012).

All things being equal, how much health an individual enjoys is a function of the level of personal commitment towards achieving health. During infancy and childhood, the task of ensuring health is undertaken by parents/guardians but as one advances in age from Adolescents, he begins to take responsibilities for actions and behaviors especially as they relate to achievement of health (Yemi, 2012). Most, if not all causes of diseases are traceable to man's habits and neglect of self. Before now, even without any formal health education, life expectancy was comparatively higher than today that technological advancement has made access to health services and health information easy. The issue of concern is, how many people utilize health services or heed to health education tips on healthy living?

Theoretical Framework.

The theoretical framework is on the fact that for one to stay healthy, it requires conscious personal commitment to activities and behaviors that promote health. The Theory of Reasoned Action propounded by Fishbein and Middlestadt in 1989 is appropriate in this work. The theory states that human beings are reasonable creatures who, in deciding what action to take, systematically process and use information available so that at the end, whatever behavior is performed is a function of the individual's intention hence a reasoned action.

Relating the theory to this topic (you and your health), health services and health information on healthy living abound. It is expected of individuals to utilize available health care services and health information by adopting positive behaviors in order to stay healthy; where they don't, they stand a risk of poor physical, mental/emotional and social health.

Health has been defined by Smith,(2003) as the level of functional and (or)metabolic efficiency of a living being. It is the general condition of a person in the mind, body and spirit usually meaning, to be free from illness, injury or pain. In 1964, the World Health Organisation defined health in its broader sense to mean "a state of complete physical, mental and social well-being of an individual not merely the absence of disease or infirmity (Yemi, 2012). This definition though has been subject to controversy remains the most enduring because it clearly shows that there are different dimensions of health and the interrelationship between these dimensions of health (Physical, mental/ emotional and social dimensions of health) enhances good health of individuals. To make for better understanding of this topic, the various dimensions of health, challenges impeding achievement of the various dimensions of health and individuals' responsibilities towards attaining the various health

dimensions will be discussed.

Physical Health

Physical health is defined by Davidson,(2006) as the state of the body and organs functioning condition. Proper functioning of the body cells, tissues, organs and systems can be achieved through adequate health maintenance. Achieving and maintaining health is an on-going process, shaped by both the evolution of health care knowledge and practices as well as personal strategies and organized interventions for staying healthy (Famakinwa, 2002). This means that there are practices, strategies and organized interventions that foster health. Physical health is to a reasonable extent enhanced by a good physical environment, high level of personal hygiene, available and accessible health care services, adequate nutrition as well as good housing conditions (space in buildings, good drainages proper ventilation, good lighting, proper means of refuse disposal, good conveniences (toilet and shower), safe drinking water, unpolluted air to mention a few). Oluh, (2007) said 70% of people have negative attitude to health care services and health information either because of personal or culturally imposed limits. Nutritional preference by some people also worsens physical health in no small measure.

Social Health

The concept of social health forms one of the three pillars of most definitions of health. Social health can refer both to a characteristic of a society and of individuals (Famakinwa 2002). A society is healthy when there is equal opportunity for all and Access by all to the goods and services essential to full functioning as a citizen (Russel, 1973 in Famakinwa 2002). On the other hand, the social health of individuals refers to "that dimension of an individual's well being that

concerns how he gets along with other people, how other people react to him, how he interacts with social institutions and societal mores and very importantly, individual behaviour towards self (Victor, 2007). Social health is enhanced by positive behavioural choices, good social relationship with others and availability of health-promoting material conditions of life; for instance the poor material conditions under which 60% of people live may well be responsible for the deviant behaviour unacceptable by society displayed by such persons. Living under conditions of material deprivation, the stress associated with such conditions and the adoption of health threatening behaviors some of which are looked at as a means of coping with these difficult circumstances most times result in greater incidence of a variety of illnesses (Yemi, 2012).

Mental And Emotional Health

American Academy of family physicians, (2008) defines mental and emotional health as overall psychological well being. This includes the way you feel about yourself, the quality of your relationships and your ability to manage your feeling and deal with difficulties.

According to the Academy, emotional and mental health is enhanced by:

- A sense of contentment
- A zest for living and ability to laugh and have fun,
- The ability to deal with stress and bounce back from adversity.
- A sense of meaning and purpose, in both their activities and in their relationships,
- The flexibility to learn new things and adapt to change,
- A balance between work and play, rest and activity,
- Ability to build and maintain fulfilling relationships,
- Self confidence and high self esteem.

Achieving health is a matter of utmost concern. There is no gainsaying the fact that people encounter a lot of challenges that impede actualization of these dimensions of health. These Health challenges include:

Challenges Impeding Achievement Of Good Health

- A. CHALLENGES IMPEDED ACHIEVEMENT OF GOOD PHYSICAL HEALTH.**
1. Absence of conducive living environments.
 2. Exposure to toxic substances and other physical hazards.
 3. Absence of aesthetic elements like; good lighting, safe water, well ventilated buildings, good drainages, proper refuse disposal methods, good conveniences (toilet and shower), space in buildings, trees and flowers.
 4. Absence of adequate recreational facilities in some institutions of learning for school children.
 5. Poor transportation options for people

6. Poor and inadequate feeding
7. Harsh natural environment (weather or climate change).
8. Extreme low income situation.
9. Physical inactivity by young and older persons; Physical inactivity observed among some people is another issue of utmost concern. The advent of high level technological advancement and insatiable desire for sophistication and class has almost completely brought to an end the practice where young people help out in farm work, craft work, fishing and domestic chores (Oluh, 2007). The afore-mentioned activities are some of the ways body cells, tissues and organs are constantly exercised leading to slow aging process and longevity (Akintunde, 2005). Active participation in school sports by school children and regular attention to prescribed exercises by other adults and parents at home goes a long way to promoting physical health.
10. Exercises according Akintunde, (2005) spur the body growth and development, reduces risk of heart attack, keeps arteries elastic thereby keeping blood flowing at a normal pressure, improve respiratory, digestive, nervous systems functions and enhances longevity.
11. Davidson, (2006) said studies have shown that sedentary people have a 35% greater risk of developing hypertension while people who maintain an active life style have a 45% lower risk of developing coronary heart disease than sedentary people.
- Genetic inheritance (predisposing people to certain diseases and health conditions).
- Poor personal and environmental hygiene to mention a few.

Challenges Impeding Achievement Of Social Health.

1. Low income among people due to poor social support network.
2. Negative behavioural choices (smoking, alcoholism, substance abuse and a high level of immorality).
3. Low educational levels.
4. Poor access to health care services.
5. Social norms and attitudes such as discrimination and poor social interaction.
6. Inadequate safety in homes and public safety.
7. Exposure to crime, violence and social disorder some of which are due to emerging technologies etc.

Source: American Academy of family Physicians, (2008).

Challenges Impeding Achievement of Mental and Emotional Health

American Academy of family physician, (2008) points out some of the challenges to include:

1. Worries, anxiety and depression.

2. Greed (lack of contentment)
3. Poor ability to deal with stress and adapt to change
4. Low self confidence.
5. Poor attention to physical health.
6. Lack of self discipline.
7. Failure to engage in meaningful, creative work.
8. Failure to create leisure time.
9. Failure to connect to others.
10. Inability to build great relationships.

Individuals' Responsibilities towards Achieving Health.

Individuals' Responsibilities Towards Achieving Physical Health.

1. **Genetics:** "Genetic – inheritance" plays a part in determining life span, healthiness and the likelihood of developing certain illnesses therefore genetics counseling before marriage is prescribed for people intending to go into marriage.

2. Exposure to toxic substance that pollutes the air can be prevented through stringent government policies prohibiting the citing of industries close to residential areas and other public places. People should therefore avoid inhabiting such places.

3. Extreme low income situation can be improved through stronger social support networks like greater support from families, friends, communities, vacation jobs, scholarships by government and philanthropists, gain -full employment, small scale business, micro loans by finance houses and getting involved in Government poverty alleviation programmes.

4. Active involvement in exercises either at home or making use of public recreational outfits to promote physical activity.

5. Proper architectural housing plans with aesthetic elements like proper lighting, drainages, space, ventilation, safe water, Proper lighting options to enhance vision etc..

6. Improved environmental sanitation and personal hygiene especially the hygiene of "hand washing, oral care, bathing at least twice a day (Akinsola, 1993).

7. Adequate nutrition by consuming more of plant protein than animal proteins and fats. Natural vitamins in fruits and vegetables in place of carbonated and preserved juice and energy drinks (Victor, 2007).

Uddoh,(1994) posits that rather than eat meals prepared from natural proteins, vitamins and fibres, some people prefer snacks, sweets, chocolates, carbonated drinks and fatty meals with saturated animal fats which have a tendency to build high cholesterol levels in the body. High cholesterol level has been implicated as the cause of toxic substances referred to as free radicals in the blood system (Oluh,2007). These free radicals damage body cells, body tissues and organs resulting in auto-immune infections and high incidence of cancers.

8. Getting enough rest and observation of leisure time.

Source: American Academy of family physicians (2008).

A. Individuals' Responsibilites Towards Achieving Social Health

1. A check on negative behavioural choices like smoking, alcoholism etc. The behaviour of people plays a role in health outcomes for instance, if an individual quits smoking, his or her risk of developing heart disease is greatly reduced. If an individual quits intake of alcohol, his or her risk of developing liver cirrhosis is greatly reduced. If an individual quits sexual immorality and the practice of unsafe sex, his or her risk of developing sexually transmitted diseases with the consequence of damaging reproductive organs is greatly reduced (Davidson, 2006). Channeling energies to more meaningful and rewarding ventures like writing, publishing, arts/ craft work; membership in educationally informative organizations, book clubs within and outside school, reading Christian books and other motivational books are also positive behavioural choices.

2. Making use of available health care services and health information

3. Human beings are social creatures not meant to live in isolation. Our social brains crave companionship therefore, a level of social interaction no matter how distrustful of others we are is very necessary.

Source: Yemi, (2012).

B. Individuals' Responsibilites Towards Achieving Emotional And Mental Health

In order to maintain and strengthen your mental and emotional health, it is important to pay attention to your own needs and feelings. Do not let stress and negative emotions build up. Try to take care of yourself so as to be better prepared to deal with challenges if and when they arise. Taking care of oneself includes pursuing activities that naturally release endorphins and contribute to feeling good. Endorphins are chemical substances that energize us and lift our mood (Yemi, 2012). They are naturally released:

1. When we do things that positively impact others

2. When we practice self discipline: Self control naturally leads to a sense of hopefulness and takes away negative thoughts.

3. When we learn or discover new things.

4. When we enjoy the beauty of nature or arts: Studies have shown that simply walking through a garden, strolling through a park or an art gallery, an evening walk round the school compound, admiring architecture or sitting in a beach, lowers blood pressure and reduces stress.

Other tips on individuals' responsibilities for managing challenges impeding achievement of emotional health include according to Yemi, (2012) include:

5. Appeal to your senses: Stay calm and

energized by appealing to the 5 senses; sense of touch, sight, sound, smell and taste. Listen to music that lifts your mood, place flowers where you will see and smell them, massage your hands and feet. etc.

6. Engage in meaningful creative work by doing things that challenge your creativity and make you feel productive, whether or not you get paid for it. e.g gardening, drawing, playing an instrument etc.

7. Make leisure time a priority: Take time "off academic work" to relax and play. Play is an emotional and mental Health necessity.

8. Manage your stress levels by trying to avoid becoming absorbed in repetitive mental habits like negative thoughts about yourself and the world. Such thoughts suck up time, drain your energy and trigger feelings of anxiety, fear and depression, learn to talk to somebody or people you enjoy being with. Choose friends, neighbours, colleagues, family members, classmates who are positive and interested.

9. Avoid isolation and be a joiner: Join networking social action, special interest groups, religious activities. These groups offer wonderful opportunities for finding people with common interest.

10. Counseling: Make use of counseling services.

People are expected to build and maintain good and emotional health in order to cope with the rigors of life. To achieve this, the American Academy of family Physicians, (2008) identifies "Red Flag feeling or symptoms" for which people must make timely appointment with a mental health professional to be:

- Inability to sleep
- Feeling down, hopeless or helpless most of the time
- Concentration problems that are interfering with your work or home life.
- Using smoking, over eating, drug or alcohol to cope with difficult emotions.
- Negative or self destructive thoughts or fears that you can't control
- Thoughts of death or suicide.

Conclusion

In conclusion, health is a precious jewel. Individuals should demonstrate commitment to their health by utilizing available health services, health information and adopting positive health behaviors. This way, health challenges will be reduced to the barest minimum.

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PERCEPTION OF DOCTORS AND NURSES' TOWARDS THE NEED FOR NURSE COUNSELLORS IN HOSPITAL SETTING IN UNIVERSITY OF PORT HARCOURT TEACHING HOSPITAL PORT HARCOURT NIGERIA

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Abstract

The study assessed the perception of Doctors and Nurses towards the need for Nurse Counsellors in hospital setting in the university of Port-Harcourt Teaching Hospital Nigeria. The objectives were to assess the perception of Doctors and Nurses on the need for Nurse Counsellor in hospital setting, the effect of counselling on patient's recovery, identify whether or not status affects their perception and find out gender effects on their perception. Data for the study was collected from 199 respondents comprising of Doctors and Nurses through the use of structured questionnaires. A purposive random sampling was used to select 199 respondents. Data collected were analysed using descriptive and inferential statistical technique. The result showed that 87% of the respondents recognized the need for nurse counsellor, 78% agreed that making informed consent through counselling aids the patients' recovery. There was no significant difference between status and gender difference in the need for a counsellor. It was concluded that doctors and nurses have high positive perception on the need for Nurse Counsellor in hospital settings.

Introduction

Nurses assume a number of roles when they provide care to clients. Though Nurses often carryout these roles concurrently, not exclusively of one another, for example the nurse may act as a counsellor while providing physical care and teaching aspects of that care.

Counselling is the process of helping a client to recognize and cope with stressful, physiological or social problems to develop improved interpersonal relationships and to promote personal growth and restoration of health (Juba, 2006). Counselling provides emotional, intellectual and psychological support.

The nurse counsel both the sick and healthy individuals with normal adjustment difficulties and focuses on helping the person develop new attitudes, feelings and behaviours by encouraging the clients to look at alternative behaviours, recognise the choice and develop a sense of control.

Denga (1986) opined that counselling services are needed in non-school settings such as hospitals, prisons, remand homes, rehabilitation centres, churches, industries and families etc. since nurses are found in all these places counselling in whatever setting exist to assist individuals in coping with varieties of personal, social emotional and psychological problems for healthy personal development.

Needless to mention that problems are part of the existential nature of human beings. Nevertheless in the case of Nigerians, problems have assumed an alarming rate and this has necessitated the urgency of the need for Nurse Counsellors to also contribute through counselling in rendering quality nursing care.

A fore most step in this direction is conducting

empirical research studies to establish the need for the services of Nurse Counsellors in hospital settings. It is against this Background that the presented survey tried to find the perception of medical Doctors and Nurses of the need for nurse counsellors in Hospital settings.

Review Of Related Literature

A counsellor as perceived by the writer is any person trained in the field of counselling. Counselling according to Kolo (1997) has been defined in various ways. Common among the definition is that it is a special helping relationship. He explains that the special nature of the relationship between the counsellor and the client is growth producing in the client. Citing Gesinde (1991), Kolo (1997), Further highlighted that counselling goes far beyond advice -giving as it involves more than solution to immediate problem. He went on to unveil counselling as an in-depth interaction between two or more individuals with the aim of helping the clients to better understand himself/herself/themselves in relation to present and further problems.

The relationship that takes place, he added, is so tightly knit that the result is positive behaviour change on the part of the client as a result of learning. Juba (2002) asserted that counselling in hospital setting by a nurse counsellor is a genuine dialogue which aims at managing health and psychosocial concerns the patient and relations are facing. Counselling patients on the physical and emotional adjustment imposed by illness is an integral component of patient care given by a nurse counsellor and this is aimed at restoring health (Modinpale, 2006). Counselling means helping people to explore problems clarify conflicting issues

and assisting such people to discover alternative ways of dealing with such problems by taking appropriate decisions, thus helping them to help themselves (Juba 2002).

There are two conceptual bases of counselling considering nurse counsellor in nurse-client-relationship the developmental or preventive approach and the remedial or curative model Curtis (1985) whatever model of counselling is used by a nurse counsellor, affecting necessary cognitive, affective and behavioural changes to enable individuals attain better health become primary foci of the nurse counsellor (Modinpale, 2006).

As could be observed, counselling is so much about problem solving. Thus Nurse by virtue of their professional knowledge and skills acquired through training are at advantage in assisting people in whatever setting to solve their problems.

Dileep (2007) listed emotional, behavioural, organization, personal and environmental problems that are to be handled by the Nurse in hospital settings on areas covered by counselling in hospital setting. Oliagba (2000:16) stated that it includes giving information, decision-making, helping the patient clarify his own problem or even facilitating the development of his own solutions.

Denga (1986) identified the following solutions that creates the need for counselling in hospital setting.

- (i) Some physical ailments are intertwined with psychological/emotion aspects of patients
- (ii) Patients with long-standing and terminal illnesses need extra-time to be consoled and comforted by an empathic and trusted person.
- (iii) Other care givers are disadvantaged to offer effective psychological support needed by patients due to their numerous routine duties with in-and out patients
- (iv) Need for vital information among some patients
- (v) Need for career counselling for patients who may have to change jobs as a result of loss of part of the body.

In addition, the inability of the other health, care professional to offer their patients effective counselling due to inadequate training presents a situation requiring the creation of unit for the services of Nurses counsellor in hospital setting. Ihejirika in Oliagba (2000) noted that:

Counselling services may be required in hospital setting not only for the good of the patients but also for the benefit of others like the patients relations and other health care givers. These people like the patients do experience personal problems in relation to which may wish to seek counsellors assistance.

Similarly, communication among these professionals is sometimes not smooth and this sometime leaves the patient at the receiving end. Consider the case of a terminally ill patient who needs the care of a specialist was referred to a specialist for one treatment and the latter insisted on what he considers more appropriate with both specialists refusing their positions leaving the patient in a more

anxious state. A nurse counsellor in intervention in situation like this could help enhance communication among these most significant specialists in the life of the patient.

Statement Of Problem

Multiple factors have increased the need for nurse counsellor, counselling as one of the role of the nurse has to a large extent been neglected and subsumed into other roles thus neglecting patients with counselling needs. Today there is new emphasis on health promotion and health maintenance rather than on management of disease conditions and nurse counsellors are being called on to encourage clients to look at alternatives recognise their choices, and develop a sense of control in a rapidly changing Health care environment.

Background literature seen to establish the relevance of Nurse counselling services in hospital settings. However, experiences have revealed almost complete absence of nurse counsellors in hospital settings. This arouse the researcher's interest to find out whether or not doctors and nurses (the most important health care providers) perceive the need for nurse counsellors in hospital setting with a view to suggest the way forward for nurse counselling services in the hospital setting.

Objectives

- (1) To assess the perception of Nurses and Doctors on the need for nurse counsellor in hospital settings.
- (2) To identify whether or not there is status effect on the perception of medical doctors and nurses in their perception of the need for nurse counsellors in hospital settings.
- (3) To find out whether gender affects the perception of medical doctors and nurses on their perception of the need for nurse counsellors in hospital settings.

Research Question

1. What is the perception of Doctors and Nurses in the need for Nurse Counsellor on the hospital settings?
2. What is the effect of counselling on patients' recovery?

Hypotheses

1. There is no significant difference between doctors and the nurses perception of the need for nurse counsellors in hospital setting.
2. There is no significant gender difference in perception among doctors and nurses.

Significance Of The Study

The finding of this study will reveal the feelings of medical doctors and nurses about setting up nursing counselling services unit in the hospital. Such information will expose the neglected role of the nurse as a counsellor; it will serve as a medium for drawing the attention of hospital policy makers and nursing services department to the need to create a nursing

counselling service unit in hospital setting.

Methodology Sample Size And Sampling Technique

A sample of 199 respondents consisting of eighty six (86) medical doctors (5D males and 36 females) and 113 nurses (10 males and 103 females) was selected using purposive random sampling.

Data Collection

Questionnaire title perception of doctors and Nurse on the need for Nurse Counsellors in hospital setting (PDNUCHS) was used for data collection in this study.

The questionnaire comprised two sections A and B section A gave the socio-demographic data of the respondents while section B consists of fifteen (15) statements on the need for nurse counsellors in the hospital setting and the effect of counselling on patients' recovery. The questions are to be responded to by Yes or No.

The content validity of instrument was established by experts on the field and the reliability coefficient of instrument was at 0.85.

Method Of Data Analysis

Data from the questionnaires retrieved were analysed using descriptive and inferential statistical techniques. The findings were presented and analysed in frequency distribution tables, percentages and chi-square of 0.05 significance level.

Table 1: Showing the Socio-Demographic Data of Respondents

Variables	Frequency	Percentage
Age: 21 - 30	18	9%
	62	31%
	89	45%
	30	15%
	199	100%
Sex: Female	139	70%
Male	60	30
	199	100%
Marital Status: Single	10	5
Married	154	77
Divorced	5	3
Separated	2	1
Widowed	28	14
	199	100%
Religion: Christianity	194	97
Islam	5	3
	199	100%
Profession: Medical Doctor	86	43
Nurse	113	57
	199	100%
Year of Working Experience:		
1 - 5yrs	25	13
6 - 10yrs	39	20
11 - 15yrs	35	18
16 - 20yrs	44	21
21 - 25yrs	30	15
26 - 30yrs	22	11
30 - 35yrs	4	2
	199	100%

Table 1 showed the socio-demographic characteristic of the respondent as 18: (9%) had age range of 21-30yrs, 62: (31%) were between 31 and 40 years, 89: (45%) were between 41 and 50 years while 30 (15%) were 51years and above the mean age of respondents is42.08..... (SD)8.41..... out of the 199 respondents, 139 (70%) were females and 60(30%) were males. The marital status distribution showed that 1% were separated, 3% were divorced, 5% were single, 14% were widowed and 77% were married. 97% of the respondents were Christians while 3% were Muslims. 57% were nurses and 43% were medical doctors. Their years of working experience showed that 2% had 30 – 35years, 11% had 26 – 30yrs 13% had 1-5years, 15% had 21-25years, 18% had 11-15years, 20% had 6 – 10 years and 21% had 16-20years of working experience.

Table 2: Perception of Doctors and Nurses on the need for Nurse Counsellor in the Hospital Setting

S/ N		Frequency X Percentage			
		Yes	%	NO	%
1	Do you think there is the need for a nurse counsellor to be employed in clinical areas in the hospital	173	87	26	13
2	Some ailments are psychological/emotional in nature and therefore require psychological intervention to aid recovery and this can be best provided by nurse counsellors	150	75	49	25
3	Patient with long standing and terminal illnesses need extra-time to be consoled and comforted and this can best be provided by nurse counsellor.	115	58	84	42
4	Frequently patients counselling needs are ignored due to the absence of nurse counsellors.	156	78	43	22
5	The routine duties of doctors and nurses with numerous in and out patients do not allow time to attend to the psychological and counselling needs of patients.	161	81	38	19
6	Other health care givers may find it difficult to mobilize financial support for patients who cannot take care of their medical expenses and therefore, the need of counsellor to assist.	109	55	90	45
7	Patient's relations also do experience some personal problems because of patients illness which they may want to be discussed with a nurse counsellor.	114	72	35	18
8	Patients may sometimes need change of job as a result of illness or loss of parts of the body hence need rehabilitation and counselling which is better provided nurse counsellor	126	63	73	37
9	Do you think that the presence of nurse counsellor in hospital setting will be duplication of nursing role and waste of manpower and resources.	60	30	139	70

From table 2 above showed that 87% recognized the need for the employment of nurse counsellor in the hospital setting, 81% agreed that the busy routine duties of doctors and nurses don't allow them to attend to the psychological and counselling needs of the patients, 78% of the respondents agreed that the patients' counselling needs are frequently ignored due to the absence of nurse counsellors, 75% of the respondents affirmed that some ailments are psychological/emotional in nature and therefore require psychological intervention to aid recovery, 72% of the respondents confirmed that patients' relations also do experience some personal problems arising from patients' illnesses which they may want to discuss with a nurse counsellor.

70% of the respondents do not think that the presence of nurse counsellor in the hospital settings will be duplication of nursing role and waste of manpower and resources 63% of the respondents agreed that sometimes there may be need for change of job as a result of illness or loss of parts of the body which may need rehabilitation and counselling, 58% of the respondents agreed that patient with long standing and terminal illness need extra time to be consoled and counselled by a nurse counsellor while 55% of the respondents affirmed that other health care givers may find it difficult to mobilize financial support for patient who cannot take care of the medical expenses.

Table III: What is the effect of Counselling on Patients Recovery

S/N		Frequency X Percentage			
		Yes	%	No	%
1	Counselling service is one of the avenues for helping patients and their relations to recover faster and therefore should be established in the hospital setting.	112	56	87	44
2	Counselling patient to value and to focus on specific measures to restore health is one of the determinant factor to patients' recovery during illness	126	63	73	37
3	Availability of a knowledgeable nurse counsellor who can counsel the patients and family during illness help in decreasing fear and anxiety over the outcome of that illness, and this contributes to patients' recovery.	152	76	47	24
4	The nurse counsellor to a large extent assist patients and relations in making an informed consent on a treatment which aids patient recovery.	156	78	43	22
5	Patients openness to a nurse counsellor over his/her medical and non-medical problems than any other health care giver promotes therapeutic interpersonal relationship aspects of nursing and this aids recovery	105	53	94	47

Table 3 shows that counselling has a positive effect on patients' recovery. In this study a total 156 representing 78% agreed that the nurse counsellor helping patients and relations to make an informed consent on a particular treatment aids the patient's recovery, while 152 (76%) agreed that counselling the patients and family during illness help in decreasing fear and anxiety over the outcome of that illness. 126(63%) opined that counselling patients to value and to focus on specific determines patient's recovery during illness. 112(56%) agreed that counselling service is one of the ways of helping patients and their families to recover faster from illness while 105(53%) affirmed that therapeutic interpersonal relationship is promoted because of the patient's openness to the nurse counsellor over his/her medical and non-medical problems than other health care givers promotes recovery from illness.

Hypotheses Testing

HO₁: There is no significant difference between the doctors and the nurses perception of the need for nurse counsellors in hospital settings.

Table IV: Chi-square for difference in Doctors and Nurses perception

Status	Yes	No	Total	DF	X ² Cal	X ² Cri	P value	Decision H _{O1}
Nurses	110	3	113					Accepted
Doctors	80	6	86	1	2.39	3.84	0.05	

Chi-square analysis on table 3 shows that the calculated value of 2.39 is less than the critical value of 3.84 at 0.05 level of significance indicating no statistical significance the H_{O1} which states that there is no significance difference between the doctors and nurses perceptions of the need for nurse counsellors in hospital setting is accepted.

HO₂: There is no significant gender difference among doctors and nurses perception of the need for nurse counsellors in the hospital settings.

Table V: Chi-square of Gender difference in Perception among doctors and nurses.

Status	Yes	No	Total	DF	X ² Cal	X ² Cri	P value	Decision H _{O2}
Male	48	12	60					Accepted
Female	124	15	139	1	3.02	3.84	0.05	

Chi-square interpretation on table IV is as follows: the calculated X² of 3.02 is less than the critical value of 3.84 at 0.05 level of significance. This indicated that the null hypothesis stating that there is no significant gender difference in perception among doctors and nurses of the need for nurse counsellors in the hospital settings is upheld.

Discussions

In this study, it was discovered that there is a generally higher positive responses on the need for nurse counsellors in hospital setting on all the items except item 9 in which the respondents do not see the

presence of nurse counsellor resulting to duplication of nursing role and waste of man power and resources. The positive responses are clear evidences of positive perception among doctors and nurses of the need for nurse counsellors in hospital settings. These findings are in agreement with the areas of counselling needs identified by Denga (1986), Ihejirika in Oliagba (2000).

The findings in table 3 revealed that counselling in hospital setting contributes immensely to the recovery of the patient during illness. The finding corroborates Juba (2006) who asserted that counselling is the process of helping client to recognize and cope with problems both physiological psychological and social problems which is aimed at restoring health or recovery from ill health. There is no significant difference between doctors and nurses perception on the need for nurse counsellor in the hospital setting and no significant gender difference among male and female.

On the perception of the need for nurse counsellors in hospital setting as shown in table IV and V respectively explained that role performance of nurses and doctors are not gender differentiated.

Conclusion

Based on the findings of the study, it can be concluded that doctors and nurse have high positive perception on the need of nurse counsellors in the hospital settings as the counselling services are not beneficial only to patients but also their relations and other health care givers and counselling also contributes to health promotion restoration of health and recovery during ill health.

It is said that opportunity knocks only once, nurses should cash in to this opportunity of having a fertile employment ground in the expanded role of nurse counsellors in hospital settings clinics and primary health centres since counselling is highly expedient in the hospital setting as perceived by doctors and nurses, and its positive effect on the patient recovery during illness the hospital authority/policy makers should work towards providing counselling services that are effectively managed by nurse counsellors in the hospital setting.

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ACCIDENT AND EMERGENCY NURSING (SPECIALTY AREA) CONTEMPORARY ISSUES [EDUCATION]

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Introduction

Emergency nursing as a discipline refers to the content and process of all the different roles nurses have in the care of a traumatized patient. Basically, nursing knowledge normally employed is derived from theory, clinical observations, as well as empirical studies. Others are knowledge derived from disciplines like ethics, esthetics and personal knowing. However, its practice especially as relate to Chemical Burns (CB) in Rivers State calls for concern for practitioners and patients.

The Belief Statement Of An Emergency Nurse

After analyzing the impact of trauma internationally and the potential for positive contributions by professional nurses in the care of the trauma patients, the Emergency Nurses Association (ENA, 2009) formulated the following belief statements:

- i. The optimal care of the trauma patient is best accomplished within a framework in which all members of the trauma team use a systematic, standardized approach to the care of the injured patient.
- ii. Emergency nurses are essential members of the trauma team. Morbidity and mortality of trauma patients can be significantly reduced by educating nurses to provide competent trauma care.
- iii. The ENA and its constitutions have the responsibility to facilitate trauma-related, continuing education opportunities for nurses who provide care to trauma patients.
- iv. The ENA supports injury prevention and control that is collaborative, specific problem within specific populations, utilizes databases, and addresses the three approaches to prevention (technology, enforcement and education/behavioural).

Emergency Nursing Roles And Responsibilities

A collaborative nursing model utilizes the nursing process for interaction and recognizes the role trauma nurses have within the organization where they practice. (Joann Zerwekh & J.O. Carol Claborn; 2009)

Recognize and take appropriate actions in life-threatening situations, including notifying the primary care provider of the client's emergency situation.

- Evaluate client's response to emergency interventions complete the proper documentation.
- Suggest changes in emergency treatment based upon evaluation of the client's response to interventions.
- Nurses must have the ability to identify emergent situations.
- Nurses must be able to rapidly assess and intervene when life-threatening conditions exist.

- Emergency care is guided by the principle of ABCDE.
 - a. Airway/Cervical Spine
 - b. Breathing
 - c. Circulation
 - d. Disability
 - e. Exposure
- Emergent conditions are common to all nursing environments.

The roles and responsibilities the trauma nurse assumes include, but are not limited to, the following:

- I. II.
 - III.
 - IV.
 - V.
 - VI.
 - VII.
- Designs, manages, and coordinates care**
In the emergency care setting, the professional nurse is responsible for the clinical leadership and direction of nursing activities with respect to the trauma patient. The professional nurse may also be responsible for communicating with health care members outside the emergency setting (e.g., the intensive care unit, operating room, labour and delivery), and/or nursing staff located in other facilities where a trauma patient may be transferred. The emergency nurse is often the team coordinator responsible for organizing, through effective use of communication skills, the care of the trauma victim.

- Engages in and promotes a nurse-patient relationship to provide care.**
A nurse-patient relationship not only results in direct patient care, but also promotes patient care, but also promotes patient advocacy and patient education.

The nurse-patient relationship suggests that the "professional power" the relationship generates for the nurse is actually being given by the patient in exchange for knowledgeable and safe care. Within a holistic view, the emergency nurse engages in relationships with individual patients, families, and often communities.

- Documents the care of the traumatized Patient**
The nurse's documentation of care provides an important source of data to evaluate the extent, appropriateness, quality, and timeliness of care. Analysis of the emergency

- team's performance serves as an important resource for identifying educational needs of the staff and may contribute to a database such as a trauma registry, which is used to monitor and evaluate trauma care.
- VIII. Evaluates research and incorporates appropriate findings into practice.**
- Nursing Process To Emergency Nursing**
- The standards of emergency nursing practice developed by the ENA are the standards that describe the implementation of the nursing process. The ENA had itemized the nursing process into six phases: assessment, nursing diagnosis, expected outcomes, planning, implementation, and evaluation. This nursing process forms the basis for clinical decision-making (Kozier and Erb's; 2008).
- XI. Performs an Organized, Initial Assessment Of The Trauma Patient to Identify The Extent And Severity of Injuries**
- In some settings, the nurse is the first health professional to interact with the patient and may be solely responsible for patient assessment. In other settings, the nurse may function as a member of a trauma team with predefined responsibilities, one of which may be patient evaluation.
- XII. Determines appropriate nursing diagnoses based on assessment findings**
- Nursing diagnoses are the basis of a classification system that conceptualizes the patient's current health status and identifies problems that develop. To arrive at a nursing diagnosis, the nurse must make judgements based on the patient's condition and assessment findings. The North American Nursing Diagnosis Association (NANDA) currently has 150 labels that can be used to summarize a patient's health status. In critical and/or life-threatening circumstances, assessment and determination of nursing diagnoses may occur simultaneously and spontaneously. Actual nursing diagnoses are differentiated from risk diagnoses. The formulation of actual nursing diagnoses are based on the patient's signs and symptoms. The formulation of risk diagnoses are based on whether the patient is vulnerable to certain problems because of risk factors or other contributing factors.
- XIII. Identifies specific outcomes as patient-centered goals based on nursing diagnoses.**
- Specific patient outcomes are often determined simultaneously when nursing diagnoses are being formulated. For example, the nurse caring for a patient who is having difficulty breathing may simultaneously identify the nursing diagnosis as being an altered breathing pattern and one outcome of intervention as being the return of the patient's respiratory rate to normal. In the emergency care, nursing diagnoses and
- XIV. expected outcomes are listed together.
- Develop a plan for achieving identified patient outcomes**
- In the settings associated with care of critical trauma patients, the planning phase of the nursing process may occur simultaneously with the intervention phase. Ideally, the plan of care should be written to document the nursing diagnoses, expected outcomes, and interventions. The plan of care, developed in consultation with the patient and his or her family, should address discharge plans, if indicated. Standardized care plans for specific types of trauma patients may serve as a basis for developing an individual plan. In the emergency care, the planning and implementation phases are presented together.
- XV. Implements interventions according to priorities based on threats to airway, breathing circulation, and/ or any compromises to the function of body system**
- Interventions are conducted according to a sequence whereby airway/cervical spine stabilization, breathing, and circulatory problems are addressed first. The degree of independent or interdependent nursing interventions is a function of state nurse practice acts, institutional policies, and educational nursing interventions is a function of state nurse practice acts, institutional policies, and educational background. In some settings, the development of trauma protocols has enabled the professional nurse to function with a greater degree of autonomy in providing care to the trauma patient.
- XVI. Evaluates and monitors the patient's responses to interventions.**
- An analysis of the trends in the patient's responses to the injury event and interventions will assist all the members of the trauma team to adjust their care in order to achieve optimal patient outcomes. The evaluation phase is, therefore, not always last, but is integrated into the entire process as an ongoing activity.

Emergency Nursing: The Triage Management Approach

Triage is derived from a French word meaning "to sort." The most knowledgeable Emergency Nurse becomes the Triage Officer (TRO). The TRO calls for additional help if needed, assigns available personnel and equipment to patients, and remains at the scene to assign and coordinate personnel, supplies, and vehicles. (Daniel L. M. F. & O'Keefe; 2005)

Primary Triage

When faced with more than one patient, your goal must be to afford the greatest number of people the greatest chance of survival. To accomplish this goal, you must provide care to patients according to

the seriousness of illness or injury while keeping in mind that spending a lot of time trying to save one life may prevent a number of other patients from receiving the treatment they need.

To properly triage a group of patients, you should quickly classify each patient into one of four groups:

- **Priority 1: Treatable Life-Threatening Illness or Injuries.** Airway and breathing difficulties; uncontrolled or severe bleeding; decreases mental status; patients with severe medical problems; shock (hypoperfusion); severe burns.
- **Priority 2: Serious But Not Life-threatening Illness or Injuries.** Burns without airway problems; major or multiple bone or joint injuries; back injuries with or without spinal cord damage.
- **Priority 3: "Walking Wounded."** Minor musculoskeletal injuries; minor soft-tissue injuries.
- **Priority 4: (sometimes called priority 0):** Dead or fatally Injured. Examples include exposed brain matter, cardiac arrest (no pulse for over 20 minutes except with cold-water drowning or severe hypothermia), decapitation. Severed trunk, and incineration.

Patients in arrest are considered priority 4 (or 0) when resources are limited. The time that must be devoted to rescue breathing or CPR for one person is not justified when there are many patients needing attention. Once ample resources are available, patients in arrest become Priority 1.

How triage is performed depends on the number of injuries, the immediate hazards to personnel and patients, and the location of the backup resources, local operating procedures will give you more guidance on the exact method of triage for a given situation. Basic principles of triage are presented here.

The first triage cut can be done rapidly by using a bullhorn, PA system, or loud voice to direct all patients capable of walking (Priority 3) to move to a particular area. This has a two-fold purpose. It quickly identifies the individuals who have an airway and circulation, and it physically separates them from patients who will generally need more care.

You must rapidly assess each remaining patient, stopping only to secure an airway or stop profuse bleeding. It is important that you not develop "tunnel vision" - spending time rendering additional care to any one patient and thus failing to identify and correct life-threatening conditions of the remaining patients. If Priority 3 patients are nearby and well enough to help, they may be employed to assist you by maintaining an airway or direct pressure on bleeding wounds of other patients. Priority 3 patients who have been reluctant to leave ill or injured friends or relatives may be permitted to stay near them where they can be of possible help later.

Once all patients have been assessed and treated for airway and breathing problems and severe bleeding, more thorough treatment can be initiated.

You will need to render care to the patients who are most seriously injured or ill but who stand the best chance of survival with proper treatment. This requires treating all the Priority 1 patients first, Priority 2 patients next, and Priority 3 patients last. Priority 4 patients do not receive treatment unless no other patients are believed to be at risk of dying or suffering long-term disability if their conditions go unattended.

Usually patients will be immobilized on backboards if necessary and carried by "runners" to the appropriate secondary sector (as described below). Extensive treatment does not occur at the incident site since it is in a hazard zone and since it could impede rescue and initial treatment of other patients.

Nursing Assessment, Monitor And Intervention

- Head - to - toe assessment
- **Airway patency** (especially burns of the face that occur in closed spaces)
- Mouth, nose, and pharynx for singed hairs (evidence of inhalation injury)
- Oxygenation status.
- Vital signs, heart rhythm (especially with electrical burns)
- Fluid status
- Circulation status (hypovolemia, decreased cardiac output, edema, third spacing).
- Size and depth of burns - body surface area (BSA), rule of nines, Lund-Browder and Berkow methods.
- Renal function (urine output decreased first 24 hr)
- Bowel sounds (commonly reduced/absent)
- Stool and emesis for evidence of bleeding (ulcer risk).

Nursing Interventions

- Ensure airway patency (intubation, tracheostomy) and provide oxygen as needed (for example, mechanical ventilation).
- Maintain the client's thermodynamics (warm room, cover with blankets)
- Monitor vital signs, pulses, capillary refill (particularly for evidence of shock and adequate tissue perfusion).
- Administer fluids, inotropic agents, and osmotic diuretics as needed to maintain adequate cardiac output and tissue perfusion.
- Begin IV fluid and electrolyte replacement.
- Keep the client NPO (reduced gastrointestinal blood flow, risk of ileus, Curling's stress ulcer). Administer H₂-antagonists.
- Elevate the client's extremities (increase venous return).
- Encourage the client to cough and deep breathe and to utilize incentive spirometry.
- Administer tetanus prophylaxis per hospital protocol.
- Prevent infection and implement infection control measures.

- Wound care and dressing changes should be done with surgical aseptic technique as ordered; use pressure dressing to prevent scarring and edema.
- Monitor and assess for pain.
- Encourage range of motion exercises to prevent immobility and the use of splints to maintain correct positioning.
- Collaborative care is vital for these clients. Physical therapy, occupational therapy, dietary, pharmacy, social services, and other disciplines should be involved in the plan of care.
- Initiate referrals as appropriate (counselling, support groups).
- With above management prepared for a burns patient's by the emergency nurse, most of the patient where seen in the hospital with sepsis in a late hour. Management of this patient depends on the golden hour and the prompt arrival to the hospital.

Recent Challenges to Triage Management Approach on Fuel Explosion (Burns) Dated On The 11/07/2012. In Rivers State

In this triage management two categories of barriers exist and they include:

- Provider barrier
- System barrier

Documentation is Very Poor Due To Lack Of Statistical Data.

- Causes of chemical exposure.
- Morbidity rate from chemical exposure
- Lack of continuity of care
- Poor collaborative management
- Efficiency of care

Lack of Public Awareness Of Chemical Burn

- Keep people separated from excessive heat
- Separate with a barrier
- Separate by time
- Use of fire extinguisher

Experiences in recent past suggest that exposure of fuel tank was due to bad road and proliferation illegal refineries with poor quality of products, should be co-curtailed.

Lack of Emergency Medical Services

- Establishment of emergency centres across the three senatorial districts.
- Lack of adequate manpower. More personnel (A&E nurses and burns nurses) should be trained in the places of burns.
- Inadequate facilities
 - (i) Provision of working materials
 - (ii) There should be no out of stock syndrome.
- There should be promptness to service e.g in cases of fire outbreak

Poor Policy Implementation: Finance, drugs, bedspace and 24hrs emergency medical services.

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Models of Service

- The group envisages a service with main A&E departments based at the major acute hospitals, with multi professional specialist teams led by Consultants in Accident & Emergency Medicine. As an integral part of this team, nurse led departments, such as minor injuries units could be established. These nurse led departments would be based either within the core A&E department or at a remote distance from it.

- Key to these Minor Injuries Units will be the development of a clinical network and the rotation of staff between the core and peripheral units. As part of the continuing professional development and maintaining professional standards of practice, staff in minor injuries units should work a minimum of one week and ideally one month a year in an A&E environment. This period should be tailored and extended to meet individual needs as required.

Education

1. The Group recommends that education programmes should:

- Be competency based; Be flexible providing a pathway to higher level qualifications if so desired by the practitioner;

- Equip nurses with the skills to practice within all A&E environments;

- Be developed in partnership with clinical practitioners;

- Where appropriate must make the best use of opportunities for multi professional learning;

- Be delivered in innovative ways, through for example work based and online learning.

Quality

1. The development of clinical guidelines needs to take into account their acceptability to patients, professionals, commissioners and the public and reflect the needs of the new equality legislation.
2. Protocols for care and treatment cannot be developed by any one professional group, but should be developed by the clinical team. It is vitally important that all professionals involved in the care and treatment of patients are involved in and agree with their content and application.

Aggression and Violence

1. Nursing staff need to be trained adequately to anticipate and deal with violent patients. This training should be regularly updated and involve all staff who work in the A&E and minor injuries environments.
2. Risk assessments should form part of a regular review of services and should involve alongside relevant members of the A&E team, including appropriate security staff.
3. A system, which records violent incidents or acts of aggression, verbal or physical, should be in place.
4. A key and integral part of the management

process is the support and care of patients and staff following violent and aggressive incidents. (Sujata Sarabahi; 2010).

Conclusion

A&E services are valued by local communities, patients and their families must have confidence in the clinical standards of care delivered. Many A&E units do not have specialist multi professional teams providing care, nor do they provide the full range of services required to support the management of patients with major trauma or major illnesses.

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AUTOMATED EXTERNAL DEFIBRILLATION (AED): THE ROLE OF THE NURSE.

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Port Harcourt,

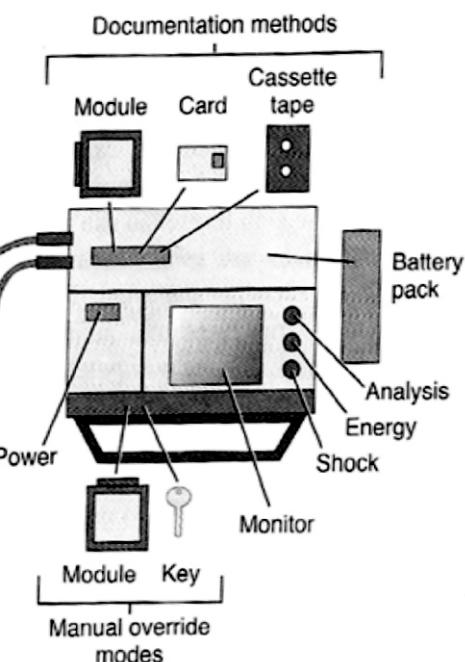
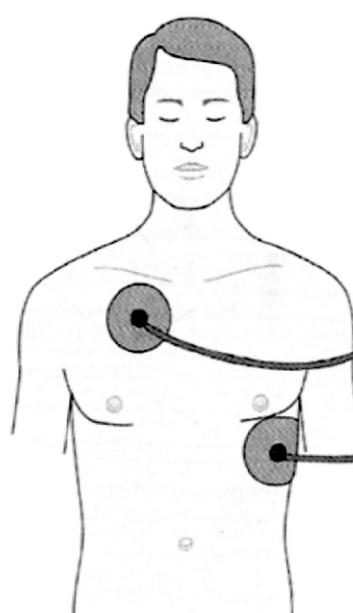
Rivers State, Nigeria

INTRODUCTION

An automated external defibrillation (AED) is a defibrillator that uses a computerized detection system to analyse cardiac rhythms, distinguishes between rhythms that require defibrillation and rhythms that do not, and delivers a series of preprogrammed electric shocks.

- Defibrillation is the therapeutic use of an electric shock that temporarily stops or stuns an irregularly beating heart and allows more coordinated electrical activity to resume. Physiologically, it is thought that the shock depolarizes the myocardium, terminates ventricular fibrillation (VF) or ventricular tachycardia (VT), and allows normal electric activity to occur. VF and pulseless VT are the only two rhythms amenable to conversion by an AED.
- Time is the major determining factor in the success rate of defibrillation. For every minute defibrillation is delayed the chance of success decreases by 7% to 10%.

- The AED is attached to the patient using adhesive electrode pads. Through these pads, the rhythm is analyzed and shock delivered, if indicated. If the AED recognizes VF or VT, visual or verbal prompts guide the operator to deliver a shock to the patient. The AED not the operator, makes the decision about whether the rhythm is appropriate for defibrillation. The AED should be applied only to unresponsive, non breathing and pulseless patients. To keep artifact interference a minimum, the patient should not be touched or moved during the analysis time. Equipment that emits strong electromagnetic frequency or radio frequency could affect analysis. Radio frequency interference may cause electrocardiogram (ECG) distortion and failure to detect a shockable rhythm. Keep equipments such as cellular phones, CB radios, and emergency medical system (SMS) radios at least 6 feet away from the AED while analysis is occurring.



In using the AED Machine Automated External Defibrillation (Aed)

- Although defibrillation is the definitive treatment for pulseless VT and VF, the use of the AED is not a stand alone skill: it is used in conjunction with cardiopulmonary resuscitation (CPR).
- Most AEDs use in SMS or in the hospital have a method of recording the event. This can be in the form of rhythm strip print outs, audio and event recording devices, data cards or computer chips that can print an event summary.
- An important safety issue an AED operator must address is the possibility of inadvertently shocking a bystander or other provider at the scene. It is imperative that the operator clear the patient verbally or visibly by looking at the patient from head to toe, before discharging energy to the patient.
- AEDs can be purchased with and without monitor screens. AEDs with screen may allow the provider with rhythm recognition skills to over ride the AED's analysis and recommendations. AED is now recommended for use in children 1 to 8 years if, the child shows no sign of circulation and if the defibrillation shows high specificity for paediatric shocking rhythm. Check with the manufacturer if the defibrillation has paediatric pads which have an attenuator in the cord that decreases the amount of energy delivered. If you cannot fit the paediatric pads on the child's chest in a lead two position, use an anterior posterior pad placement. Do not use paediatric pad on adult or large child to prevent the electrode from delivering reduced energy level that will not be effective in the treatment of VF.

AED Equipment

- AED
- Disposable gloves
- Barrier device or airway management equipment
- Spare sets of gauze pads in sealed packages
- Hand towel
- Scissors
- Razor

Attach the pads to the patient. One pad below the right clavicle to the right of the sternum and the other to the left of the left nipple on the midaxillary line. Placing the sterna pad on the sternum decreases the effectiveness of the shock because the defibrillating energy is going through bone to reach the heart. Place the apex pad down on the midaxillary line to ensure that the energy is delivered to the heart. Increasing your effectiveness.

An alternative pad position would be anterior/posterior placement where one patch is anterior over the left apex and the other is posterior behind the heart in the infrascapular location. Ensure that the patches are directly above and below each other.

Place pads firmly to eliminate air pockets, air

pocket under the electrode can cause electrical sparks and skin burn and divert defibrillation energy away from the heart, and to form a complete seal. AED uses the electrode pads to monitor and to shock. Some models require attaching cables to the pads before placing them on the patient. Polarity of the pads is interchangeable for defibrillation purposes.

* Do not place the pads over any medication or monitoring patches. Remove any medication pads from the chest. Example if ECG monitoring is being done, the QRS complex is inverted.

* Do not place an AED pad directly over an implanted device try to stay at least 1 inch to the side of the power source of the pacemaker or internal cardiac defibrillator. This is because placing electrode directly over an implanted device can divert defibrillating energy away from the heart.

Press the analyze button to analyze the patient's rhythm. Some AEDs automatically analyze the rhythm when they sense a patient connection or when the electrode pads are applied. This is because the machine needs to analyze the rhythm to determine if the heart rhythm is amenable to defibrillation. Avoid CPR, transport or any contact with the patient during the analyze mode. Radio transmitters and receivers, cell phones should be off or at least 6 feet from AED.

If a shock is advised, clear the patient visually and verbally. Use a mnemonic such as I am clear, you're clear, we are clear; and look at the patient head to toe while talking to ensure that no one is touching the patient.

If AED has determined that the rhythm is either VF or VT: defibrillation is needed. Maintain safety for everyone around the patient. If anyone is touching the patient or any conductive apparatus that is in contact with the patient (e.g. stretcher frame, intubation stylet) where the energy is discharged, he or she also may receive the shock.

Push the shock button or buttons as prompted. The shocks are delivered in sets of three as long as a shockable rhythm is detected.

A CPR time interval usually occurs between the sets of shocks. Although some AEDs are fully automatic and deliver a shock if needed without user interaction. In this case, the AED warns the user to stand clear before delivering the shock.

Reanalyze the rhythm. The rhythm must be analyzed to determine if a shockable rhythm still persists. Shocks are delivered in sets of three unless the AED determines that another shock is indicated.

If a shock is advised, clear the patient, and push the shock button. The AED now delivers shocks according to preprogrammed energy settings, appropriate to the AED's technology and typically based on the American Heart Association (AHA) AED algorithm (a series of three shocks at 200, 300, 360J or equivalent biphasic).

Repeat steps 10 and 11 as needed. No pulse check is needed between shocks.

After the third shock or if a "no shock advised"

message occurs, check the pulse. Checking the pulse determines whether the last shock restored a perfusing rhythm and determines the need for continued CPR.

If no pulse, do CPR for 1 minute or as per your protocol. This provides oxygen and circulation. Most AED have a CPR timer that counts down and alerts you when the time for CPR is complete. Time interval is usually 1 minute.

Repeat steps 7 to 14 is so advised until Advanced Cardiac Life Support (ACLS) team arrives (Algorithm is a series of three shocks followed by 1 minute of CPR with the series repeated until resuscitation units arrive).

If at any time a "No shock advised" message occurs, check the pulse, the patient is not in a rhythm appropriate for defibrillation.

If a "No shock advised" message occurs and there is no pulse, begin CPR to maintain circulation in absence of pulse.

A "No shock advised" message occurs and the patient has a pulse, check for breathing. If the patient is not breathing, begin rescue breathing 12-15 breaths/min. this indicates that defibrillation has been successful in restoring the patient to a perfusing rhythm, but spontaneous respiration are not present.

Check blood pressure and treat as needed

Monitor vital signs and rhythm after resuscitation to rule out arrhythmias or other cardiac instability because patient experiencing VF and VT is at risk of developing arrhythmias.

Administer appropriate anti arrhythmic agents if indicated to decrease further arrhythmia.

Transport patient into appropriate follow up care.

Documentation

- Type of arrest
- Time from patient's collapse to first shock if witnessed
- CPR information (start to stop)
- CPR performed before AED application yes/no
- Application of AED
- Time from activation of AED to first shock
- Number of times patient was defibrillated
- Level of energy for each shock
- Preshock and post shock rhythms
- Any complication
- Assessment for resuscitation
- Unexpected outcome
- Nursing intervention of any

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OBESITY: REDUCING THE RISK FACTORS

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Introduction

Obesity can be defined as a condition in which there is an excess body fat accumulation, with weight 20% above the average ideal body weight for age, height and body build. (Intral 2005). It has been recognized as a major public health problem because of the risk factors and complications which include coronary heart disease, cancer, hypertension, strokes, diabetes, etc. It is estimated that about 1.1 billion people in the world are overweight and about (300,000) three hundred thousand people die annually in the United states as a result of obesity and its complications. It has also been rated as the number two killer in the United States (Gordon et al; 2002).

One of the factors attributed to the increase in the prevalence of obesity amongst others include - an increase in the consumption of fast foods, snacks high in calorie especially of sugar and fat content.

Obesity is also the total body fat percentage (%) over 25% in men and 35% in women, with a body mass index (BM1) of 30kg/M² (Gordon et al., 2002). When energy intake from food exceeds individual's energy requirement and expenditure, the excess is converted and stored in the adipose tissue. This is called positive energy balance.

Causes of Obesity

There are the genetic and psychological factors (Akinyele/Oguntona, 1995). Genetic background - accounts for about 40% of weight difference in people. Psychological factors can increase and influence the risk of obesity especially in people who are already genetically predisposed (Anthony, 1998)

Genetic Factors

Genes determine the rate of metabolism and differences in brain chemistry, all of which affect the weight of a person. The specific body types or structure inherited, that is endomorph, mesomorph and ectomorph determine human body size and shape which influence the body's metabolism and weight (Gordon, 2002).

Psychological factors - such as feeding patterns, eating habit, mode of food preparation as well as environmental factors including food availability, high fat diets and inactivity can all contribute to obesity. Other factors necessitating the development of obesity include - the use of drugs (e.g anti-hypertensive), neurological drugs, excess weight gain in pregnancy, lack of exclusive breastfeeding, sedentary life style, etc.

Criteria for Classification and Assessment of Obesity

1. Weight for height of tables
2. Weight status by body mass index (BM1)
3. Using body fat distribution
4. Waist - hip - ratio

Health and economic implication of obesity

- There is an important link factor between obesity and health risks and diseases. For instance, central obesity is associated with raised plasma

triglyceride and reduced plasma high density lipoprotein (HDL) cholesterol which is a risk factor for cardiovascular diseases. Other health problems associated with excess body fat are hypertension, stroke, diabetes, cancer, gall bladder disease, arthritis, polycystic disease of the ovaries, impaired respiratory function, surgical and pregnancy risks as well as high mortality rate. In addition, obesity produced their physical problems which do not lead to death: stress, incontinence, menstrual irregularities, pregnancy complication, excess factual hair in women, depression and increased surgical risk.

- It has consistently been shown that thin people live much longer. The Framingham heart study which followed peoples lives for up to 26 years, found that the risk of death increased by 2% between 50 and 62. In 2002, the U.S. surgeon general estimated that 65.4% of Americans were clinically overweight of which 30.5% were obese. The weight of overweight and obesity has drastically increased since the 1950's (Vance 2008). The medical costs related to overweight and obesity are simply staggering. According to statistics back in 1995, the direct economic cost of dealing with excess body fat in the U.S. was 899.2 billion dollars. Indirect costs (lost wages due to sickness or disability) amounted to another 847.6 billion dollars. These costs continue to sky rocket. In Nigeria, though there has not been enough data on the death toll of obesity among the people, physical observations show that there have been incessant records and stories of sudden collapses and deaths of people "standing up" or "eating" only to die or "died from sleep" etc. These are most often attributed to cardiac arrest (from possible atherosclerosis), hypertension and obesity, etc.). The complication and deaths records including economic costs in Nigeria if documented may be

greater than that of the U.S. considering the vogue life style we have indulged in which includes - high consumption of synthetic fruits and juices with preservatives, consumption of high calorie diets like snacks and other fast foods, etc.

Management of obesity (diet therapy), obesity is a chronic disorder that necessitates a life long management, yet a more logical approach to weight loss is actually very straight forward - eat less, increase physical activity and change problematic eating behavior. The goal of management is to meet the dieter's nutritional needs and at the same time, control the kilo calorie intake. This can be done by emphasizing a wide variety of low fat/non fat food intake, substituting with moderated amount of food rich in complete carbohydrate and dietary fiber. Fiber - soluble fiber is found in barley, at bran, vegetables and fruits. (Insoluble fiber is made from cellulose and in the body, increases bulk in the stool. Research studies have found that an increase of either in the diet increases a sense of fullness after a meal. They also decrease body weight some how. The best time to take fiber is with the highest fat meal of the day. It helps to absorb the fat so that it does not enter the blood stream.

- Fruits and vegetables should also be an ample part of the diet. In a study of over fifteen (15) nations according to Vance (2008), there is a close corollary between the amount of dietary fat and breast cancer. A French study found that women who ate the most total fat increased their risk of breast cancer by 60%. The risk was greatest among post-menopausal women. Their risk of breast cancer more than tripled. Between 1964 and 1978, the Japanese were said to have doubled their fat consumption and with it, their rate of breast cancer. Women who used more olive oil, which is far healthier, had a 25% decrease to breast cancer risk according to (anred 2005). In another Japanese study, thin women had the lowest rates of breast cancer. Over weight women were five times as likely, and those who were obese were 12 times more likely to develop breast cancer. Other research studies have also found that prostate and skin cancers also increased with fat consumption. (Vance 2008).

The Solutions

The most important aspect of dieting is maintaining a daily eating schedule. According to FAO (2001) what an individual eats may not have a critical influence on weight gain, when he eats definitely does.

Immediately, after awakening, eat a large breakfast. This should be done for a life time. An individual needs proper nourishment; obtain most of it at breakfast. Ideally, breakfast should consist of fruits and whole grains. If high calorie is to be consumed, it must be in the morning not late. In the mid afternoon, a small snacks and a small dinner not later than 6.30pm. Do not skip breakfast. Make breakfast the largest, lunch moderate meal and dinner the lightest or skip evening meal entirely. Do not eat before bed time or at night. It is best to eat nothing after 3.00pm.

- Primarily, eat vegetarian protein foods with some

moderation: beans, sprouted beans, seeds, nuts, etc.

- All refined carbohydrates are forbidden. This includes sugar, alcohol, white flour products, quick oats, most packaged cereals and processed starch. People who are over weight should do well to eat as much raw food as possible rather than cooked food. If cooked, the food should be baked, steamed or boiled but never fried.
- After dinner, consume nothing by mouth but standardized avocado extract pill and water required to swallow them. Two of those pills may be taken if hunger returns later in the evening.
- The objective is to reduce fasting insulin to zero or near zero levels - only then can the body fat begin to be released from the fat cells. Enough fat loss should have occurred during the initial 45 days on this new eating programme that will be motivated to start reducing total calorie intake and begin to exercise. The individual can then gradually switch over to 2-3 meals a day.
- Those standardized avocado extract pills will make restricting calorie intake much easier by reducing carbohydrate cravings. The key to weight loss for severely overweight people is to consume the bulk of their calories for breakfast and then avoid eating all food after 6.30pm. Unfortunately, most physicians are unaware of the insulin - fat connection, the proper time to eat and the avocado extract solution. The result is that they treat diseases associated with obesity (cardiovascular, cancer, diabetes, etc). Only two tablets of avocado extract will help some people lose weight while those who want to significantly reduce calorie intake may take two or three tablets per day. The key factor in deciding this will be how long the appetite suppressing effects remain before more tablets are needed.

Other ways of losing weight

Chromium and magnesium

These two minerals work together in weight reduction and in breaking down the insulin resistance in cells which causes higher blood sugar levels.

Chromium lowers serum glucose levels by increasing insulin sensitivity. It produces a slight reduction in body fat and increase in lean body mass.

Magnesium is even more important in regulating carbohydrate metabolism. It is involved in several enzymes reactions needed for cells to take in and use glucose. Lack of magnesium increases insulin resistance by the cells and higher blood levels. A dose of 300 - 500mg daily magnesium is helpful Niacin-improves the effect of chromium. It is best to take all the B vitamins. Always take antioxidant supplements such as vitamin E to protect against free - radical activity. Conjugated linoleic acid (CLA) reduces the size of the fat cells. It produces less fat and more lean body tissue. It also protects against atherosclerosis and cancer.

Essential fatty acids - hydrogenated fats are the kind found in hardened fats including margarine. They do not contribute much to the body function but can make the fat cells larger. There are two types:-

Omega 3 and Omega 6.

Omega 3 (alpha-linolenic acid) and omega 6 (linolenic acid) are healthy fats and have nice flavor but can become rancid after a few weeks even with refrigeration. The best oil sources for omega 3 are olive oil, flaxseed oil, borage oil, evening primrose oil, etc. They are cold pressed to avoid the chemical changes that occur during heating.

For omega 3, 2 - 4 table spoons of olive or flaxseed oil is helpful. Do not put it in the cooking, but put a table spoon of it in the mouth at the table along with a mouthful of other food, chew and swallow. Omega - 6 sources are sunflower oil, walnut oil, evening primrose oil or quality soybean oil. Borage oil is a richer source of omega - 6; one tablespoon should be taken daily.

Exercise - A regular exercise programme is needed. Aerobic exercises are better than other kinds. This simply means exercise done in the open air. It helps to lose weight and build strength. It strengthens the heart, arteries and veins. It also invigorates the vital organs and endocrine glands.

Walking - uses up to 120 calories per hour while actual jogging burns off about 44 calories per hour. But walking remains the best exercise.

Swimming - is usually done in cold water: this triggers the body to store extra fats as protection against the cold. So swimming does not help one to lose weight.

Bowel movement - regular bowel movement is very important and should be ensured.

Fluids - drink at least 6 - 8 glasses of water each day.

Other points to note:

- Do not eat food for fun; eat for health. Avoid junk foods, fatty foods, fried food processed food, caffeine, nicotine and soft drinks.
- Do not skip breakfast.
- Do not eat before bed time or at night.
- Do not over feed children with excess of cow's milk and starch.
- Reduce salt intake.
- Avoid gum chewing - It gets the stomach moving and makes you hungry.

The Possible Ways Out of Obesity

People frequently gain weight as they age. However, that added weight can lead to serious physical disorders including cardiovascular diseases, type II diabetes and even cancer. Two facts stand out: First, the typical approaches to conventional weight loss have a high failure rate. It is discouraging to continue dieting without success or ending up heavier than before. Second, scientific research has provided data which indicates that sustained weight management is indeed attainable. There are several factors which cause aging people to add fat and prevent them from loosing it. There are never ways of avoiding "adding and never shading", when fat is added to the body, not only is there an increase of fat cells, but there is also an increase in the size of those fat cells.

- It is not safe to be over weight, it is the second

leading cause of preventable deaths (tobacco being the first) stated. Vance (2008). Over weight and obesity are special risk factors for diabetes, heart disease, stroke, hypertension, osteo-arthritis, gall bladder disease, sleep apnoes and some forms of cancer (breast, kidney, gall bladder, uterine, colorectal (polyps) and prostate.

- Diet and obesity - Significantly, not even eating less total fat in the diet seems to change the situation. There are several body hormones which affect how many calories are stored as body fat. If any of them is out of balance, a person can gain weight even though they may eat less food. One important hormone is insulin.

- The excess insulin problem - Insulin produced in the pancreas enables the liver to store excess serum glucose. But it also stimulates the liver to form fatty acids that are transported to fat cells and stores as fat. It also helps some carbohydrate and protein in the body

- A poor diet greatly increases insulin production. Eventually, body cells become resistant to all insulin by decreasing the number of insulin receptors within the cells. This only adds to the excess insulin problem: For as cells become insulin resistant, the body stabilizes blood glucose by producing still higher levels of insulin. The effect of this is weight gain and possibly type II diabetes. When that occurs, blood glucose levels become unstable, even though insulin levels are dangerously high. As excess fat is accumulated, hyper insulinemia (excess insulin production by the pancreas) develops. This is a radicals excess of insulin flooding into the system, which the body cannot use.

- So part of the solution to loosing weight - is to reduce the amount of excess insulin in the body. Some researchers are convinced that it is impossible to loose body weight as long as they have insulin over load. Even in children, insulin levels are fair higher in obese than non obese children. About 64.5% of Americans are over weight. On daily basis about half of these people are trying to loose weight. But dieting (eating less than one usually does) only results in short term loss of weight. Dieters typically loose lean tissues and not fat. Because excess insulin blocks the release of fat from the storage, most people will not loose stored fat by lowering food intake as long as any insulin is present in the blood. One effect of excess insulin is constant hunger that leads to excessive eating - which means more insulin is secreted and more fat is added to the body. Although added insulin (by injection) saves the lives of type I diabetics, it ruins the lives of over weight people who do not find the way to get rid of it. As early as 1968, the Cecil Test book of medicine noted that "elevation of fasting (low level) insulin is the difference between thin and obese individual. (Vance 2008).

- Excess insulin in the blood stream causes other problems as well. It promotes high blood pressure by impairing sodium balance, it injures the kidneys, damages the blood vessels, increases the risk of certain cancers and causes prostate cells to become larger - resulting to benign prostate enlargement. One study found that the risk of developing coronary disease

increased by 60% for each single - digit increase in fasting insulin level among men aged 45 - 70. Ideally, fasting insulin should be 0 - 3, although it increases with age, these levels in the obese often exceed 20. Yet adopting to this situation laboratory reference ranges now declare that fasting insulin levels of 6 - 27 mclu/ml are normal. But normal is not healthful. The normal changes of aging that makes it easy to gain weight include alterations in endocrine hormone levels, insulin, cortisol and estrogen (in men) are hormone that do not decrease as we grow older yet they favour fat gain.

▪ As long as insulin is present in the blood, fat cannot be released from storage in the fat cells. Because of this reason, the weight lost by over weight people due to "dieting" is largely protein and water. Neither calorie nor exercise reduction can solve the problem.

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DISPOSAL OF MEDICAL WASTES IN HEALTH CARE INSTITUTIONS

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Abstract

The study investigated the methods of disposal of medical wastes in Health care institutions. The population consisted of 210 health workers drawn from hospitals and health centres using simple random sampling techniques. The instrument used for data collection in the study was questionnaire. Three research questions were formulated by the researchers for the study, and the data collected were analyzed using frequency distribution and percentages. The result indicated low rates of injuries sustained by health workers during disposal of medical wastes, and that health care institutions scored average percentages in the use of incineration, burning and burying as final methods of disposing medical wastes.

Keywords: Disposal; Medical Wastes; Bloodborne Pathogens; Healthcare Institutions

Introduction :

Handling of all medical wastes demands utilization of universal precautions, treating all used needles, sharps, blood and other medical wastes as potentially infectious (SBD, 2009). According to OSHA (1991), used needle disposal is regulated and requires a licenced medical waste company for disposal. Used needles must be packaged in a puncture proof, leak proof, approved sharps container; and disposal of all used needles, used syringes, medical sharps and other medical wastes shall be in accordance with all applicable Local, State and Federal regulations.

SBD (2009) has it that medical waste includes blood and other body fluids like semen, vaginal secretions, cerebrospinal fluid (CSF), synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, and any body fluid that is visibly contaminated with blood and body fluids in situations where it is difficult or impossible to differentiate between body fluids. Also included in medical wastes are contaminated bandages, dressings, gauze pads, compresses, lancets, any item contaminated when rendering emergency medical services, gloves, beddings, used needles and syringes as well as medical sharps. These are considered "Regulated Waste" under the code of Federal Regulations (CFR 1910.1030).

Improper managing or securing of used needles and medical sharps for disposal allows used needles, syringes and other medical sharps to pose a health risk to the public and other workers. Loose used needles thrown illegally into household and other trash containers and bags expose waste management workers to the potential of needle sticks and occupational exposure to bloodborne pathogens incidents. This illegal disposal of used needles and syringes may result in the transmission of HIV, Hepatitis and other serious bloodborne illnesses. ECRI (2001) reports that as healthcare safety research indicates, needlestick injuries, after blood draws, are most likely to occur while removing the blood-drawing needle from the patient's arm or while disposing of an unprotected

needle into a sharps container. Weltman, Short & Mendelson (1995) cited by Delaune & Ladner (2002) in their study of disposal-related sharps injuries in a teaching hospital observed that out 361 persons who reported of sharps injuries, 72 of the injuries were related to sharps disposal, and that majority of exposures to hepatitis B virus (HBV) and HIV were caused by sharp objects. The practice of removing contaminated needles and reusing blood tube holders can also pose multiple potential hazards. The manipulation required to remove a contaminated needle (even a safety engineered needle) from a blood tube holder may result in a needlestick with the back end of the needle which is only covered with a rubber sleeve (EPINet, 1993). Because the reuse of the tube holders require the removal of used needles, exposing healthcare workers to contaminated, unsafe, backend needles, professional phlebotomists have been urged not to reuse holders (Safety Alert National Phlebotomist Association. Inc). The safety measures require immediate disposal of the entire blood tube holder unit with needle attached after activation of the safety feature into a sharps container. In addition, contaminated needles and other contaminated sharps shall not be bent, recapped, or removed, unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical or dental procedure.

For appropriate handling and disposal of contaminating sharps, Bloodborne pathogens Standards (29 CFR 1910.1030) has it that employers must make available, closable, puncture resistant, leakproof sharps containers that are appropriately labeled and color-coded. The containers must also have an opening that is large enough to accommodate disposal of the entire blood collection assembly (blood tube holder and needle).

Employees must have access to sharps containers that are easily accessible to the immediate area where sharps are used; and if employees move from one location to another (eg from one patient room to another or from one facility to another), the

employee must be provided with sharps container which is conveniently placed at each location/facility. According to Delaune & Ladner (2002), other precautionary measures in handling and disposal of contaminating sharps are: needles and others sharps must not be bent or recapped, wearing of gloves in procedures/areas that are at risk of potentially infectious materials, immediate disposal of needle and/or syringe after use by dropping it into a biohazard sharps container from a height no greater than 6 inches, contaminating needle/syringe should not be left in an area with chux and other disposables as this may increase the likelihood of needle sticks, sharps container should be at every beside in a hospital and next to each gurney during invasive procedures, hands should not be placed into sharps container, lid of sharps container should be closed when $\frac{3}{4}$ full (the container should not be overfilled), use of hemostat or one-hand technique if needle is to be removed from the syringe, and no attempt should be made to push out a vacutainer needle with fingers so as to avoid posterior needle puncture.

Appropriate handling and disposal of other contaminated materials include immediate washing of hands and replacement of gloves when torn, punctured, covered with blood or other potentially infectious materials, disposal of all disposable materials such as gloves, gauze sponges, alcohol pads and/or chux pads in regular trash, and if grossly contaminated dispose in a leak proof, red "Biohazard" bag, always take extra time to look closely for any hidden needles, ampoules or sharp objects when gathering and disposing contaminated materials, dispose of blood specimens in a container that prevents leakage (red "sharp" container), if blood spill occurs, use decontamination procedures stipulated within the Bloodborne pathogen SOP, and above all use universal precautions and consider all body fluids as potentially infectious materials (CDC, 1987).

It is the responsibility of Health Institutions to finally dispose all the medical wastes collected from the various units. Clark (1999) pointed out that safe disposal of such wastes is important so as to prevent injuries and other hazards like environmental pollution to the community. Choice of method of final disposal of medical wastes in health institutions differ with institutions. Some health institutions may choose a medical waste disposal company as the disposal choice while some may choose incineration with the incinerator installed in the institution.

All medical waste companies disposing of used needles and other medical sharps are required to be licenced and insured, and are subject to the same State, Local and Federal Regulations, and reporting requirements regardless of the size of the medical waste company. Incineration is particularly beneficial for treatment of certain waste types such as medical wastes and certain hazardous wastes where toxins and pathogens can be destroyed by high temperature (Onu, 2003). In addition, incineration of waste reduces the solid mass of the original waste by 80 to 85% and the volume by 95%-96% (Lucas & Gilles, 1981; Mckenzie & Pinger, 1997). Other used needle disposal options are

Syringe and used Needle Exchange Programmes (SEP) and Sharps Mail-back Services. SEP are established to ensure that used needles are disposed of properly and to decrease the risk of transmission of diseases. SEP also ensure that used needles are exchanged for new needles keeping the used needles out of the public hands (North American Syringe Exchange Network). In Sharps Mail-back Services, new sharps containers are mailed to the home, and when full of used needles and syringes, they are mailed back for destruction. Sharps Mail-back Service is a good safe way to dispose of low volume of used needles and syringes, and it is economical time saver.

Problem:-

Safety-engineered medical devices have been improved and have become more available to health care workers. While engineering controls exist to significantly reduce injuries to health care workers, hazardous work practices continue to cause injuries which could be linked to how medical wastes are handled by health care workers. Hence, the problem this study addresses is the strategies for disposal of used needles and other medical wastes in health care institutions.

Research Questions:-

- . What type of injuries do Health care providers sustain during the process of disposal of medical wastes?.
- . What precautionary measure do health care providers adopt to guard against injuries from medical wastes?.
- . How are medical wastes finally disposed of in Health care Institutions?.

Method:-

Descriptive survey design adopted for the study. The population for the study were nurses, medical doctors and medical laboratory scientists drawn from Health Centres, General Hospitals and a Teaching Hospital in Anambra State. Simple random sampling was adopted in selecting a sample size of 210 respondents for the study.

The instrument used for the data collection was questionnaire on Disposal of Medical Wastes (QDMW). For face and content validity the questionnaire was given to experts in Health and Safety measures Blood pathogen standards. The recommendations of the experts were effected in the final draft of the instrument.

Reliability co-efficient of the instrument was established through test-retest procedure. Copies of the questionnaire were administered to 20 nurses and medical laboratory scientists in a General Hospital that was not used as a sample in the main study. The instrument was administered twice in the same subjects, and the retest interval was two weeks. Using kinder Richards formular 21 method of estimating reliability, the reliability coefficient of the instrument was 0.82. The researcher used direct contact approach in collecting data from the respondents. Also the service of research assistants was employed to

facilitate the work. Frequency distribution and percentages were used in the data analyses.

Result:-

Table 1: Injuries sustained during disposal of Medical Wastes

Types of injuries	Frequency	Percentage
Cuts/punctures	63	30
HVB	8	3.8
NIL	139	66.2
Total	210	100

In table 1, 30% of the respondents sustained cuts/punctures while 3.8% contacted hepatitis B virus (HVB) during the process of disposal of medical wastes

Table 2: Precautions taken by the respondents

Precautionary Method	Frequency	Percentage
Needle Recap:		
Yes	70	33.3
No	136	64.8
Missing value	4	1.9
Needle separated from mixed materials:		
Separated	70	33.3
Not separated	140	66.7
Hand washing:		
Before procedure only	3	1.4
After procedure	24	11.4
Before & after procedure	112	86.7
Missing value	1	0.5
Extent of filling sharps containers:		
¾	153	72.9
½	24	11.4
Top level	28	13.3
Hipped above top level	5	2.4
Use of Hand to push in wastes:		
Yes	12	5.7
No	198	94.3

Total population N=210

Table 2 shows the extent to which precautions are taken while disposing medical wastes with regard to needle recap, separation of needle from mixed materials, hand-washing, filling of sharps containers and use of hands to push in wastes into containers.

Table 3: Final methods of medical wastes disposal by Health Institutions.

Final methods of medical wastes disposal	Frequency	Percentage
Incineration:		
Yes	106	50.5
No	104	49.5
Burning:		
Yes	113	53.8
No	97	46.2
Burying:		
Yes	90	42.9
No	119	56.7
Missing value	1	0.5
Land filling:		
Yes	25	11.9

No	185	88.1
Public Refuse Dump:		
Yes	6	2.9
No	204	97.1
SEP:		
Yes	5	2.4
No	205	97.6
Sharp Mail-back service:		
Yes	3	1.4
No	207	98.6
Contractor company:		
Yes	42	20.0
No	168	80.0

Total Population N = 210

Table 3 shows the extent to which medical wastes are finally disposed of by incineration, burning, burying, land filling, use of public refuse dump, SEP, Sharps Mail-back services and through contractor companies respectively.

Discussions:-

Findings from the study indicate that there are no incidence of injuries in majority (66.2%) of cases (table 1). However, the injuries sustained by the health workers during the process of disposal of medical wastes are cuts/punctures (30%) and HBV infection (3.8%). The HBV infection could be linked to the cuts from contaminated sharps, splashes of body fluid on the body or non-observance of universal precautions during the process of handling infected materials. Generally, these injuries could be linked to improper disposal. ECRI (2001) reports that needlestick injuries are most likely to occur while disposing of an unprotected needle into a sharps container.

The study also shows the various precautionary measures taken by the healthcare workers while disposing of medical wastes (table 2). However, the precautionary measures taken by some are wrong and could endanger them into sustaining injuries, for example, 33.3% recap needles, 66.7% do not separate needles from mixed materials before disposal, 11.4% do not wash hands after procedures, 27.1% wrongly fill-in sharps containers, while 5.7% use hands to push in wastes into containers. These risky behaviours contradict with the precautionary measures recommended by OSHA's Bloodborne Pathogens Standards (29 CFR 1910.1030).

Finally, the result of the study showed the methods adopted by Health care institutions for final disposal of wastes (table 3). The three mainly adopted methods are incineration (50.5%), burning (53.8%) and burying (42.9%). Onu (2003) has it that incineration is particularly beneficial for treatment of certain wastes types like medical wastes and certain hazardous wastes where toxins and pathogens can be destroyed by high temperature. Lucas & Gilles (1981) and McKenzie & Pinger (1997) added that incineration of wastes reduces the solid mass of the original wastes by 80 to 85%, and the volume by 95 to 96%.

The use of public refuse dumps in 2.9% of cases (table 3) should be cautioned because some bloodborne infections suffered by members of the

public could be linked to the consequences the punctures they sustained from such improperly disposed medical wastes in the community. Clark (1999) pointed out that safe disposal of such wastes is important so as to prevent injuries and other hazards like environmental pollution in the community.

Conclusions:-

The study indicated low incidence of cuts/punctures and HBV among Healthcare workers in the process of disposal of medical wastes, high rate of precautionary measures adopted by the health care workers, and varied methods by which health institutions finally dispose of medical wastes with incineration, burning and burying scoring the highest percentages respectively.

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CLIMACTERIC AND MENOPAUSE: A WOMAN'S ISSUE.

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Introduction

The female climacteric is defined as the series of phenomena accompanying the loss of the female reproductive function. The menopause has a major place among these phenomena.

The female climacteric is usually divided into three periods:

1. Premenopausal
2. Menopause
3. Postmenopause

1. The Premenopausal

It is the climacteric phase which occurs when a woman is around 45 years of age in countries with a Mediterranean climate, precedes menopause by several months, and sometimes by years. Its cause lies in the regressive anatomical and physiological phenomena in the ovaries, which have an influence on the woman's whole life, both physical and emotional. The severity of complaints accompanying the menopause is in direct proportion with the age of the woman, and the earlier she undergoes the menopause, the greater this will be (Vance & Harold 2008)

Premenopausal Disorders

At about age 45, some disorders peculiar to the stage called the pre menopause may appear. Menstrual disorders or abnormal menstrual cycles are often observed where the periods become irregular in duration, intensity or in frequency due to hormonal imbalance peculiar to this stage in a woman's life.

There may be dysmenorrhea of intense pain during the menstrual period as well as mastodynia (pain of the breast). Usually, there is also increase in libido or sexual urge produced by an oestrogen increase. Emotional and behavioural upsets are frequent, often evident through mood swings. The woman becomes irritable and is dominated by anxiety and great emotional frailty (UN/WHO 2009). Each will experience all these changes, and will show them in very different ways. Education, culture, social environment and personality will all have a bearing on this.

2. The Menopause

The word menopause comes from the Greek work menois (month) and pausis (stop). The blossoming or maturing of female characteristics and attributes usually lasts around thirty years, after which menopause occurs, at present, a delay in the onset of the menopause has been observed. It is not infrequent to observe its presence at the age of fifty. For the woman, the menopause means a notable change in her life. Therefore, it is advisable to prepare herself to be able to assume it adequately and take full advantage of the new situation. The menopause or natural cessation of menstruation usually occurs around the

age of 45 or later. Like pregnancy, the menopause itself is not a disease although it is accompanied by certain disorders.

Causes Of Menopause

The fact that some women have an early menopause and others have a late, maybe influenced by some factors ranging from racial, hereditary, climatic, psychological and others. Menopause can also be provoked artificially, for example, by drugs, surgically or medically like the removal of the ovaries or termination of their function by chemical means or radiotherapy. It may even be brought about by psychological traumas, sudden violent shock, bereavement or significant stress. This is due to the close link between the brain cortex, the diencephalons, the pituitary gland, the ovaries and the other organs in the body.

Early menopause, either temporary or definitive, may also be the result of physical or intellectual exhaustion, nutritional deficiencies, certain serious illnesses and other causes.

The Appearance And Effect Of The Onset Of Menopause

The moment of the onset of menopause is related to sexual activity. The menopause occurs earlier in single women than in widows and earlier in widows than in women who have a normal regular sex life. As already stated, appears between the ages of 44 and 48 years in temperate climate and is accompanied by series of signs which usually last about two to four years. The immediate total stopping of menstruation is only observed in less than one quarter of cases which sometimes lead women to think they might be pregnant (Royston 2009). Menopause arrives with different disorders and discomforts which should be corrected or alleviated.

Disorders Of Menopause

The best known symptom of menopause and doubtless the most frequent is the hot flush, a consequence of vasomotor disorders, this manifests as episodes of excessive sweating and sensation of burning or itching. These can be accompanied by general disorders, such as anxiety, fatigue, insomnia, pain in the joint (arthrosis), nervousness, vertigo,

palpitations, pericardial pain (which may sometimes spread to the left arm), depression and sensorial disorders. Quite often these women will also gain weight, suffer from swollen feet in the late afternoon and have irregular blood pressure. The fundamental cause of these disorders is the aging of the ovaries. A premature appearance of ovarian insufficiency provokes a series of phenomena that affect the blood vessels, bones, joints and the other hormonal glands. All of this affects or modifies the entire body to such an extent that even obese women generally gain some weight (Whitehead 2005).

The libido keeps changing although the sex drive and the orgasm may be possible for some years since they are mainly determined by the psyche and emotions. The figure becomes more rounded and there is an increase in the amount of fat on the hips. The breasts usually drop or increase in size because of the added fat. There is also an increase in hairiness, particularly on the chin and the upper hip. Sadness and melancholy may appear with crying and irritability.

3. The Post Menopause

It is a stage in life of possibilities. It allows the woman a greater, more intense activity since apart from no longer having periods, their children are grown ups and do not require as much dedication. Also, this period allows sexual relations which are more pleasurable as the inhibitions caused by the fear of possible pregnancy or by the use of certain contraceptives have now disappeared.

Benefits/Advantages Of Menopause (Post Menopause)

It is certain that some well known changes and disorders occur, it is also true that the post menopause stage offers many women numerous interesting advantages:

1. Lack of menstrual periods: Many women welcome this phenomena with great satisfaction as they do not have to expect blood and waste money on sanitary every month. No more of those episodes that herald menstrual cycles and flows.

2. Impossibility of fertilization: For couples who do not really want more births, this is an automatic birth control.

3. Increase in sex drive: In some women there is increased sexual drive, either because of purely hormonal causes or may be because of the certainty that they will not become pregnant. They go to their partner with lesser reservations and can fully enjoy the physical relationship.

4. Freedom of movement: At one time or another many women have had to cancel serious important appointments or occasions because of having menstrual periods. This kind of problem is now over.

5. Free time: Menopause at times coincides with a greater independence from children. The children may be grown, working or married, domestic responsibilities are reduced for the woman and she has more leisure time for herself. Some women use the time to engage in a more meaningful business

ventures or trips, some further their education or engage in one activity or the other to better their life.

6. A greater togetherness in the couple: At this period many women neglect themselves and become more reserved, this should not be so. If the above benefits are taken full advantage of, it is precisely the ideal moment for the couple to devote more time to each other and to reach a better mutual understanding.

A balanced bright woman will know how to focus the new stage in her life. She will continue to be attractive and probably more interesting and funnier than before.

Treatment

Four lines of treatment can be identified:

1. Dietary
2. Physical
3. Psychological
4. Medication and phytotherapy

1. **Dietary treatment:** The diet should have a stimulating effect to avoid bouts of constipation: eat whole grain bread, fermented diary products, raw vegetables, plenty of fruits, linseed, cereal oats, wheat bran (at least 4 spoonfuls a day). The diet must be balanced and rich in vitamins (especially A.B.E) and minerals, calcium, magnesium and phosphorus.

Pulses: Especially soy and all soy products are highly recommended because they have high content of isoflavones- substances that act in a similar way to estrogen which alleviate the complaints associated with menopause and promote hormonal balance, and protects against osteoporosis. Isoflavone extracts and pharmacological preparations containing these can also be taken.

Low protein diet: In general for most nervous and vasomotor (hot flushes) problems, a low protein diet is recommended. Little meat, very few eggs, little dry legumes and restraint with other foods. Royal jelly may be very useful due to its revitalizing effects.

2. **Physical Treatment:** The aims of physical treatment is to complement the hormonal treatment prescribed by the doctor by stimulating circulation and the whole hormone system through the skin. Cold and hot hydrotherapeutic treatments are the most important parts of physical treatment.

1. Jet alternate temperatures over the whole body
2. Walking through water, gymnastics, sweating
3. Arm baths at progressively hotter temperatures
4. Swimming, massages
5. Sauna
6. Simple enemas

Also the use of oestrogen and skin patches cream applied externally and locally is becoming

more widespread.

3. Psychological Treatment: The definite loss of ability to procreate is a considerable psychological shock for a woman, and she will need help to cope with this period of notable changes to her physiology emotionally. Estrogens are generally very adequate for the treatment of the different disorders of the menopause, both psychological (anguish, anxiety etc) and physical ones (osteoporosis, general atrophy).

4. Medical and Phytotherapy

Medical

1. Preparations based on hormones (oestrogens, gestagens, androgens) that aim to alleviate ovarian insufficiency and which should only be prescribed and dosed by gynaecologist.

2. Anxiolytics may be given

Phytotherapy: Preparations based on medicinal plants. There are several herbal medicinal preparations that can help alleviate menopausal problems and which do not have complications characteristic of medication. Normally they are used as teas or extracts, the most commonly used plants are sage (*salvia officinalis*), valerian (*vaterinans officinalis*) milfoil (*achillea millefolium L*), rue (*Ruta graveolens L*), rosemary (*rosemarinus officinalis L*) wild betony (*stachys sylvatica L*) and evening primrose (*Oenothera biennes L*) cypress (*cupressus semperivens*)

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NURSES WORKPLACE STRESS AND PATIENT SAFETY IN GENERAL HOSPITAL CALABAR, CROSS RIVER STATE, NIGERIA

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Abstract

Stress is a universal phenomenon experienced by everybody in the course of life on earth. It is a phenomenon that no one can evade as man struggles to survive. As a psychological construct, the concept of stress have proven to be relatively difficult to define as the word stress depicts different array of things to different people thus posing the problem of a most acceptable definition. According to Ghandi, Benson and Gyaranzama (2011) the frequently used definition by Lazarus and Folkman states that "stress is a condition or feeling experienced when a person perceived that demands exceed the personal and social resources the individual is able to mobilize". Some perceive stress as negative with negative outcomes while others view stress as a challenge that spur creativity and motivates us to achieve. Mcvicar (2003) posits that, a certain amount of stress is actually needed to plan and push us on, live and achieve goals but when stress is unremitting, it causes one to respond in maladaptive physiological, physical and psychological ways.

Many events in life can cause stress and produce stress reactions in individuals. This may include death and bereavement, ill health, divorce, changes in financial status, social activities, busy schedules, workplace factors and even personal achievements and fame. Stressors are found everywhere, in our homes, workplaces, social gatherings, market places among others.

Certain factors in the workplace can cause stress; this type of stress is identified as work-related stress. The international council of nurses (2008) described work-related stress as "the harmful emotional and physical reactions resulting from the interactions between the worker and his/her work environment where the demands of the job exceed the worker's capabilities and resources". Some professions have been identified as the most stressful professions and nursing occupies a conspicuous position because they relate with humans mostly in times of pain, suffering and death.. According to Hughes (2008) Nursing can be an extremely exciting and satisfying profession but very stressful. The nurses role has long been regarded as stress-filled based on physical labor, human suffering, work hours and shift, staffing and interpersonal relationships that are central to the work nurses do. The sources of stress in nurses workplace are varied and include; work overload, dealing with the critically ill, death and dying, uncertainty concerning treatment plans, lack of social support, conflict with colleagues, supervisors, patient and other team members, lack of task autonomy as well as reduced advancement opportunities amongst other factors. These have implication for the quality of care the nurses render.

A stressed nurse may transmit stress indirectly to her patients through his/her inability to offer quality nursing care thus compromising patient safety. Patient safety may be compromised through medication and procedural errors, failure to rescue, neglect and abandonment, verbal and physical hostility. Patient safety implies prevention of harm to the patient. Emphasis is placed on the system of care delivery that prevents error and learns from the error that occurs. It also involves freedom from accidental or preventable injuries produced by medical and nursing care. Nursing is synonymous with caring and the goal of nursing is quality care, thus, if patient safety is compromised then, the goal of nursing is defeated. These concerns gave birth to this study.

This study was therefore carried out to investigate Nurses' workplace stress and its impact on patient safety. Specifically, the impact of workload, Critical Care Nursing and dysfunctional workplace relationship on patient safety are considered.

Statement of the Problem

Nurses are indispensable members of the healthcare team. They form the largest group of professionals in the healthcare team. In the healthcare milieu, patients' meets the nurse at point of entry and

point of exist and nurses spend the longest hours with the patient, this implies that, they are cardinal to patient safety and determine client satisfaction with health care services.

Nursing is all about caring, not just care but

quality care that should lead to patient recovery, but, sometimes patient care and safety is compromised due to workplace stressors which impair job performance.

In Cross River State, the State government hospitals and health facilities are experiencing shortage of nurses as nurse migrate out of the state service in search of greener pastures without a corresponding reduction in patient population. This trend has increased the nurses' workload, coupled with poor pay, poor workplace relationships and un-conducive work environment and conditions. How does this affect patient care and compromise patient safety? These issues and concerns gave impetus to this study.

This study is therefore determined to investigate Nurses' workplace stress and impact on patient safety. Specifically, this study;

1. Examined the relationship between nurses work load and patient safety.

2. Determined the association between critical care nursing and patient safety.

3. Investigated the relationship between dysfunctional workplace relationship and patient safety.

The study was guided by the following research questions.

- Is there any significant relationship between workload and patient safety?
- Is there any association between critical care nursing and patient safety?
- Does dysfunctional workplace relationship significantly influence patient safety?

Statement of Hypothesis

The following hypotheses were tested in the study:

- There is no significant relationship between nurse's workload and patient safety.
- Critical care nursing has no significant relationship with patient safety.
- Dysfunctional workplace relationship does not significantly influence patient safety.

Significance of the study

The findings from this study would enlighten stakeholders in the health sector in Cross River State as to the detrimental effect of Nurses workplace stress which would spur them to formulate policies that would reduce nurses' workplace stress. Also, nurses would be aware of sources of stress which would enable them to explore and apply coping strategies to ameliorate the effect of work stress on patient safety. Based on the findings, nurses would be more cautious of their behavior towards their patients and task-implementation even when stressed. This would curb verbal hostility, medication and procedural errors, failure to rescue as well as patient neglect. Again, the public would appreciate the level of workplace stress experienced by nurses; understand the reason for some irate and unpalatable behavior sometimes portrayed by nurses. This would enhance good nurse-patient relationship. This research would act as a spring

board for more researches on patient safety in the health institutions in cross river state as well as add to the existing body of knowledge.

Review of Related Literature

Nursing can be an extremely exciting and satisfying profession. The excitements of seeing patient move from ill-health to health and from disability to independence are great. Nursing a dying client in a way that enables him to die without pains and with dignity can also be very fulfilling. Despite this fascinating picture of nursing it is very stressful (Griffiths, Cox and Cox, 2003). Factors identified as stressors in the nurses workplace by Boone(2005) include high work load, working relationship with more senior colleagues, interpersonal relationship with patients and physicians, role conflict and ambiguity, dealing with the critically ill, death and dying, lack of resources and keeping with changes in technology, low work control, autonomy and poor wages.

Obadiya (2011) observed that some advance countries have approximately 1,000 nurses per 100 000 population while many developing countries including Nigeria work with ten (10) nurses or less per 100 000 patient population increasing the stress level of nurses in Nigerian hospitals. High workload is a key job-stressor of nurses in a variety of care settings. Nursing workload definitely affects the time that a nurse allots to various task which have a direct effect on patient safety. Nurses under a heavy workload experience reduced physical and cognitive resources resulting in errors therefore compromising patient safety (Moustaka and Constantinidis, 2010). Aiken, Clarke and Sloane (2002) in their study found that each additional patient per nurse beyond the ratio of 1:2 was associated with a 7 percent increase of the likelihood of mortality within 30days of admission and in the likelihood of failure to rescue. In a study of 120 nurses, Alper, Karsh and Holden (2006) observe that about 30 percent of nurses reported violations in routine situations and between 32percent and 53 percent of the nurses reported violations in emergency situations. They observed that the most frequent violations occurred in matching the medication record and checking patient identification due to work pressure. Carayon and Gurses (2005) assert that with high workload, nurses have less time to observe aseptic technique resulting in nosocomial infections, pressure sores, failure to rescue, patient falls and increase patient acuity.

Forgaca, Carvalho and Citaro (2008) observed that stress is inherent in critical care units because of the intensive emotion generated by human suffering, death and dying which generates compassion fatigue in the nurse. They added that, the attention and care expected in this units require agility, ability and quality decision making abilities as they are situations of extreme urgency where the patient life is at risk. They added that a stressed nurse cannot offer this due to reduce cognitive and physical resources. Increasing the stress is the highly technical equipments and monitoring gadgets which require specialized skills. The resultant effect of the nature of critical care nursing on the nurse therefore affects the quality of

patient care and compromise patient safety. The stressed nurse may experience low tolerance of patient complaint, insensitivity to patient suffering, loss of commitment and desire to leave the job. The nurse sense of the world may become jaded. A nurse who feels ineffective, frustrated and fatigued, designs and render poor quality of care. This delays recovery and prolongs period of hospitalization (Lelanie,2008).In a study on medication errors, Stanton (2006) observed that critically ill-patients in critical care units experience an average of 1.7 percent medication errors each day while Camrie (2009) asserts that procedural error and abandonment, forgetfulness, discontinuity of task, inadequate observation and non documentation of care characterize critical care units due to frequent interruptions in care as the nurse switch from original task to attend to another patient in urgent need.

The nature of health care services demands the collaboration of health professionals. Inevitably, the degree of interaction among these groups fluctuates constantly and sometimes may be so disruptive as to compromise patient safety. When patient care takes place in an atmosphere of mutual contempt for one another's expertise, professionalism and authority, a tug of war that has the patient on the rope can be precipitated. Such is the nature of nurse-physician relationship which results in errors of diagnosis, prescription, care and unwillingness to voice out errors injurious to the patient. Relationship could be so strained that patient safety as a risk. (Watson, 2008, Berland, Natvig and Gundersen, 2008). According to Arford(2005) Disruptive and physical hostility, silence, ambiguous orders, yelling, gossip, demeaning facial expression and exaggeration of nurse's mistakes and perceived powerlessness result in strained relationship where the nurses feel reluctant sharing their experience and expertise; they do not discuss client complaint with physicians, and keep silence over physician mistakes. This exposes the patient to adverse drug reaction, failure to rescue, inappropriate medical management, prolonged hospitalization and sometimes death.

Also, strained nurse-nurse (peer and supervisor) relationship and lack of social support impairs proper patient take over and ward handover, errors in medication, duplication of procedure and uncoordinated care, as the patient is at the end of the rope. Mojoyinola (2008) observed that nurses experience more negative moods and distress on days when they have distressing interaction with supervisors and peers. The nurse distress affects her mood and mode of communication with her patients who are at the receiving end of the spoilt day.

Theoretical Framework

The study was embedded or discussed under the demand-control theory of Karasek and Theorell (1990).The demand control theory is a variant of job strain occupation. It is concerned with the joint effect of job-demand and job – control on the worker which influence job performance. Work demand is subdivided into work load, work hazard; physical and emotional demand, role conflict and role ambiguity. Nursing work is characterized with various stressors as

work overload, exposure to infections, emotional demands of working with critically ill, dead and dying. According to Lasebikan and Oyetule (2012) demanding work environment with minimal control and social support from colleagues result in increase nurses stress that can often have an effect on patient safety.

Lack of job control is clearly seen in the therapeutic milieu where only the physician has the decision authority over patient management and medication: The nurse cannot use his/her skilled discretion to change patient medication even with high risk of injury or harm tendencies. This has generated much conflict between nurses and physician with clients at the receiving end. The consequences of this conflict manifest as silence over physician mistakes, medication errors, failure to rescue as well as prolong hospitalization and sometimes death.

Methodology . A descriptive survey research design was adopted for this study.

Research Area.

The study was conducted in general hospital Calabar , Cross River State , Nigeria. T general hospital Calabar is situated in Calabar south local government area. It has twelve wards with a nursing staff strength of two hundred and three nurses.

Population of Study

The population of study consisted of all registered nurses working in various wards of general hospital Calabar. They formed the representative sample for this study because they were in a better position to provide dependable information based on their experience in the wards.

Sample and Sampling Procedure

A purposive sampling technique was used. Since the nurses in the study area were few, the researcher purposively used the entire population. This can be said to be a 'Census' study since the entire population was used. The sample population was 203 registered nurses consisting of thirty nine (39) males and one hundred and sixty four (164) females.

Instrument for Data Collection

The instrument used for this study was a 30-item questionnaire which was validated by a research statistician in college of health technology Calabar. Test for reliability was done with a sample of 18 nurses from teaching hospital calabar. The instrument had two sections; section A was the demographic data while section B; had three subsection to cover the three major independent variables of the study; workload, critical care nursing and dysfunctional work place relationship.

Ethical Considerations

Permission was obtained through a formal application to the hospital administrator through the hospital Director of nursing. Also, respondents (nurses)

were informed about the research who gave consent before distribution of the questionnaires.

Administration of Instrument

The questionnaires were administered by the researcher with the help of two research assistant to 203 purposively selected nurses. This enhanced coverage of the three shifts. The data collection exercise lasted for seven days and 100 percent retrieval was achieved.

Data Analysis. Data collected was analyzed using Pearson Product Moment Correlation.

Results

Table 1: demographic characteristics of respondents (N=203).

Variable	Frequency	%
Sex		
Male	39	19.2
Female.	164	80.8
TOTAL	203	100%
Marital status		
Single	70	34.5
Married	95	46.8
Divorced	30	14.8
Widowed	8	3.9
TOTAL	203	100%
Educational level		
Registered nurse/midwife	90	44.3
Registered psychiatric/and other specialties	69	34.0
Bachelor degree	44	21.7
	203	100%
Ranks		
Nursing officer 1	3	1
Nursing officer 2	17	8
Senior nursing officer	30	15
Principal nursing officer	63	31
Asst. chief nursing officer	40	20
Chief nursing officer	40	20
Asst director of nursing	10	5
TOTAL	203	100%

TABLE 2:

Pearson product moment correlation analysis of the relationship between work-load and patient safety (N=203)

Variable	Σy	Σy^2	Σx	Σx^2	Σxy	r-cal
Quality of patient care (y)	1290	9680	13200	0.843		
Work load(x)		1740	18980			

Correlation is significant at p<.05, df=201, crit=r=0.196

Table 3:

Pearson product moment correlation analysis of the relationship between critical care nursing and patient safety (N=203)

Variable	Σy	Σy^2	Σx	Σx^2	Σxy	r-cal
Quality of patient care (y)	1290	9680			13980	0.712
Critical care nursing (x2)	1680	15860				

Correlation of significant at PL.05, df = 201, crit-r=0.196

TABLE 4

Pearson product moment correlation analysis of the relationship between dysfunctional workplace relationship and patient safety. (N=203)

Variable	Σy	Σy^2	Σx	Σx^2	Σxy	r-cal
Quality of patient care (y)	1290	9680			11900	0.430
Dysfunctional workplace relationship	1850	9650				

*correlation is significant at p<.05, df = 201, crit-r=0.196

1. Hypothesis one: There is no significant relationship between workload and patient safety
From table 2, the calculated r-value of 0.843 was found to be greater than the critical r-value of 0.196 needed for significance at 0.05 alpha (probability) levels with 201 degrees of freedom. With this result, the null hypothesis was rejected while the alternative was accepted. This implied that a significant relationship exist between workload and patient safety due to in adequate man power.

2. Hypothesis two: Critical care nursing has no significant relationship with patient safety.

In table 3, the calculated r-value of 0.712 was found to be greater than the critical r-value of 0.196 for significance at 0.05 alpha (probability) level with 201 degrees of freedom. This informed the rejection of the null hypothesis. This implies that a significant relationship exist between critical care nursing and quality of patient care.

3. Hypothesis three dysfunctional workplace relationships do not significantly influence patient safety.

Table 4 reveals that the calculator r-value of 0.430 was found to be greater than the critical r-value

of 0.196 needed for significance at 0.05 alpha (probability) level with 201 degrees of freedom. The null hypothesis was rejected in favor of the alternative hypothesis. This indicates that a significant relationship exist between dysfunctional workplace relationship and patient safety.

Discussion of Findings

The result of the statistical analysis of hypothesis one of this study revealed that nurses workload has a significant relationship with patient safety. The study showed that the heavy workload of nurses is a problem in State-owned health institutions in Cross River State due to shortage of nursing man power, which has resulted in medication and procedural errors, inability to document care as well as non completion of procedures. This result corroborates the findings of Moustaka and Constantinidis (2010) that high workload is a key-job-stressor of nurses in a variety of care settings. Nursing workload affects the time a nurse allots to various task, nurses under heavy workload experience reduce physical and cognitive resources resulting in errors and compromising patient safety. Also, Alper, Karsh and Holden (2006) in their study reported that about 30 percent of nurses reported violations in routine situations and 32 percent and 53 percent of the nurses reported violations in emergency situations. The findings of this study also support the observation by Carayon and Gurses (2005) that with high workload, nurses have less time to observe aseptic techniques, resulting in nosocomial infections. Also, pressure sores, failure to rescue, patient falls and increase patient acuity are significantly related to nursing workload.

On critical care nursing and patient safety, the findings from this study reveal that a positive significant relationship exist between critical care nursing and patient safety. The more critical the unit, the higher the level of stress experienced. This finding agree with the assertion of Forgaca, Carvalho and Citaro (2008) that stress is inherent in critical care units because of the emotions generated by human suffering, death and dying which generates compassion fatigue in the nurse. The nurse experiencing compassion fatigue may respond with detachment from patient, negligence and indifference to patient groans of pains. This delays recovery and prolongs period of hospitalization (Clarke, 2005). The findings of this study also support Camrie (2005) observation that procedural error, abandonment, forgetfulness, discontinuity, of task, inadequate patient observation and non-documentation of care characterize critical care nursing due to work-stress.

The findings of the statistical test of hypothesis three reveal that dysfunctional workplace relationship significantly affects patient safety. This findings corroborate the report of Arford (2005) and Smith (2004) that the "observed physician behavior and perceived powerlessness of the nurse result in strained relationship where the nurse feels reluctant sharing experience and expertise and do not discuss client complaint and keep silence over physician mistakes. This exposes the patient to adverse drug reaction, failure to rescue, inappropriate medical management,

prolonged hospitalization and sometimes death. Smith observed that nurse-nurse (peer and supervisor) relationship and lack of social support impairs proper patient take over and ward handover, errors in medication, duplication of procedures, uncoordinated patient care as patient is at the end of the rope.

Conclusion and Recommendation

The result of this study provided a greater understanding of the workplace stress nurses experience and its effect on patient safety. The stress experience by nurses in critical care settings and the high workload may be attributed to low staffing level increasing the number of patients per nurse thus affecting nurses' ability to provide quality care, thereby compromising patient safety. Based on the findings the following recommendations were made:

The government should pay closer attention to the feelings of nurses who provides care by employing more nurses so as to reduce the number of patients per nurse.

They should be effective collaboration of the various professions that make-up the health team in a therapeutic milieu and respect for the contributions and professional abilities of each team member.

Seminars and workshops on the importance of effective communication skills in the therapeutic environment should be organized to enhance partnership among health team members.

Nurse Managers and peers should provide social support to colleagues so as to enhance coping as the nurse renders care to more patients beyond her physical and psychological resources or abilities.

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COMMUNIQUE ISSUED AT THE END OF THE 3RD ANNUAL CONVENTION/SCIENTIFIC CONFERENCE OF THE NATIONAL ASSOCIATION OF NIGERIAN NURSES IN NORTH AMERICA (NANNNA) HELD AT THE DOUBLE TREE HOTEL, NEWARK, NEW JERSEY FROM THURSDAY, 8TH TO SUNDAY, 10TH NOVEMBER, 2012

Introduction

The Nigerian Nurses in North America once again had the opportunity to gather together to deliberate on the challenges impacting the healthcare systems in North America and Nigeria, presented projects and initiatives generated from 2011 conference and poster exhibition session on research conducted. The event built on the success of 2011 conference and added several significant new features, as well as expanding the number of participants and sessions organized. To focus on viable strategies to meet the demand of the complex healthcare environment, this year's conference was in collaboration with Rutgers University College of Nursing, Center for Professional Development. Again, the conference was designed to bring new ideas, challenge perspectives, and facilitate the growth of the conference participants by providing new ways to be a catalyst for change in the healthcare systems at the local, national and global level!

The convention/scientific conference attracted over 350 Nigerians and non-Nigerians across the globe with more than three hundred Nurses in attendance and dignitaries from Nigeria and North America. The Director of Nursing Services at the Federal Ministry of Health, Mrs. Mojisola Olanike Okodugha, represented the Minister of Health of the Federal Republic of Nigeria. Also in attendance were the Consulate General of Nigeria in New York, Honorable Habib Baba Habu, Dr. William Holzmer, the Dean of nursing at Rutgers University College of Nursing, Dr. Minerva Guttmann, the Dean of nursing at Fairleigh Dickinson University School of Nursing, and Dr. Rosaline Olade, a Retired Nigerian Nurse who developed and implemented the MSN and PhD in Nursing at the University of Ibadan, just to name a few.

Bringing together leading health experts and practitioners from North America and beyond, the conference started with a live radio program on the Future Women Want: *The Role of Nurses in the Prevention of Violence Against Women and Girls*. The program was hosted by Dr. Ada Okika of the African Views, a Framework for African Intelligence on Global Affairs. The pre-conference education event proved an excellent opportunity for networking and sharing experiences in meeting the challenges of healthcare through application of Health Information Technology and Effective Strategic Policies for women's health in cultural diversities.

There were three panel discussions, four special sessions and five plenary sessions during which experts gave 24 presentations. The special sessions were dedicated to:

- Identifying strategies for transforming medical mission into a platform for improving health care delivery in Nigeria,
- Identifying strategies for implementing NANNNA memorandum of understanding (MOU) with Nigeria National University commission and the Federal Ministry of Health (FMoH),
- Building partnerships for advancing nursing education in Nigeria and capacity development for nurses in practice
- Building a support system for Nigerian Nurses Doctoral Candidates and
- A focus group on Domestic Violence in the Nigerian Community

The four days convention/scientific conference ended with a special high light on the Doctoral Candidates Network inaugural meeting and the formal induction ceremony of the New Jersey chapter of NANNNA.

Observations:

Conference participants made the following observations:

1. The health care system in North America continues to undergo constant changes as it responds to increasing costs, changing demographics, new technology, and pharmaceutical

- advancements
2. The health care system in Nigeria is in urgent need of major improvements in policy, infrastructure, delivery systems, education and training.
 3. Maternal and Infant mortality rates in Nigeria are way beyond the global averages.
 4. Domestic Violence in some Nigerian communities in North America is on the rise.

Recommendations:

To meet the challenges of the complex healthcare environment, the following recommendations were made:

1. Improvement of health care delivery is the responsibility of all health care professionals and Policy makers.
2. Nigerian leaders need to demonstrate their support and vested interest in the Nigerian Healthcare system by using the system rather than travel abroad for their personal healthcare needs.
3. All Nigerians have access to high-quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success
4. Empowerment of Nigerian nurses through education and research for evidence based practice should be a priority
5. Nigerian federal and state governments to provide basic infrastructure and conducive environment for nursing education and practice in Nigeria
6. A collaboration between Nigerian Nurses in North America and various Schools of Nursing in educational and technical assistance for capacity building through teaching at schools/departments of nursing in Nigeria to alleviate shortage of Nurse Faculties
7. Collaboration between NANNNA and the Nursing and Midwifery Council of Nigeria to maintain licensure renewal of Registered Nigerian Nurses and Midwives living in North America
8. Develop strategies for Implementing Measurable Interventions for improving healthcare system in Nigeria
9. Form partnerships with UN, CDC Nigeria USAID, CEDA and other international agencies working with Govt. of Nigeria (for enhanced participation by NANNNA in policy making processes and technical assistance).
10. Create a Database & Network of Nigerian nurses & faculty living in North America
11. Conduct more research to explore the extent of domestic violence in the Nigerian community and culturally sensitive ways to prevent it, protect victims, and assist families and perpetrators gain access to timely psychosocial support to address issues.
12. During Medical Mission to Nigeria, Health Professionals must renew their Nigerian medical/nursing license before providing care in Nigeria

Conclusion:

The well-attended conference was a very significant step towards effectively tackling the challenges impacting today's healthcare systems and identifying strategies for Implementing NANNNA memorandum of understanding (MOU) with Nigeria National University commission (NUC) and the Federal Ministry of Health (FMoH).

We look forward to this endeavor.

Signed

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