



New vision

Volume 9

Issue 2

December 2020

Publication of the Graduate Nurses' Foundation of Sri Lanka

ISSN 2613-8735

Office Bearers and Members of the Executive Committee 2020/2021

President:

Dr. K.A. Sriyani

Vice President:

Mr. W.A. Keerthiratna

Secretary:

Dr. G. Kisokanth

Assistant Secretary:

Dr. M.R.S. Jayethilake

Treasurer:

Ms. G.H.P.D.S. Wijeratne

Assistant Treasurer:

Mrs. G.T. Anuruddika

Media and Public Relations Officer:

Dr. S.S.P. Warnakulasuriya

Executive Committee:

Ms. S.M.K.S. Seneviratne

Dr. M.K.D.L. Meegoda

Dr. B.S.S.de Silva

Ms. R.A.D.C. Karunarathne

Ms. M.H.C. Pieris

Ms. K.W.M.R. Jayanatha

Ms. Uneska Abeypala

Ms. W.M.P.D.S. Wijekoon

Editors

Dr. K.A. Sriyani

Dr. G. Kisokanth

Ms. M.K. Jayakody

Ms. S.A.S.K. Perera

Reviewers

Dr. S.S.P. Warnakulasuriya

Dr. M.K.D.L. Meegoda

Dr. H.D.W.T. Damayanthi

Dr. M.R.S. Jayethilake

Dr. R.M.T.B. Abeyratne

Dr. I.M.P.S. Ilankoon

Message from the President



Dr. K.A. Sriyani
President of GNFSL

As the newly nominated President for the 2020/2021 session of the Graduate Nurses' Foundation of Sri Lanka (GNFSL), it is my great pleasure and privilege to send a message to the official publication of the GNFSL newsletter "New Vision".

I wish to record the deepest appreciation for the late Patron of the GNFSL, Mrs. Trixie Marthenesz for her invaluable contribution extended to the foundation throughout its successful journey. She passed away peacefully in mid-August 2020 after serving as the Patron of the GNFSL for 15 years. Her constructive criticism and advice highly influenced us to move forward smoothly. As a writer and editor, she provided a huge contribution towards publishing the newsletter, and her departure will remain a great loss to the foundation. May she attain the Supreme Bliss of Nibbana!

To align with the purposes of the GNFSL, during the past, we were able to improve knowledge on the academic writing skills of nurses and create a research culture among nurses. We were able to conduct the 2nd Biennial Scientific Sessions on 22nd February, 2020 and publish abstract proceedings as well as the annual issue of the newsletter. We believe that as a professional association, we were able to provide an opportunity for the nurses to share their knowledge and research findings among the nursing community.

Though Sri Lankan nurses have a greater need in disseminating their research findings, lack of nursing journals in the local context is the main barrier. To fill that gap, the GNFSL is in the process of publishing its research journal in the near future. We are pleased to invite you to submit your original research articles to the inaugural issue of the Sri Lankan Journal of Nursing (SLJN), published by GNFSL. Moreover, we are planning to conduct monthly webinars for nurses to raise their awareness and interests on professional development, research and clinical practice.

Dear members, please feel free to communicate with us any constructive comments on the development of the Foundation. I would like to invite you to participate in the

webinars, special events and general meetings of the GNFSL and extend your contribution and encouragement to move forward in serving the profession.

Thank you

Dr. K.A. Sriyani

skumarasinghe5@gmail.com

INSIDE OF THIS ISSUE

In Memory of Our Patron: Mrs. Trixie Marthenesz, p2

Importance of Higher Education in Nursing, p3

Breaking Bad News: Essential Skill for Health...p4

Health Alert on Risk of T2DM among Overweight ...p6

Primary Care Needs of Children with CHD...p8

Forthcoming Conferences, p12

Sri Lankan Journal of Nursing - Author Guidelines, p14

In memory of our Patron
Mrs. Trixie Marthenesz



Dear Madam,
You were the wisdom, the facilitator and the guide,
who inspired us for the past fifteen years.
You appreciated, acknowledged and loved all of us,
and taught us the 'loving kindness'.
To keep our heads high, be confident and walk with
dignity,
but to be humble, accept errors and make apologies.
To seek for unknown and widen our horizons,
and shoulder the responsibilities of leading the
profession.
MAY YOU ATTAIN THE SUPREME BLISS OF
NIBBANA.

With our deepest condolences- from the Executive
Committee- GNFSL

Importance of Higher Education in Nursing

W.A.A. Subhashini¹, R.A.N.D. Ranaweera², G. Kisokanth²

¹Department of Fundamental of Nursing, Faculty of Nursing, University of Colombo

²Department of Clinical Nursing, Faculty of Nursing, University of Colombo

Formal Nursing Education in Sri Lanka was initiated in the late 1939; nearly eight decades ago. Throughout the history of Sri Lanka, a total of 17 Nurses' Training Schools have been established which award a three-year Diploma in Nursing. Further, the Post Basic Collage of Nursing was established for the fulfilment and enhancement of the management and teacher training in Nursing, most importantly for the Nursing Managers and Nursing Tutors (Banduthilake, 2002; Jayasekara *et al*, 2006). Importantly, in Sri Lanka, the university education was proposed in 1963. Nevertheless, it took few more years to initiate the concept. Previously, it was proposed to have a five-year diploma programme which was suggested to be commenced at the University of Ceylon (Jayasekara *et al*, 2006). It took around 31 years to establish the Bachelor's Degree Programme for Nurses in the Open University of Sri Lanka where thousands of nursing graduates have been produced.

Moreover, the involvement of nurses in higher education will be beneficial for both patients as well as nurses. Considering the different objectives that are expected to be fulfilled by the nurses who are involve at the Masters level and Doctoral level studies, it is clear that a huge impact can be created with higher education in Nursing.

Masters level nursing students should always think critically or possess critical attitudes; they should play the role of a teacher and conduct research by involving specialist knowledge in clinical practice. In addition, they must implement the practices independently. A doctoral nursing student is expected to be concerned about developing research programmes, initiating research-based practices, developing theory and policies, playing the role of the teacher and most importantly developing evaluation instruments like scales and tools (Davis & Burnard, 1992; Jennifer, 1996). The expected aspects indicate the impact of what higher education can do for the improvement of professionalism in nursing.

When considering Sri Lanka, it is clear that one of the main importance of higher education is to enhance the quality of the health care system of the country in

relation to the global health care systems in developed countries. In addition, it will be beneficial for the augmentations of the standards in nursing practices in our country. Far beyond that, this would improve more opportunities in higher education that might be influenced for the increasing professional development in nursing. More accurate nursing education will help to develop qualities in the nursing profession such as leadership, problem solving skills, clinical decision making, critical thinking and working as a team. Developing nursing professionals can even have a better chance for them in migrating to foreign countries that would benefit the development of the economy of Sri Lanka as well.

Especially, engagement in higher studies would help nurses to upgrade their knowledge with time. Higher education can make a difference in patient safety in several aspects such as correct medication administration, improved patient outcome, high rescue rates, fewer readmission and many more aspects.

Nurses are not only providing care for the patients but also, they educate their patient and family members in order to prevent recurrence of diseases. Higher education provides an utmost lifting of implementing health education and awareness programmes. Currently evidence-based care is a new trend in Nursing. Research and new information are mainly essential for the evidenced-based practice. Therefore, nurses should conduct nursing research and studies for the improvement of the nursing profession. Even though Sri Lankan nurses can access international as well as national research articles and gain knowledge from them, sometimes, those studies might not be suitable to be conducted in the hospital settings in our country. Then, the nurses must study new things according to the suitability of our country with their research knowledge. In order to continue this process, nurses must possess enough knowledge which they have gained from higher studies.

Breaking Bad News : An Essential Skill for Health Care Professionals

H. Deepani, Nursing Tutor, School of Nursing, Colombo.

Breaking bad news to patients or being present when bad news is given is a part of the daily activity of many health care professionals; mainly doctors and nurses (Camargo *et al.*, 2019). Information that drastically alters the life of the patient is termed as bad news (Erawati, 2017). Conveying bad news is a skilled communication and not at all easy. A rising body of evidence has proved that most patients want to be informed about their illness, treatment and prognosis whether this information is good or bad (Jameel , Noor & Ayub, 2012; Camargo *et al.*, 2019 & Sarwar *et al.*, 2019). Bad news can be categorized in the range of the need to undergo further laboratory or radiological tests to confirm a life-threatening disease such as cancer or informing the family or friends of a death or catastrophic illness of their patient (Baile *et al.*, 2000). The way a doctor or other health care professional conveys bad news places an ineradicable mark on the professional-patient relationship.

Despite the importance of this skill in clinical practice, formal education for health care professionals to communicate bad news has been limited (Baile *et al.*, 2000; Camargo *et al.*, 2019). The obscurity of the interaction can sometimes create serious miscommunications such as patient misunderstanding about the prognosis of the illness or the dissatisfaction of the family about the treatment provided for the deceased loving member (Singh & Agraval , 2017). Poor communication, especially with cancer patients, has been found to produce unfavourable physical and psychosocial outcomes such as poor pain control, worse compliance to treatment and patient dissatisfaction (Alshammery *et al.*, 2017).

It has been shown that several factors influence health professionals' communication skills when delivering bad news. Some of these factors include burnout and fatigue, time restraints, insufficiency of experience, individual barriers such as spiritual and cultural beliefs, personal attitudes and the fear of hurting the patient/family or fear of being responsible (Warnock ,Buchanan &Tod, 2017: Camargo *et al.*, 2019). Conveying bad news is found to be more difficult when the health professional has a long-standing relationship with the patient, when the patient is young or when faith had been retained for a successful outcome previously (Cialkowska & Dzierzanowski , 2013).

Over the past years, medical communities have developed evidence-based recommendations to improve the communication skills of health professionals. These educational programmes provide an individual benefit to health professionals by improving their self-confidence in breaking bad news. 'SPIKES' (Setting, Perception, Invitation, Knowledge, Empathy, Strategy and Summary) is a well-known six-step protocol that has been shown to enhance the confidence of medical professionals who use it in communicating bad news with cancer patients (Baile *et al.*, 2000). Others (Narayan, Bista & Koshy, 2010 : Eid *et al.*, 2009: Monden, Gentry & Cox , 2016 & Periera *et al.*, 2017) have produced a similar framework designed to aid the physicians such as 'BREAKS' (Background, Rapport, Explore framework for breaking bad news (beginning the session, sharing the information, being sensitive to the patient, planning and support, follow-up and closing), ABCDE protocol (Advance preparation, Build therapeutic relationship, Communicate, Deal with reactions, Explore patient's understanding) and the P-A-C-I-E-N-T-E Pro-ocol (Prepare, Assess how much the patient knows and how much they want to know, Invite the patient to the truth, Inform, Emotions, Do not abandon the patient, Outline a strategy).

Typically, bad news is communicated by the medical consultant or senior medical officer who is known to the patient or in whom the patient and family have a trust (Baile *et al.*, 2000). In abrupt circumstances of sudden death of an inward client, a member of the nursing staff has to break the bad news. Nurses, however, play a vital role in relation to breaking bad news to the hospitalized patients. They are often contiguous when the reality of a situation becomes obvious, and the patient and relatives feel the need to ask questions (Warnock , Buchanan &Tod , 2017).

Breaking bad news is part of the art of healthcare, especially in medicine and nursing. Bad news is always bad news; no matter how well it is said (Singh & Agraval, 2017). Yet, the manner in which it is conveyed can have a compassionate consequence on both the receiver (the patient/ family members)

and giver (health care professional). If done badly, it will impede the wellbeing of patient or family, and future contact with the health care professional will be disenchanting (Baile *et al.*, 2000).

Breaking bad news is a proficiency that has to be learnt by the health care professionals. It is, therefore, vital to include breaking bad news training in medical education focusing more on ethical and legal issues in terminally ill patients.

References

- Alshammery, S.A., Hamdan, A.B., Saleem, L.M.A., Ratnapalan, S., & Pureisamy, B. (2017). Physician's perceptions of breaking bad news to cancer patients and family. *Journal of Health Specialities*, 57-60.
- Baile, W.F., Buckman, R., Lenzi, R., Glober, G., Beale, E.A., & Kudelka, A. P., (2000). SPIKES- A Six step protocol for delivering bad news: Application to the patient with cancer. *The Oncologist*, 302-311.
- Camargo, N.C., Lina, M.G.D., Brietzke, E., Mucci, S., Gois, A.F.T.D. (2019). Teaching how to deliver bad news: A systematic review. *Rev.Bioet. (Impr.)*, 7(2), 27-30.
- Cialkowska, R.A. & Dzierzanowski, T. (2013). Personal Fear of death affects the proper process of breaking bad news. *Arch Med Sci*, 9, 127-131.
- Eid, A., Petty, M., Hutchins, L. & Thompson, R. (2009). "Breaking bad news": standardized patient intervention improves communication skills for hematology- oncology fellows and advanced practice. *J. Cancer Educ*, 154-159.
- Erawati, E. (2017). Learning practice of a breaking bad news exercise by nursing student. new trends and issues. *Proceedings on Humanities and Social Sciences*, 4(2), 80-85.
- Jameel, A., Noor, S.M. & Ayub S., (2012). Survey on perceptions and skills amongst post graduate residents regarding breaking bad news at teaching hospitals in Peshawar, Pakistan. *JPMA*, 62, 585-589.
- Monden, K.R., Gentry L., & Cox T.R., (2016). Delivering Bad news to patients. *Bayler University Medical Center Proceedings*, 29(1), 101-102.
- Narayan, V., Bista, B., & Koshy, C. (2010). BREAKS Protocol for breaking bad news. *Indian Journal of Palliative Care*, 16(2), 61-65.
- Periera, C.R., Calonego, M.A., Lemonica, L. & Bairos, A.M.D. (2017). The PACIENTE Protocol: An Instrument for breaking bad news adapted to the Brazilian medical reality. *Rev.assoc. Med.Bras.*, 63 (1), 43-49.
- Sarwar, M.Z., Rahman, F., Fatima, S.M., Suhil, M. & Naqii, S.M. (2019). Breaking bad news skill of post graduate residents of Lahore, Pakistan: A cross sectional survey. *JPMA*, 69(5), 695-699.
- Singh, M.M. & Agrawal, R. K. (2017). Breaking Bad news in clinical setting: A systematic Review. *Indian Journal of Applied Research*, 7 (12), 29-32.
- Warnock, C., Buchanan, J., & Tod, A.M. (2017). The difficulties experienced by nurses and health care staff involved in the process of breaking bad news. *Journal of Advanced Nursing*. 73(7):1632-1645.

Importance of Higher Education in Nursing *continued from page 3....*

Currently, there is a shortage of nursing professionals in the Sri Lankan health care system and there are only 17.6 nurses that are available for 10,000 patients (Central Bank Report, 2019). Therefore, it is mandatory to absorb a younger generation of Sri Lankans who are interested in nursing into the education system. Proper guidance should be provided along with motivation and support to the students by qualified nurse educators. Better knowledge investment provided at the grass root level would help in the development of the nurse's higher education and their interest in higher education.

References

- Banduthilake, M. (2002). History and trends in nursing. Deepani Press.
- Davis, B. D. & Bumar, P. (1992). Academic levels in nursing. *Journal of Advanced Nursing*, 17: 1395-1400.
- Jayasekara, R.S. & McCutcheon, H. (2005). The history of nursing services and education in Sri Lanka and the effects of developing professionalism. *Journal of Nursing Education*, 45 (10): 391 - 395.
- Jennifer, R.P.B. (1996). Post graduate education in nursing: A case study. *Journal of Advanced Nursing*, 23 (3): 620 -629, <https://doi.org/10.1111/j.1365-2648.1996.tb00027.x>
- Ministry of Health Sri Lanka. (2020), retrieved from www.health.gov.lk on 20th August 2020.
- Central Bank Report of Sri Lanka (2019), retrieved from www.cbsl.gov.lk on 22nd August 2020.

"Life is about accepting the challenges along the way, choosing to keep moving forward, and savoring the journey."

— Roy T. Bennett, *The Light in the Heart*

Health Alert on Risk of Type 2 Diabetes Mellitus among Overweight and Obese Adolescents in Sri Lanka

M.T. Ismath Banu & G Kisokanth

Department of Clinical Nursing, Faculty of Nursing, University of Colombo

Type 2 Diabetes Mellitus (T2DM) is a disease that has reached epidemic proportions globally. The World Health Organization (WHO) estimated that there were 135 million people living with diabetes in 1995; this number will increase to 300 million by 2025 (Gaidhane *et al.*, 2018). T2DM is not only an adult disease but also occurs in childhood and adolescence due to excess body weight and physical inactivity. Over the past 2 decades, the prevalence has been increasing in low and middle-income countries and every day, more than 200 children and adolescents are developing the disease worldwide (Arslanian *et al.*, 2018). Sri Lanka also has a notable increase in the number of new cases of T2DM among children and adolescents.

As you get older, the risk of developing T2DM goes up but progression of the disease can be 'invisible' for a long time. About 40% of people with T2DM or pre-diabetes are unaware of their condition. At the time of diagnosis, cell damage is already in progress and leads to diabetes-related complications in many parts of the body. Adolescents who are diagnosed with T2DM are predicted to lose 15 years from their remaining life expectancy when compared with their peers who do not have T2DM (Prasad, 2011).

The major risk factors for T2DM in children are obesity, inactivity, race, family history of T2DM in first-degree and second-degree relatives, effect of sex hormones and growth hormone at puberty, low birth weight and maternal history of gestational diabetes (GDM). Earlier onset of overweight and obesity in adolescents is strongly associated with the occurrence of T2DM. Mainly, excess body fat stored around the abdomen rather than hips and thighs is a major triggering factor for insulin resistance and it leads to the onset of impaired glucose tolerance in children and adolescents. The insulin receptor signaling pathway is altered in the presence of excessive free fatty acids and inflammatory substances which will further lead to metabolic syndrome like diabetes.

With time, diabetes can damage the heart, blood vessels, eyes, kidneys and nerves that can lead to an increase in the risk of heart attacks and strokes, chronic infected foot ulcers, chronic kidney failure, blindness and ultimately

the patient will die. Early onset of childhood T2DM is associated with severe micro vascular and cardiovascular complications. The fundamental cause of obesity and overweight is an energy imbalance between calories consumed and calories expended, genetic factors, environmental factors, diet, medication, psychological factors, lifestyle preferences, culture, urbanization and technological advances (Lawoyin *et al.*, 2002).

Adolescents with T2DM and their families should be provided with culturally appropriate comprehensive lifestyle programmes. These programmes are integrated with diabetes management to achieve 7 – 10% decrease in excess weight. Further, lifestyle intervention should be based on a chronic care model and offered in the context of diabetes care. People should be encouraged to participate in at least 30–60 minutes of moderate to vigorous physical activity for at least 5 days per week (and strength training on at least 3 days per week) and should be encouraged to decrease sedentary behaviour; should focus on healthy eating patterns that emphasize the consumption of nutrient-dense, high-quality foods and decrease the consumption of calorie-dense, nutrient-poor foods, particularly sugar-added beverages (Weekly Epidemiological Report, 2019).

Moreover, 70% of T2DM cases can be prevented among children and adolescents at the level of primary prevention including a public health approach that targets the general population. Health professionals need to be involved in developing and implementing school and community-based programmes to promote improved dietary and physical activity behaviours for all children and their families; programmes that provide children and their families with the knowledge, attitudes, behavioural skills and encouragement to consume a healthy diet and engage in regular physical activity that may be effective in attenuating the expanding problem of obesity. At the community level, schools, religious organizations, youth and family organizations and government agencies should assume some

responsibilities for promoting a healthy lifestyle. School programmes should promote healthy food choices and increase the physical activities. Planning of effective preventive efforts for populations at risk needs the involvement of members of the community. Encouraging the child or adolescent to eat healthy foods, limit sweet drinks (juice, pop-sicles), get plenty of physical activity, get adequate sleep, screening for intervention and optimization of glycemic control and implementation of educational workshops in the schools will be benefited to prevent the early onset of T2DM (Almeida, Wagner, & Freire, 2010).

Furthermore, there should be strong recommendations for screening to identify prediabetes and/or T2DM after the onset of puberty or after 10 years of age who are overweight (BMI 85th percentile) or obese (BMI 95th percentile) and who have one or more additional risk factors for diabetes. If BMI is increasing further, repetition of the tests at a minimum of 3-year intervals needs to be carried out. In addition, fasting plasma glucose level, 2-h plasma glucose after 75-g OGTT (Oral Glucose Tolerance Test) or HbA1C can be used to detect the pre-diabetes or diabetes (Almeida, Wagner, & Freire, 2010).

The nurses, who are providing care to adolescents with T2DM should extend their field of action to the prevention of diseases and further promotion of the health should be enhanced for the achievement of longer and healthier life in the general population.

References

- Almeida, P. C. De, Wagner, R., & Freire, J. (2010). Risk factors for type 2 diabetes mellitus among adolescents. *OnLine*, 44(4), 881–887.
- Arslanian, S., Bacha, F., Grey, M., Marcus, M. D., White, N. H., & Zeitler, P. (2018). Evaluation and management of youth-onset Type 2 Diabetes : A position statement by the American Diabetes Association. *Diabetes Care*, 41(December), 2648–2668.
- Gaidhane, S., Mittal, W., Khatib, N., & Zahiruddin, Q. S. (2018). Risk factor of type 2 diabetes mellitus among adolescents from rural area of India. *Journal of Family Medicine and Primary Care*,6(3),600-604.
- Lawoyin, T.O., Asuzu, M.C., Kaufman J., Rotimi, C., Owoaje, E., Johnson, L., et al. (2002). Prevalence of cardiovascular risk factors in an African, urban inner city community. *West Afr J Med* 21,208-211
- Prasad, A.N (2011). Type 2 Diabetes Mellitus in Young: Need for Early Screening. *Indian Pediatrics* 48(17); 683-688.
- Weekly Epidemiological Report (2019). *WER, Sri*



What does OER mean ?

Open Educational Resources (OER) are teaching, learning and research materials in any medium – digital or otherwise – that reside in the public domain or have been released under an open license that permits no-cost access, use, adaptation and redistribution by others with no or limited restrictions.

OER form part of ‘Open Solutions’, alongside Free and Open Source software (FOSS), Open Access (OA), Open Data (OD) and crowdsourcing platforms.

Source: <https://en.unesco.org/themes/building-knowledge-societies/oer>

Primary Care Needs for Children with Congenital Heart Disease

S.G.M.L. Madawala

Nursing Tutor, College of Nursing, Anuradhapura

Congenital Heart Disease (CHD) is a common problem in the pediatric age group (Rohith & Shrivastava, 2018) which causes morbidity and mortality during early childhood. The highest birth prevalence of CHD is 9.3 per 1000 live birth reported in Asia (Van der Linde *et al.*, 2011) and this is high in Sri Lanka as well (Gamage *et al.*, 2019). Most of the children (60% - 70%) with CHD require continuous medical treatment and care (Samarasingha, 2018). Children with CHD are generally treated with medication, cardiac catheterization and surgery. Medication is primarily aimed at preventing or treating complications of the disease such as congestive heart failure (CHF).

Cardiac catheterization counts as an interventional invasive procedure that is used to correct various congenital heart defects such as device closure procedure for Patent Ductus Arteriosus (PDA), Atrial Septal Defect (ASD) and Ventricular Septal Defect (VSD). Surgical intervention can be divided into two types: palliative surgery and corrective surgery. Palliative surgery is performed to improve the child's hemodynamic stability for a temporary period until corrective surgery is set. Corrective surgery is a complete repair of the defect (Luo *et al.*, 2019). Corrective surgery claims to treat the defect permanently, especially, in a single malformation of acyanotic CHD.

The nature of this defect and incomplete developmental stage of the children are the common causes for preoperative complications. Complications of children with CHD prior to surgery are respiratory tract infections (RTI), congestive heart failure (CHF) and infective endocarditis (Suklertrakul *et al.*, 2018). Those complications lead to increased morbidity and mortality (Rohit & Shrivastava, 2018). RTI, such as common cold, pneumonia and bronchiolitis are common health problems among children with acyanotic CHD (Luo *et al.*, 2019). Moreover, children with acyanotic CHD are likely to develop feeding difficulty, failure to thrive poor growth (Rohit & Shrivastava, 2018), malnutrition, delayed development and emotional and behavioural problems. and mortality due to complication while waiting for curative surgery.

Therefore, these children should be noted for proper preoperative care so they are in optimal health for surgery as scheduled. However, growth and development of children should remain orderly and sequential especially during the age of 1 - 5 years because this age group children's cognitive, motor skills, sensory, communication and social development have not yet fully completed (Woodward, 2011). Therefore, they need special care. Yet, most parents are unable to perform most of these activities by themselves. It is important that the appropriate care aid is provided to decrease morbidity and mortality due to complication while waiting for curative surgery.

Care Practices of Children with CHD

The goal of care is to promote the health status of children, reduce complications and facilitate the success of medically planned surgery. Care practices refer to care activities that the care giver (mother, father or guardian) performs in order to promote the health of her/his child with CHD. Care that needs for children with CHD is multi-dimensional. Care practices of daily living include eating, bathing, dressing and hygiene. Although, these are normal day-to-day care activities parents attend to, these vulnerable children require more attention as they are at a high risk for having complications from CHD.

Growth failure is a common problem among children with CHD. Growth retardation occurs due to multiple causes including genetic causes, increased metabolic demands and insufficient nutritional intake. Genetic causes are intrauterine growth retardation, genetic syndrome, extra-cardiac anomalies and hormonal deficiencies (O'Brien & Baker, 2009). Increased metabolic rate, hemodynamic abnormalities, congestive heart failure and chronic hypoxemia are the causes for the increased metabolic demand of children with CHD. Weakness, tachypnea, poor oral feeding skill and iron deficiency are reasons for insufficient nutrition intake (Wright & Rocchini, 2002). Promoting growth involves weighing the child at least once a week or as part of a treatment plan; plotting a growth chart (Wright & Rocchini, 2002) and assessing the child's growth. Poor growth can be

improved by modifying nutrition by increasing the amount and type of nutrition, providing medical treatment for CHD and preparing the child for a timely surgery.

It is more important to provide adequate nutrition to children with CHD because their caloric requirement is high in order to meet their high metabolic needs (O'Brien & Baker, 2009). Inadequate nutrition leads to the development of malnutrition prior to surgery. Provision of care practice as an aspect of nutrition includes paying close attention to the feeding of sufficient food containing the five nutrient value food groups relevant to the medical regimen (Srichantaranit *et al.*, 2010; Wright & Rocchini, 2002). Breast milk is the best nutritional source for an infant. However, it should be fortified to meet their increased metabolic needs (Wright & Rocchini, 2002). More calories can be provided by fortified formula at 24 to 30 calories per ounce (Woodward, 2011). It is more difficult to provide adequate nutrition for children with CHF. Consulting a dietitian will be helpful for the parents of CHD children who plan to feed them appropriately (O'Brien & Baker, 2009).

Child development is mainly present in physical, cognitive or intellectual and socio-emotional areas. Parents can play active roles promoting child development. Parental care practices in relation to child's development include making an appointment with medical personnel for ongoing screening and early treatment, provide age-appropriate developmental activities such as providing a variety of toys, talking and singing to the child encouraging the use of hands, toilet training and play activities. According to Gomes *et al.* (2017), parental care practices are playing games, dancing, running, drawing and reading books. It is important to encourage the child to engage in a range of physical activities according to the guidance of a cardiologist or child's physician. Language development can be improved by talking with the child by encouraging him/her to talk by pointing at some object in the environment; similar activities that can be used by a child with CHD as other children. Consulting service from a speech therapist can be obtained to improve language delay. Timely immunization is another important care practice as children may have missed their regularly scheduled immunizations due to illness (Woodward, 2011). Children with CHD should receive immunization according to the national immunization programme standards. (Woodward, 2011).

It is very important for children with acyanotic heart disease to receive an influenza vaccine (Hib vaccines) which may benefit from prophylaxis as these children they are more vulnerable and often get infected with respiratory tract infections (Wright & Rocchini, 2002). According to the Sri Lankan hospital policy for infants with previously diagnosed severe congenital heart disease, infants should be admitted to a hospital where the service of a pediatrician is available for vaccination and to observe the patient for a minimum period of 24 hours after vaccination, before the patient is discharged (Mendis, 2012). Care practice for the vaccination of children with CHD including receiving immunization on time according to the immunization schedule, tracking immunization records, recognizing contraindications and complications of vaccines and taking their children to receive vaccine should be established (Chaisom, 2008). In terms of prevention of illness, care practices are needed to ensure daily hygiene care and provide them with clean and dry clothes. Moreover, frequent hand washing, avoiding crowds (Woodward, 2011) and avoiding contact with individuals with upper RTI (Srichantaranit *et al.*, 2010) are also important measures that a parent should monitor. Suklerttrakul *et al.* (2018) and Woodward (2011) have mentioned that monitoring signs and symptoms of CHF and respiratory infection is an important care practice for protecting a child from the disease's complications. Other care practices for children with CHD receiving from parents include maintaining body temperature, maintaining posture to helping to reduce the work of breathing and improve oxygenation and preventing and treating infections (O'Brien & Baker, 2009). Furthermore, it is very important to have close monitoring of clinical feature of CHD. Children with CHD usually receive medication and care to treat or prevent CHF. Care practice in giving medication includes knowing the list of prescribed medications and information including indication and dose of medication (Woodward, 2011); provision of the correct dose of medication as prescribed on time without skipping (Srichantaranit *et al.*, 2010); close monitoring of the child for adverse effects and being cautioned by any signs of renal insufficiency or drug toxicity; frequently obtaining the child's bodyweight as drug doses are prescribed based on weight; keeping medications in a safe place to prevent accidental (O'Brien & Baker, 2009).

Primary Care Needs for Children continued from page 9...

ingestion (O'Brien & Baker, 2009). Every child with congenital heart disease must be advised to maintain good oral hygiene (Saxena, 2008). Practices on dental care include the provision of daily oral care, avoiding frequent intake of sugary food and drinks, avoiding sugared milk/drinks in a bottle during the night and maintaining routine visits to the dentist at least once in every six months (Ali *et al.*, 2016) to prevent dental caries.

Since the child with CHD needs periodic observation by the child health specialist and at times to monitor clinical manifestations, bringing the child for follow-up visits as appointed is an important care practice. Likewise, providing Infective Endocarditis (IE) prophylaxis including prophylaxis antibiotics before invasive procedures (according to cardiologists), provision of daily oral hygiene, frequent visits to the dentist and maintenance of proper skin care are all needed. The underlying hemodynamic and physiologic instability of many children with CHD can make these children particularly vulnerable to any adverse event (Chaisom, 2008). Therefore, taking the child for follow-up visits as guided is an important care practice as the child with CHD needs periodic observation by the child health specialist. Sometimes, they require undergoing procedures such as an echocardiogram and electrocardiogram to decide their treatment plan. Children with medical treatment for the underlying disease may need to frequently visit medical appointments to do the blood investigations and measure body weight to decide on future treatment plans (Woodward, 2011). Children treated with anti-coagulation drugs have to be taken for routine blood investigation as the decision of frequency and duration of therapy has to be decided on the blood results.

In conclusion, children with CHD need proper care from their parents which includes daily living care, continued growth, provision of nutrition, promotion of development, timely immunization, prevention of illness, giving of medication, dental care, taking the child to follow up medical appointments and provi-

sion of infective endocarditis prophylaxis, all which aid in promoting the health status of these children.

References

- Ali, H. M., Mustafa, M., Nasir, E. F., Lie, S. A., Hasabalrasol, S., Elshazali, O. H., . . . Skeie, M. S. (2016). Oral-health-related background factors and dental service utilization among Sudanese children with and without a congenital heart defects. *BMC Oral Health*, 16(1), 123 - 135.
- Chaisom, P. (2008). Predicting factors of dependent care behaviors among mothers of toddlers with congenital heart disease (Unpublished doctorate desertation). Chiang Mai University, Thailand.
- Gamage, M. P., Sithamparapillai, K., Perera, S. N., Ranawaka, R., & Jayatissa, R. (2019). prevalence of malnutrition in children with congenital heart disease awaiting cardiac intervention at a tertiary care setting Sri Lanka. *Sri Lankan Journal of Cardiology*, 1(2), 39-43.
- Gomes, A. M., Ribeiro, R. F., Prat, B. V., Magalhães, L. D. C., & Morais, R. L. D. S. (2017). Parental practices and beliefs on motor development in the first year of life. *Fisioterapia em Movimento*, 30(4), 769-779.
- Luo, H., Qin, G., Wang, L., Ye, Z., Pan, Y., Huang, L., . . . Wang, E. (2019). Outcomes of infant cardiac surgery for congenital heart disease concomitant with persistent pneumonia: A Retrospective Cohort Study. *Journal of Cardiothoracic and Vascular Anesthesia*, 33(2), 428-432.
- Mendis, A. (2012). Guidelines on vaccination of infants with severe congenital heart diseases. Colombo. Retrieved from <http://www.health.gov.lk>
- O'Brien, P., & Baker, A.L. (2009). The child with cardiovascular dysfunction. In M. J. Hockenberry & D. Wilson, (Eds.), *Wong's Essentials of Pediatric Nursing* (8th ed., pp. 861-910). St. Louis: Mosby.
- Samarasingha, D. (2018). A project by the community to save the children of Sri Lanka. *Sri Lanka Journal of Cardiology*, 1 (1), 112-116.
- Saxena, A. (2008). Consensus on timing of intervention for common congenital heart disease. Working Group on Management of Congenital Heart Diseases in India. *Indian Pediatrics*, 45(2), 117-126.
- Srichantarant, A., Chontawan, R., Yenbut, J., Ray, L., Lao-haprasittiporn, D., & Wanitkun, S. (2010). Thai families' caring practices for infants with congenital heart disease prior to cardiac surgery. *Pacific Rim International Journal of Nursing Research*, 14(1), 61-78.

- Suklertrakul, T., Picheansathian, W., Jintrawet, U., & Chotibang, J. (2018). Support program for Thai mothers of toddlers with congenital heart disease: A randomized control trial. *Pacific Rim International Journal of Nursing Research*, 22(2), 106-120.
- Van der Linde, D., Konings, E. E. M., Slager, M. A., Witsenburg, M., Helbing, W. A., Takkenberg, J. J. M., & Roos-Hesselink, J. W. (2011). Birth prevalence of congenital heart disease worldwide: A systematic review and meta-analysis. *Journal of the American College of Cardiology*, 58(21), 2241-2247.
- Woodward, C. S. (2011). Keeping children with congenital heart disease healthy. *Journal of Pediatric Health Care*, 25, 373-378.
- Wright, G. E., & Rocchini, A. P. (2002). Primary and general care of the child with congenital heart disease. *ACC Current Journal Review*, 11(2), 89.



ICN calls on the public to embrace properly tested and regulated COVID-19 vaccines as soon as they are available.



Geneva, Switzerland, 07 December 2020 – The International Council of Nurse's (ICN) leadership is calling on the public to back the newly approved, tested and regulated COVID-19 vaccines that are beginning to be rolled out across the world. ICN President Annette Kennedy and Chief Executive Officer Howard Catton have both expressed their willingness to be vaccinated at the earliest possible opportunity, and they are urging others to do likewise.

Ms Kennedy said: "The COVID-19 pandemic has killed more than 1.5 million people world-wide. It has closed down our lives, prevented people from visiting their most vulnerable loved ones in care homes, and kept family members from the bedsides of their dying relatives when they needed them most. It has taken a massive toll on our mental health as people have been forced to live isolated lives away from their families, friends and work colleagues.

"I believe it is now our public duty and the responsibility of every one of us to be vaccinated as soon as possible to stop the spread of the virus and save lives, including those of frontline healthcare workers, who continue to be at high risk. ICN has reported that at least 1,500 nurses have died from the virus and we believe the true number will be very many more.

"We are referring only to the vaccines approved by respected medicines' regulatory authorities. The speed with which these vaccines have been created, tested, trialled and regulated is due to an unprecedented concerted global effort in which safety has been paramount. Let's get the message out about the safety and necessity of having a COVID-19 vaccine, and make sure the public is not swayed by unfounded conspiracy theories and irresponsible scare-mongering."

Source: https://www.icn.ch/sites/default/files/inline-files/PR_61_COVID%20vaccination%20Dec%202020%20V6%20-

CALLING FOR ARTICLES FOR NEXT ISSUE OF "NEW VISION"

Send your articles related to Health and Nursing

- * Include in-depth discussion of the topic of interest:
- * Include a brief introduction, body; with subheadings and paragraphs according to your content, and the summary.
- * Include the references according to the APA 7th format where ever necessary. Limit your references maximum of 10.
- * Word limit -'750-1000
- * Fonts: Times New Roman, 12 size, 1.5 spacing

"Never memorize something that you can look up."

— **Albert Einstein**

Forthcoming Conferences



RCHS - 2021

RESEARCH CONFERENCE IN HEALTH SCIENCES - 2021

Fostering healthcare needs through
research and innovation

31st March
2021

Faculty of Allied Health Sciences
University of Sri Jayewardenepura
Sri Lanka

Abstract submission deadline - 15th January 2021

Tracks :

- Clinical Practice and Management in Nursing
- Nursing Education and Research
- Prevention and Promotion of Health
- Formulation and Quality Assurance of Pharmaceuticals
- Natural Medicine and Drug Discovery
- Pharmaceutical Care and Quality use of Medicines
- Advances in Laboratory Sciences
- Clinical Laboratory Diagnostics
- Health and Nutrition

RCHS 2021 will be a
virtual conference

Registration fee: **Rs: 500.00**

Abstract submission:

rchs.fahs@sjp.ac.lk

Further information:

<http://health.sjp.ac.lk/rchs/>

Contact :

Dr. N. R. Samaranayake - +94714467919
Dr. N. D. Withanage - +94773406736

I
INTERNATIONAL COUNCIL OF NURSES CONGRESS

2-4 November 2021

In response to COVID-19 public health issues and travel restrictions, ICN will no longer hold a physical ICN Congress in June 2021. Instead ICN will bring together National Nurses Associations and their members in an innovative virtual congress format.

Theme 'Nursing Around the World'

Call for abstracts: 8th January to 4th March 2021

Details: events@icn.ch

38th Global Nursing Care and Patient Safety Conference

May 08-09, 2021 Toronto, Canada

Exploring Latest Advancement in Nursing Education and Digital Health

Details: <https://nursingcongress.conferenceseries.com/>

iPURSE 2021

University of Peradeniya

Important Dates

Abstract Submission Deadline: 28 February 2021

iPURSE : 19, 20 August 2021

More information: <http://www.pdn.ac.lk/ipurse/2021/>

Calling for Articles for Sri Lankan Journal of Nursing (SLJN)

The first ever Nursing Journal in Sri Lanka

“Sri Lankan Journal of Nursing (SLJN)” is a peer-reviewed journal published annually by the Graduate Nurses’ Foundation of Sri Lanka. The SLJN is dedicated to sharing quality research by the nurses of Sri Lanka.

Introduction

“Sri Lankan Journal of Nursing (SLJN)” is a peer-reviewed journal published annually by the Graduate Nurses’ Foundation of Sri Lanka (GNFSL). The SLJN is dedicated to sharing quality research by nurses from Sri Lanka. This journal provides a forum for previously unpublished research and review articles related to the areas of nursing education, clinical nursing, public health nursing, and allied health sciences.

Peer-review policy

All research articles to be published in this journal will undergo peer review, based on initial editor screening and anonymized refereeing by at least two anonymous referees. Thus the journal adheres to a rigorous double-blind peer reviewing policy.

Copyright

It is a condition of publication that manuscripts submitted to this journal should not have been published elsewhere. By submitting a manuscript, the author agrees that the copyright for the article is transferred to the publishers, if and when the article is accepted for publication.

Article-processing charges

Authors pay a one-time Article Processing Charge (Rs. 5,000.00) to cover the costs of printing the journal. No charges need to be paid for paper submission and rejected articles. No surcharges need to be paid based on the length of an article, figures, or supplementary data.

Language

All submissions must be in English.

Submission of papers

Submissions should be sent to the Editor-in-Chief through

the email address- sljngnf@gmail.com

The manuscript should be submitted by one of the authors, who will act as the Corresponding Author. S/he should provide all the other authors' details upon submission of the article. The article must be prepared according to the guidelines provided below. The word count of the article should be limited to 3,000-4,000 words, and the abstract should not exceed 300 words. The manuscript should be language edited before submission.

Cover page

A separate cover page must include a concise and informative title and the name/s of the author/s with affiliation/s, address/es of the affiliation, contact number/s and e-mail address/es of each author. (Authors' names should **not** appear elsewhere in the article).

Formatting

All manuscripts must consist of the following elements:

- Abstract
- Keywords
- Introduction
- Materials and methods
- Results
- Discussion
- Conclusions and recommendations
- Acknowledgment and funding

Abstract

The abstract should not exceed 300 words and should be devoid of citations and abbreviations. It must include the purpose of the study, the method, major results, and conclusions. .

Keywords

A maximum of 05 keywords should be included below the abstract.

Introduction

The Introduction should explain the scope of study giving background information and state the objectives of the study.

Materials and methods

Methods used in the study should be clearly explained in detail. All papers must state the full name of the ethics review committee and the approval number. A copy of the approval notice should be submitted with the manuscript.

Results

This section should clearly mention the main findings of the study. Unnecessary repetition of results should be avoided.

Discussion

The Discussion should include interpretation of results, comparison with previous studies, and strengths and weaknesses in relation to other studies.

Conclusions and recommendations

Clearly state the main conclusions of the study, implications and recommendations.

Acknowledgment

All acknowledgments (if any) should be included at the end of the manuscript before the references. Anyone who made a contribution to the conducting of the study or preparation of the manuscript but is not a listed author should be acknowledged (with their permission).

Funding

This section should consist of an acknowledgment of all funding sources that supported the submitted work, as well as any commercial association that could pose a conflict of interest or create a bias.

Sections

Each section of the manuscript should be numbered in Hindu-Arabic numerals and the subdivisions should be

numbered accordingly, i.e. 1.1, 1.2, etc.. The abstract should not be numbered.

Font

The body of the article should be typed in Times New Roman 12 point, 1.5 point line-spaced, and justified.

Headings

Headings should appear in 14-point bold type in Upper- and Lower-Case letters as appropriate.

Sub-Headings should appear in 12-point bold type in Upper- and Lower-Case letters as appropriate.

Lower level sub-headings (Sub-sub-headings) should be in 12point upper- and lower-case italics as appropriate.

Use headings and sub-headings as needed.

Tables and figures

Tables and figures should be numbered according to the order of their occurrence in the text. Tables should not be presented as images. Do not use vertical lines in tables.

Conflicts of interest

All authors should declare any relevant conflicts of interest.

References

A list of references of the works cited should be presented according to the APA format (7th edition). All references should be cited in the text and vice-versa.

Visit us on Facebook

<https://www.facebook.com/Graduate-Nurses-Foundation-of-Sri-Lanka-921789544538855/>



Be updated!
Like us and Follow us!



ISSN 2613-8735