IOSR Journal of Nursing and Health Science (IOSR-JNHS)
e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 14, Issue 2 Ser. 3 (Mar. – Apr. 2025), PP 35-87
www.iosrjournals.org

"A Study To Assess The Effectiveness Of Informat On Booklet On Knowledge Regarding Quality Of Life Among Diabetic Patients With Diabetic Foot Ulcerat Selected Hosptals Bangalore'

Ms. Pavithra. B
Rajiv Gandhi University Of Health Sciences, Bangalore

Abstract
Background Of The Study:
Diabetic foot problems and foot ulcers are the most serious and costly complications and important cause of morbidity in diabetic people over the
3.To associate the level of knowledge regarding quality of life among diabetic patients with diabetic foot ulcer with their selected demographic variables
Hypothesis
H1: There will be a significant difference between knowledge scores among patients regarding quality of life before and after administration of information booklets.
H2: There will be an association between knowledge scores among diabetic patients with diabetic foot with their selected socio demographic variables.
Methods
The data will be analyzed byusing the descriptive and inferential Statistics. Frequency, percentage distribution to assess the demographic data of samples. Mean, standard deviation will be used to assess the knowledge regarding quality of life among diabetic patients with diabetic foot ulcer.
Paired 't' testto compare knowledge before and after administration of information booklet. Chi square will be used to find out association between knowledge scores with the selected socio demoraphic variables.
Results
The pretest mean knowledge score obtained, After administering PTP significant improvement in the knowledge among housewives was observed. Hence the research hypothesis stated that there will be significant difference between pre and post-test knowledge regarding was accepted. There was no statistically significant association found between the post test knowledge score with selected demographic variables.

Date of Submission: 25-03-2025 Date of Acceptance: 05-04-2025

CHAPTER-I
INTRODUTION

"Every30secondsalowerlimbislostsomewhereintheworldasaconsequence ofdiabetes".

(InternationaldiabetesFederation)

Diabetes mellitus is a group ofmetabolic diseases characterized by chronic hyperglycemia resulting from eitherinadequate insulin production, reducedtissuesensitivitytoinsulinorboth.Chronichyperglycaemialeadsto diabetic complications including peripheralneuropathy peripheralvascular disease,increasedriskofinfectionandpoorwoundhealing.Thediabeticfoot maybedefinedasagroupofsyndromesinwhichneuropathy,ischaemia,and infection lead to tissue breakdown resulting in morbidity and possible amputation.[1]

Thisreview oftheliteraturewillcoverthenatureandepidemiologyof diabeticfootdisease and how itmaybe prevented and managed,with an emphasis on studies from Africa.The review willbe illustrated with local experienceofestablishingadiabeticfootserviceatQueenElizabethHospitalin Blantyre.[2]

Healthisthelevelоffunctionalormetabolicefficiencyofalivingbeing.In humans,itisthegeneralconditionofapersonsmind,bodyandspirit,usually meaningtobefreefrom illness.Theworldhealthorganizationdefinedhealthin itsbroadersensein1946asastateofcompletephysical,mental,andsocialwell-beingandnotmerelytheabsenceofdisea endocrinesystem playsavitalrolein thebody.Itismadeupofglandsthatproduceandsecretehormones.[3]

secondmostcommoncauseoflowerlimbamputation.Theriskoflowerlimb amputationis15-46timeshigherindiabetesthaninpersonswhodonthave diabetesmellitus.Footcomplicationsaccountsfor25%ofalldiabeticpatients admitted in United States and GreatBritain.(American academyoffamily physician.200741).[4]

Diabeticfootulcer:Diabeticfootproblemsandfootulcersarethemost seriousandcostlycomplicationsandimportantcauseofmorbidityindiabetic peopleovertheyears.Diabeticfootulcersaresoresthatoccuronthefeetof peoplewithtype1&type2diabetesmellitus.Thetwomainriskfactorsthat causesdiabeticfootulcerareperipheralneuropathy,microaswellasmacro ischemia.Peripheralneuropathycauseslossof3painorfeelinginthetoes,feet, legs and arm due to distalnerve damage and low blood flow supply, (atherosclerosis arteriosclerosis)very less oxygen and eventually death of tissuesinfeetoccur.DiabeticFootSocietyofIndia(2005)estimatedthat84%of alllowerlimbamputationsareprecededbyfootulcersindiabeticclientsand everysingleday,110Indianshaveafootorpartoftheirlegamputateddueto diabeticfootulcer.[5]

pathology

TheAmericanDiabetesAssociation88reportedthatallpatientswithtype 2diabetesshouldbescreenedforpolyneuropathyupondiagnosisandatleast annuallythereafter.Itsrecommendedthatpatientswithdiabetesshouldhavea comprehensivefootexam,includingassessmentoftheskin,bone,muscles, circulation,andsensation.Uponexamination,adecreaseindeeptendonreflexes isoftenfound.Thismaybetheonlyindicationofneuropathychangesinapatient whosasymptomatic.[6]

Thehealthcareprovidermayassessprotectivesensationinthefeetby touchingthem withamonofilament(similartoabristleofahairbrush)orby pinprick.Patientswhocantfeelthetouchhavelossofprotectivesensationand areatincreasedriskforfootinjury. Fig.2:MonofilamentTestVedharaK (2008)82conductedaqualitativestudytoassesspatientperspectivesonfoot complicationsintype2diabetesmellitus,mostparticipantswereunsureofwhat arethecausesoffootulcerand complicationsofdiabeticfoot,preventive measure.Thisstudyconcludedthatpeoplewithdiabeteshavedifferentbeliefs ondiabeticfootcomplicationsthathampersfootselfcare5practices.Sohealth carepersonnelneedtoexplorethebeliefsunderlyingpatientsfootselfcare practices.[7]

Hormonesarechemicalmessengerscreatedbythebody.Theytransfer from onesetofcelltoanothertocoordinatethefunctionsofdifferentpartsof thebody.Thesehormonesregulatethebody'sgrowth,metabolism (thephysical andchemicalprocessesofthebody),andsexualdevelopmentandfunction.The hormonesarereleasedintothebloodstream andmayaffectoneorseveral organsthroughoutthebody.[8]

Theycanbeclassifiedbytheirsecretionasαcellsecreteglucagon(increase glucoseinblood),βcellsecreteinsulin(decreaseglucoseinblood),δcellssecret somatization(regulates/stopsαandβcells).TheisletofLangerhansplaysan imperative role in glucose metabolism and regulation of blood glucose concentration.[9]

Insulinisahormoneproducedbythepancreas.Itsfunctionistoregulate carbohydrateandfatmetabolism inthebody.Insulincausescellsintheliver, muscle,andfattissuetotakeupglucosefrom theblood,strongitasglycogenin theliverandmuscle.Insulinstopstheuseoffatasanenergysourcebyinhibiting the release ofglucagon.Insulin is provided within the bodyin a constant proportiontoremoveexcessglucosefrom theblood.Whenbloodglucoselevels fallbelowacertainlevel,thebodybeginstousestoredsugarasenergysource throughglycogenolysis,whichbreaksdowntheglycogenstoredintheliverand musclesintoglucose,whichcanthenbeutilizedasanenergysource.When controlofinsulinlevelsfails,diabetesmellituswillresult.[10]

Therearethreemaintypeofdiabetes:Type1diabetes:resultfrom the body'sfailuretoproduceinsulin,andpresentlyrequiresthepersontoinject insulin.(Alsoreferredtoasinsulin-dependentdiabetesmellitus,IDDM forshort, and juvenile diabetes.)Type 2 diabetes:results from insulin resistance,a conditioninwhichcellsfailtouseinsulinproperly,sometimescombinedwithan absolute insulin deficiency.(Formerlyreferred to as non-insulin-dependent diabetes mellitus,NIDDM forshort,and adult-onsetdiabetes.)Gestational diabetes:iswhenpregnantwomen,whohaveneverhaddiabetesbefore,havea highbloodglucoselevelduringpregnancy.Itmayprecededevelopmentoftype2 diabetesmellitus.[11]

changesproducetissueischemiaandskinchangesthatcancauseulcerations andinfectionsandpreventhealing. Theinterrelationshipofalltherefactors,as theycontributetolesionthatresultsingangreneandultimatelyamputation.[12]

Footproblemsconstitutetheprimarycauseofhospitalizationofpeople withdiabetes. Above15% developsfootorlegulcer. Amputationiscommon between1994and1996thenumberofdiabetesrelatedamputationwhohave hadoneamputationhave28%to51%chanceofneedingacentralizedonewithin fiveyear.[7]Theprimarystepsinthetreatmentofdiabetesfootulceriswound closure elevation ofthe affected footand reliefofpressure are essential componentoftreatmentandshouldbeinitiatedatfirstpresentationillfitting footwearshouldbereplacedwithapostoperativeshoeoranothertypeof pressurerelivingfootwear.[13]

RisingprevalenceofDiabetesMellitusespeciallyType-2DM inUrban populationisaseriousconcern.Thecountrieswiththelargestnumberofpeople withdiabetesareandwillalsobeintheyear2025,India,ChinaandtheU.S.1With the increasing prevalence ofdiabetes especially in the middle age group populationswhoarecommonlyaffectedinIndia,thechancesofdeveloping micro & macro vascularcomplicationsareveryhigh & itisgoing to bring enormousburdenonthefamily,society&thehealthcareprovidersinvolvedin themanagementofdiabetesduetohighmorbidity&mortality.[14]

During the lastdecades,developing countries have experienced an epidemiologictransitioncharacterizedbyareductionofinfectiousdiseasesand an increase ofchronic degenerative diseases.This situation is generating tormentingpublichealth,financial,andsocialconsequences.Ofrelevanceistype 2diabetesmellitusanditschroniccomplications,particularlycardiovascular diseaseanddiabeticnephropathy,becausemortalityofthepatientwithdiabetes is inmostinstances relatedtothesecomplications.[15]

thebottom ofthefeet.

- Keepthefeetcleanbywashingthem dailyinonlylukewarm water.Be gentlewhenbathingthefeet,usingasoftwashclothorsponge.After washingmoisturizethefeet,butnotbetweenthetoes.

- Cutnailstraightacrossandfiletheedges.Dontcutnailstooshort.
- Wearclean,drycottonsocks.Dontwearthickorbulky,tightelasticbands socks.Andiffeetgetcoldatnight,wearsockstowarm it.
- Shakeouttheshoesbeforewearing,useonlygoodfittingshoes.Never walkbarefoot,everinhome.

- Keepthefeetwarm anddry.
- Keepthebloodsugarlevelundercontrolbytherapeuticdietandinsulin therapy.

- Dontsmoke.[16]

Thepersonwithdiabetesshoulddothefoottheexaminationdaily.Usesa waterbasedmoisturizereverydaytopreventdryskinandcracking.Alwayscut thenailwithasafetyclipper,cutthem straightandnevertooshort.Diabetic patientshould wearcomfortable shoes to be sure,one can concern with podiatrist(footdoctor).[17]

Thediabeticpatientshoulddotheregularexercisetoimprovethebone andjointhealthoffeet,improvecirculation.Thediabeticpatientshouldavoidthe smoking,because tobacco damages the blood vessels leads to poor circulation.[18]

Forcontrolling the diabetes ,patientshould take therapeutic diet, medications,check the blood sugarlevelregularly,exercising regularlyand maintainthegoodcommunicationwiththephysician1 ..

"Uncontrolleddiabetescandamagevitalorgans".

Diabetesmellitusisthemostchallenginghealthproblem inthistwenty firstcentury.Thehavingthehighestnumberofdiabetesinthewholeworld.A worrisomeaspectisgrowing numberofyoungerand othercomponentsof metabolic syndrome.Situation where increase ofsyndrome and formulate preventivestrategies.[20]

Diabetesisoneofthemostcommon chronicdiseasesaffecting the population in India. Itis estimated thatthere are 40 million persons with diabetesinIndiaandthisnumberisscheduledtoriseupto70millionbytheyear 2025.[20]

DIABETICFOOT-Describesthefootofadiabeticpatient,thathasthe potentialriskofpathologicconsequencesincludinginfection,ulceration,and destructionofdeeptissuesassociatedwithneurologicalabnormalities,various degreesofperipheralarterialdisease,andmetaboliccomplicationsofdiabetes inthelowerlimb.(BasedonWHOdefinition.).[21]

Adisablingcomplicationwiththisdiseaseisfootulcerdevelopmentwhich leadstononhealingchronicwoundsthataredifficulttotreat.Varioustreatment modalities have been reported forthe managementofdiabetic footulcers ranging from theageold moistgauzedressing,bio engineered tissue skin substitutes,growthfactorsandnegativepressuretherapy.Thediabeticfootis consideredoneofthemostsignificantcomplicationsofdiabetesrepresentinga majorworldwidemedical,social,and economicproblem thatmainlyaffects patientqualityoflife.[22]

ondiabeticfoot.[23]

Diabetesposesahugeeconomicburdenon India.Inarecentpapershows thatoffivecountriesstudy,namelytheUS,theU.k,Finland,ChinaandIndia,India spendsthehighestshareofGDP ondiabetes.Butmorethantheeconomic impact,itisthesocialimpactthatisofgreaterconcern.Theageatonsetoftype IIdiabetesisprogressivelydecreasingandthedisordernowaffectasignificant numberofadolescentsandchildren.Theonsetofdiabetes-relatedcomplications typicallyoccurs10-20yearsafterthedisorderisdiagnosed.[24]

Inglobalscenario,theinternationalfederationestimatedthattheworld-wideprevalenceofdiabetesisinyear2003is94million.TheWHOhasprojected thatthisnumberwillincrease300millionby2025.AccordingtoIndianscenario; prevalenceofdiabetesmellitusinIndiahasbeengrowingbyleapsandbounds. Inthelast20yearstherehasbeenathreefoldincreaseinprevalenceofdiabetes andnow itisestimatedthattherearеover20millionofpatientsinIndia's diabeticpopulationnow ranksfirstintheworld. 2010inIndiathemostrecent assessmentcarriedoutbyICMR(Indiacouncilofmedicalresearch)estimated thatthereare66.5millioncasesand2.26millioncasesreachedwithdiabetes.[25]

Indiastudiesshowedtheprevalenceofdiabetesrangingfrom 2.1%inNew Delhito12.4% in2001(predeepaatal2002,DwivediandKrishna1999).In southernIndiastudiesshowed40% increaseinprevalenceoveraperiodofsix years.Innationalurbandiabetessurveyin2000,itwasfondthatHyderabadis having16.6%ofdiabetes,Chennai13.5%andcitiesofIndiapresently10.15%of populationishavingdiabetes.Percentageofdeathissignificantlyhigheramong diabetessubjects11.9%comparedtonon-diabeticsubjects.[26]

coronaryheartdisease(CHD)andworseoutcomewithmoreandearlierdeath thanChinese,Japanese,Caucasiansorblackpersons,new therapiesthancan reduce delaythe progression ofdiabetes and forpride cardiovascularrisk reduction.Thus,remainamajorneedinthetherapeuticinterventionagainst diabetes.Onanaverageonly50%ofpeoplearediagnosedandonly15%receive treatmentasregularbasis.Theaveragemetaboliccontrolachievedinstabletype 2diabetespatientsregularlyattendingprimary,secondary,andtertiarytreatment centersarenotevenclosetothestandardrecommendedfordiabetescare.[27]

AstudywasconductedatChennai,on3010diabetes,theprevalenceof micro vascularcomplications were retinopathy-23%,nephropathy-5.5%,and prevalenceofCHD-1.4%[16]Inastudycomprising720typeIIdiabetic,retinopathy wasseenin21.2%,microalbuminuria41%,peripheralneuropathyin15.3% CAD 7%,andPVDwasseenin7.4%ofpatient.[28]

InrecentstudyinChennainearly25%ofpopulationstudiedwereunaware ofaconditioncalleddiabetes,only40% ofparticipantfeltthatprevalenceof diabeteswasincreasingandonly22%ofpopulationfeltthatdiabetescouldbe prevented,throughtheawarenesslevelincreasedwitheducationonly4.2% of postgraduate and professionalincluding doctors know thatdiabetes was preventable.Theknowledgeofriskfactorwasevenlow only11.9% ofstudy reportedobesityandphysicalinactiveasariskfactor.Evenamongsttheknown diabetesonly40.6%wasawarethatdiabetescouldleadstoorgandamageand complications,manypeople46% withdiabetesfeltthatitwasatemporary phenomenon.[29]

There is a deep need foran increase in the awareness ofdiabetes

notsufficientlyequippedwiththeknowledgetocomprehensivelymanagetheir disease. Knowledgeofdiabetesisthereforeessentialforprimaryhealthcareand otherdiabeticpatientsinordertopreventco-morbidities,whichmaycompromise theirlifestylesaswellasincreasetheburdenonpublichealthcare.[30]

Theresearcherhasobservedthecomplicationsofdiabeticpatientsduring hisworkingexperience.Theindividualswho carrymostoftheirweightand longerperioduncontrolleddiabetestendtohaveahigherriskofdiabetesfoot. Sothesefactorsinstigatedtheresearchertoperform astudytoassessand imparttheknowledgeregardingdiabeticfootandqualityoflifecareamong diabeticpatients.[31]

CHAPTER-II

OBJECTIVES

ulceratselectedhospitals,Bangalore."

OBECTIVESOFTHESTUDY

- Toassessthelevelsofknowledgeregardingqualityoflifeamongdiabetic patientswithdiabeticfootulcer.
- To assess the effectiveness of information bookleton knowledge regardingqualityoflifeamongdiabeticpatientswithdiabeticfootulcer.
- To associate the levelofknowledge regarding qualityoflife among diabeticpatientswithdiabeticfootulcerwiththeirselecteddemographic variables

OPERATIONALDEFINITIONS:
Assess:

Determinethelevelsofknowledgeregardingqualityoflifeamongdiabetic patientswithdiabeticfootulcer

Knowledge:

Responses expressed by diabetic patients with diabetic footulcer regardingqualityoflife.

QualityofLife:

Itisthegeneral(physicalandpsychological&social)wellbeingamong

Thediabeticclientswithdiabeticfootulcerwhoareintheagegroup between35to65years.

Diabeticfootulcer:

It'soneofthecomplicationsofdiabetesinwhichthesoftskin commonly inbigtoes,anklesandfeetdowntothebonesarebrokenandexposingthelayers ofunderneath.

Informationbooklet:

Aselfinformationhandbookwhichbrieflyexplainaboutthemeasuresto improvethequalityoflifeamongdiabeticpatientswithdiabeticfootulcer.

HYPOTHESIS:

H_1:Therewillbeasignificantdifferencebetweenknowledgescoresamong patientsregardingqualityoflifebeforeandafteradministrationofinformation booklet.

H_2: Therewillbeansignificantassociationbetweenknowledgescoresamong diabetic patients with diabetic footwith theirselected socio demographic variables.

ASSUMPTIONS:

Thestudyassumesthat

1.Diabeticclientswithdiabeticfootulcermayhavesomeknowledgeabout qualityoflife

Thestudyislimitedto:

- D abeticClientswithdiabetesdiabeticfootulcerwithintheagegroupbetween 35to65years.
- Samp esize40

classification ofits concepts.concepts are words thatdescribe objects, properties orevents and are bsic components oftheory. the conceptual frameworkisageneralamalgam ofalltherelatedconceptsintheproblem area.

Conceptualframework deals with abstraction orconcepts thatare assembledbyvirtueoftheirrelevancetoacommontheme.conceptualizationis aprocessofformingideaswhichisutilsedandformsconceptualframeworkfor developmentofresearchdesign.Ithelpstheresecherbygivingdirectontogo aboutentireresearchprocess.

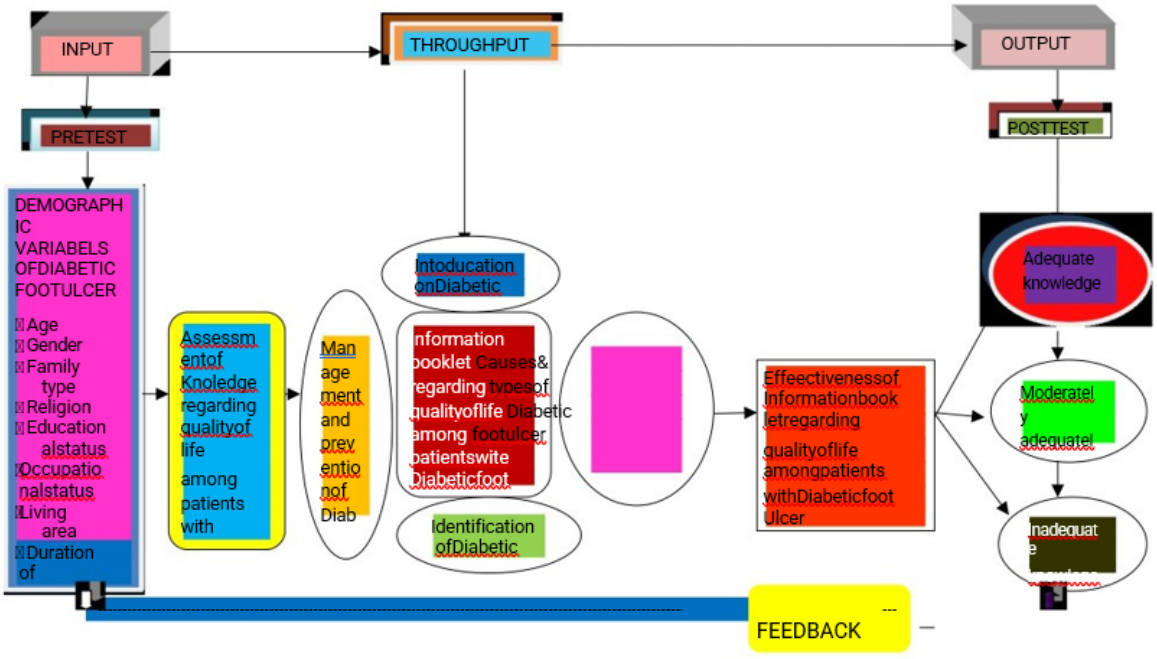
Theconceptualframeworkdevelopedbytheinvestigatorforthisstudyis basedonthehealthpromotionmodelproposedbypender.Pendersmodellevel frame workwasdesignedtobeacomplementarycounterparttomodelsof healthprotection.Healthpromotionisdirectedatincreasingaclientsoflevel well-being.

Thismodelfocusesonthreefunctions:

1. Itidentifes factors (e.g.demographic data)thatenhanec ordecrease participationinhealthpromotion.

2. Cuestoaction:Explainslikelihoodofaclientparticipatingintechingprogram.

3.Participationofperipheraldiabeticneuropathy.



Thepresentstudyaims"toassesstheeffectivenessofselfInstructionalModule onknowledgeregardingDiabeticfootulcerinamongprimaryteachinginselected hospitalBangalore".The conceptualframework ofthe study is based on general systemstheorywithinputthroughput,andfeedback.Thistheorywasfirstintroducedby LudwigVonBertanffy(1968).

According tothistheorysystemscanbeopenorclosed.Alllivingsystems can be open orclosed .In thatthere is continous exchange ofmatterenergyand information.Opensystemshavevaryingdegreeofintractionwithenvioronmentfrom which the system receives the enviornment in an alterd stageaffecting the enviornment.The enviorment.The feedbavk is the rsponce of the system.The system.The systems may be positive ,negative orneutral.In the presentstudy applincationstheconceptsareasfollows:-

INPUT:

Theinputreferstotheinformationresources,enegyormatterwhichenterthe system.Inputisthevariabelsthatcontributetowardsthevariabelsthatcontiribute towardstheknowledgeofdiabeticfootulcerregardingdiabeticmellitus.

THROUGHTPUT

Itreferstotheactionneededtoaccomplishthedesiredtasktoachivethesame output.Itistheself-instroctionalmoduleonDiabeticfootulcerqualityanditsmanagent.

OUTPUT:

Outputreferstoendresultsproductofthesystem.Inthepresentstudyevalution oftheeffectivenessofself-instructionalmoduleonDiabeticfootulcerwithdiabetic

FEEDBACK:

Itistheprocesswherebytheoutputofthesystem isredirectedtooutputofthe samesystem.Iftheknowledgeisbeinadequate,thesystem input,throughputhastobe re-evaluatedwhich is not included in the present study.The feedback is the envornmentalresponseofthesystem,feedbackemphasizesoninputandthroughputto strengthenit.

Alllivingsystem havevarying.

CHPTER-III

REVIEW OFLITERATURE

Astudywasconductedontheprevalenceofmicroandmacrovascular complicationsoftype-Iandtype-IIdiabetesmellitus.Theaim ofthisstudywas toresearchthemicroandmacrovascularcomplicationsintype-Iandtype-II. Total 168 hospitalized patients with diabetes mellitus were analyzed. Microalbuminuriawasdetectedin42%ofpatientswithtype-Iand47%ofpatients withtype-II.Amongthat34% oftype-Idiabetesmellitus and78% oftype-II diabetesmellituspatientswerehypertensive.TheResultofstudyshownthat hypertensioncanbepreventedinpatientswithtypeIIwithweightreductionand control of blood pressure which is essential for the reduction of microalbuminuriaaswellasfurthermicro-andmacro-vascularcomplicationsof diabetesmellitus.[23]

Astudywasconductedon773casesofdiabetesmellituswithaview to find outthe incidence,pattern ofneuropathy as wellas to ascertain its relationshipwiththedegreeandcontrolofhyperglycemia.Theresultshownthat ahighincidenceofneuropathywasobservedevenamongthosediabeticswith goodcontrolofhyperglycemia.Apartfrom theclinicalexamination,sensitive parameterslikethestudyofnerveconductionvelocityandtestsforautonomic dysfunctionwereemployed.Peripheralneuropathywas81% andautonomic neuropathywas48% weremorecommonthanmononeuropathywas5% and amyotrophicwas2%.Innearly25percentofthecases,subclinicalneuropathy existed and wasdetected eitherbynerveconduction studiesorautonomic functiontests.[24]

shownthattype-IIisassociatedwithmoreriskofdiabeticcomplications.The objective ofthe studywas to determine the relation between exposure to glycemia over time and the risk of macro vascular or micro vascular complications in patients with type-II diabetes.A Prospective observational designwasused4585white,AsianIndian,andAfro-Caribbeanpatientswere includedinanalysesofincidence;outofthese,3642 wereincludedinanalysesof relativerisk. Theresultsshowedthattheincidenceofclinicalcomplicationswas significantlyassociatedwithglycemia.[25]

Thestudywasconductedondiabeticfootulcerandfoundthatfootulcer isoneofthemajorcomplicationsofdiabetesmellitusitoccursin15% ofall patientswithDM andprecedes84%ofalllowerlegamputation.Majorincrease in mortality among diabetic patients observed overthe past20 years is considered to be due to the developmentofmacro and micro vascular complicationsincludingfailureofthewoundhealingprocess.

Thestudywasconductedtoevaluatethebaselinelevelofknowledgeand awarenessofdiabeticpatientsabouttheirdiseaseanditscomplications.The resultwasawarenessofcomplicationsofdiabetesmellituswaslow.Thestudy included1040patientswhowereinterviewedtoknow theirknowledgeattitude andpracticesaboutdiabetesusingastructuredquestionnaire.Theawareness aboutthediseaseinmajorityofdiabeticpatientswasnotadequateinthisstudy and routine individual teaching and counseling represents an effective educationalmodel.[26]

A cross sectionalstudy was conducted on knowledge and practice regardingfootcareindiabeticpatientsvisitingdiabeticclinicinJinnahHospital, Lahore.The aim is to assess the knowledge and practice among diabetic patientsand150sampleswereselected.Thefindingsshowedthat29.3% had

Astudywasconductedattitudeaboutdiabetesamongdiabeticpatientin WesternNepal.Theaim istostudythedemographicdetailsofdiabeticpatients andtheirattituderegardingdiabetes.Thestudydesignwasquestionnaireand thesamplesizeis182patients.Theresultssuggestedthattheoverallmean scoreis4andtheyconcludedthateducationalinterventionsareneededto improve,attitudeofdiabetespatients.[28]

Astudyconductedtoassesstheeffectivenessofmonofilamenttestto checkdiabeticneuropathy,theresultsrevealedthat80% amputationinclients withdiabeticarepreventablebyneuropathytesting,monofilamenttestissimple, reproducibleandwidelyavailableandhasahighsensitivityforthediagnosisof clinical or sub clinical neuropathy. Reported that the seims Weinstein monofilamentexaminationisasignificantpredictoroftheriskoffootulceration andamputationinpatientswithdiabetesmellitus,irrespectiveoftypeofdiabetes mellitusallclientsshouldbescreenedforriskofdevelopingdiabeticfootulcer bymonofilamenttest.[29]

Astudyconductedonlargepopulationbasedwithfootdiseaseindiabetic clients.Elderlydiabeticclientsareparticularlyburdenedbyfootdisease,themain cause forfootdisease are peripheralneuropathywhich could be detected accuratelybyusing seimmsWeinstein monofilamenttest.he Prevention of diabeticfootulcerinaprimarycaresetting.Briefhistoryandscreeningforloss ofprotectivesensationviatheSemmesWeinsteinmonofilamenttestmayenable clinician to stratify patientbased on risk and help determine the type of interventionlikepatienteducation,glycemiccontrol,smokingcessation,diligent footcare.[30]

A studywasconducted on assessing the knowledge and attitude of

complicationswereleastsuggestedbydoctor.[31]

Astudywasconductedtoassesstheknowledgeandpracticesamongthe diabetic patients regarding footcare.About29.3% respondents had good knowledge,40% hadsatisfactoryknowledgeand30.7% hadpoorknowledge aboutfootcare.Whereasonly14%respondentshadgoodpracticesforfootcare, 54% hadsatisfactorypracticesand32% hadpoorpractices.Aboutonethirdof diabeticpatientshadpoorknowledgeaboutfootcareandonlyveryfewpatients hadgoodpracticesforfootcare.Literacyhassignificantassociationwiththe knowledgeandpracticesrelatedtofootcareindiabeticpatients.[32]

Astudywasdonetoassessthediseaseknowledgeinpatientsattendinga diabeticfootclinic.Alldiabeticpatientsattendedtheclinicsbecauseoftheirhigh

-riskstatusforthedevelopmentofdiabeticfootinfectionorulcers.Allreceived ongoingfoot-specificpatienteducation.Onlyapproximately80% wereableto respondappropriatelytosimplequestionsrelatedtothecareoftheir"at-risk" feet.Thissimplequalityinitiativereinforcesthenationthatpatientswithdiabetes who areatriskforthedevelopmentofdiabeticfootulcersshould receive ongoingfoot-specificpatienteducation.[33]

Astudywasdonetodetermineknowledgeandpracticeoffootcarein peoplewithdiabetes.Themeanknowledgescorewas6.5outofapossible11. Therewasapositivecorrelationbetweenthescoreandreceivedadviceonfoot care.Deficienciesinknowledgeincludedtheinabilitytosenseminorinjurytothe feet(47.3%),pronenessto ulceration(52.4%)and effectofsmoking onthe circulation(44.5%).24.6% (20.1-29.2)nevervisitedachiropodist,18.5% (14.2-

22.7)failedtoinspecttheirfeetand83% (79.1-86.9)didnothavetheirfeet measuredwhentheylastpurchasedshoes.Theresultshighlightareaswhere

educationsessionsimprovedtheirfootcareknowledgeoverthecourseofthe program.Afterthesecondsession,themeanimprovementoverbaselinewas 14%.Thesepatientsalsoreportedimprovedsatisfactionwithfootcare;mean improvementwas 33%.Intensive education program improved the footcare knowledgeandbehaviorofhigh-riskpatients.[35]

Theretrospectivestudyconducted inTanzaniaonimportanceoftransfer ofknowledgeandfootcomplication. In2004-20073860peoplescreenedto haveriskforfootulcerandfootcareeducationwasgiventoallclientsand reassessedafter6month,resultsrevealedthat29%hadamputation.Thestudy 16concludedthattherewasasignificantincreaseintheknowledgelevelafter educationprogrammeamong59diabeticclientsinSanFranciscotoassessthe efficacy ofeducation on footcomplication.Analysis ofthe data showed statistically significantincrease in footcare knowledge afterthe teaching sessioncomparedwithbefore.(69%to85%p<001)studyconcludedthatclients knowledgeonfootcarewasimprovedafteraneducationprogram.[36]

The study was conducted to assess the knowledge and practices regarding footcare.Only one-third ofthe patients had received diabetic education.Theaveragescoreintheeducatedgroupwas42+/-0.4versus23+/- 7inthenon-educatedgroup(p=0.0001).Thebestresultswereobtainedin educatedandyoungerpatients.Ourfindingsdemonstratethatelderlydiabetics canbenefitfrom aneducationprogram andprovearealinsufficiencyincurrent educationofelderlydiabetics.[37]

Thestudywasconductedtoassesstheknowledgeofthediabeticpatient onfootcareresearchwastoevaluatehowmuchtheclientsthatfrequentlywent totheDiabetesAmbulatory knew abouttheirownill andthefeetcare.Sothe conclusionthatcouldbetakenisthattheclientsknewaboutthecarethatthey

Astudywasconductedtoassesstheeffectivenessofpatienteducation onthepreventionoffootulcersinpatientswithdiabetesmellitus.Tworeviewers undertookdataextractionandassessmentofstudyqualityindependently.Four trialscomparedtheeffectofintensivewithbriefeducationalinterventions;twoof thesereportedclinicalendpoints.Onestudyinvolvinghigh-riskpatientsreported areductioninulcerincidenceandamputationrate.Weakevidencesuggeststhat patienteducationmayreducefootulcerationandamputations,especiallyinhigh-riskpatients.[39]

AnobservationalstudyconductedinEuropeonqualityofcareprovidedto diabeticclients.Inthisstudyfourmainhealthbehaviorswereidentified.Thoseat low riskofdevelopingfootcomplicationsarecontrolofbloodglucoselevels; attendanceatannualfootscreeningexamination;reportingofanychangesin foothealthimmediately;andtheengagementinasimpledailyfootcareroutine. Studyconcludedthatfoothealthmeasuresshouldbefollowedstrictlytoreduce theoccurrenceofulcer.[40]

AdescriptivestudyconductedinCalcuttafoundthathighprevalenceof neuropathypromotesrecurrenceoffootulcers.Aswellashyperglycemiaisa majorcontributorfactorsforfootproblems.Regularinspectionofthefeetfor signs ofneuropathyand otherrisk factorwould playa majorrole in the preventionoffootulcer.Patienteducationforfootcareandearlyinstitutionof preventivemeasuresbythenursesinviewofthehighprevalenceofneuropathy testwillhelpinreducingthemorbidityandeconomicburdenfrom diabeticfoot.[41]

AexperimentalstudyconductedinSaudiwith41diabeticclients(study group=21,controlgroup=20)to assess the impactofa diabetic footcare educationprogrammeonlimbamputationrate.Therateofamputationwas70% incontrolgroupand61.9% instudygroupaftersupplementationoffootcare

A quasiexperimentalstudyconductedtoassesstheeffectofweight bearingexerciseondiabeticfootulceratCanada.10patients(88.9%)were randomizedtoankleexercisetreatmentsandnine(50%)continuedroutinecare. Theresultofthestudyshowedthat60%ofpatientswhowereprojectedtoankle 17exercisehadnoriskoffootulcerwhereasincontrolgroup52%hadhighrisk offootulcer,studyconcludedthatfootexercisealsoanelementtopreventfoot ulceranditcanbeusedinfootcarestrategies.[43]

Apreexperimentalstudyconductedamong60diabeticclientsinBrazilto evaluate the impactoffootcare on risk forfootulcer.On routine visit standardizededucationonfootcaregiven,analysisshowedthat8.7% hada regularfootwear,65% doneafootinspection,28.3% haddoneaadditional inspection,77%didcreaming,83%doneanailcare,77%inspectedshoe,95% had avoided barefootwalk,riskforfootulcershowsonly30%,theresult suggestedthatregularfootcareisessentialtopreventfootulcer.[44]

Anexperimentalstudyconductedwith53diabeticclientstoevaluatethe effectivenessoffootcareeducation.After1yeartheulcerincidenceratewas

38.1%comparedto51.15inthecontrolgroup,aftertwoyeartheparticipantsin theinterventiongrouphada75%chancesofbeingulcerfree,comparedwith61 % in the controlgroup and these results are more evidentto show the importanceoffootcareeducationinpreventionoffootulcer.[45]

Thestudywasconductedretrospectivetoevaluatetheselfcarebehavior onfootcareamong302diabeticclientsinTaiwan.155patientsreceivedgroup educationonfootcare,147patientsdidnotreceiveanyeducationboththegroup had showed inappropriateselfcarebehavioronfootcarethestudyresults revealedthatgivingdiseasespecificinformationsuchastwiceadayfootwash, avoidingbarefootwalkcanpreventdevelopmentoffootulcer.[46]

Theappliededucationalinterventionhadimprovedtheirknowledgeandpractice aboutdiabeticfootcare(p<001andp+001)Inconclusionthefindingsofthe studyshowedthatasimplefacetofaceeducationisaneffectiveandapplied methodtoimprovetheknowledgeaboutfootcare.[47]

The qualitative study conducted in India to assess the patient perspectivesonfootcomplicationintype2diabetesmellitus8sampleswere selected,mostparticipantswereunawareoffootulcer,causesandpreventive measures,complicationsofdiabeticfoot.Findingsofthestudyconcludedthat peoplewithdiabetichavedifferentbeliefondiabeticfootcomplicationsthat hampersfootselfcarepractices.Sohealthcarepersonnelneedtoexplorethe beliefsunderlyingpatientsfootselfcarepracticestopreventfootulcer.[48]

A studywasconductedamong59diabeticclientsinSanFranciscoto assesstheefficacyofeducationonfootcomplication.Analysisofthedata showed statistically significantincrease in footcare knowledge afterthe teachingsessioncomparedwithbefore.(69%to85%p<.001).studyconcluded thatclientsknowledgeonfootcarewasimprovedafteraneducationprogram.[49]

ACrosssectionalstudywith148diabeticclientstoassesstheknowledge andpracticeoffootcareinIranianpeople.Nonliteratepatientsweretheleast knowledgeable(p=.008),56%notawareoftheeffectofsmokingonthefeet,60% failedtoinspectthefeetand42% didnotknow totrim theirnail,62% were followedthehighriskpractices.Theresultsrevealedthatinadequateknowledge haverelationshipwithpoorselfcareamongIranianpeople.[50]

AcrosssectionalsurveyinChandigarhon60diabeticclientstoassess theexistingknowledgeandpracticeonfootcareandcomplicationofdiabetes mellitus.Thestudyrevealedthatfootcarewasdoneby63.3%,clientoriented

screening footcare education program among 403 diabetic clients in USA. The ulcer incidence was decreased from 66.5% to 43% among the study group after the footcare education program. So the study concluded that foot screening and footcare is effective in reduction of foot ulcer.[52]

CHAPTER IV

METHODOLOGY

bookletprocedure fordata collection tooldevelopmentand plan fordata analysis.

RESEARCHAPPROACH:

Researchapporchusedinthestudywasevaluativeapproach.

RESEARCHDESIGN:

Thereserchdesignadoptedforthepresentstudyispre-experimental design.Onegrouppre-testandposttestdesign.Thedesignchosenforthestudy ispresentedinthefigureas

GROUP:	Pre-test(day1)	Intervention	Post-test(day8)
patientswith Diabeticfoot ulcer.	O_1	X	O2

Key: O_1-Assessmentoflevelofknowledge(pre-test)

X-Informationalbookletonquaityoflifeamongpatientswith Diabeticfootulcer (Intervention)

0_2-Assessmentoflevelofknowledge(posttest)

Bangalore.
VARIABLES

Independentvariable:Theinformationbookletregardingqualityoflifeamong diabeticpatientswithdiabeticfootulceristheindependentvariableinthestudy.

Dependentvariable:Theknowledgeregarding qualityoflifeamong diabetic patientswithdiabeticfootulceristhedependentvariableinthepresentstudy.

EXTRANEOUSVARIABLES:

ItconsistsofDemographicvariablesincludeAgeGenderReligionPlaceofliving OccupationalstatusEducationalstatus,durationofdiabeticmellitus,sourceof information.

POPULATION:

Thepopulationreferedtoasthetargetpopulationwhichrepresentsthe entiregrouporallelementslikeindividualsorobjectstomeetcertaincriteriafor inclusioninthestudy.Thetargetpopulationofthepresentstudyisdiabetic patientswithdiabeticfootulcer.

SAMPLE:

Sampleisasubsetofapopulationselectedtoparticipateinthestudy.the sampleforpresentstudyisdiabeticpatientswithdiabeticfootulcerattending ..... hospitalbangalore.

SAMPLESIZE:

Thesamplesizeconsistsof40diabeticpatientswithdiabeticfootulcer

convenientsamplingtechniquewasadoptedtoelectthesamplesbasedonthe inclusioncriteria.

SAMPLINGCRITERIA

InclusionCriteria:Theschoolteacheswhoare

- Workinginprimaryandupperprimarysection.
- Willingtoparticipateinthestudy.

- Availableduringthetimeofdatacollection.

ExclusionCriteria:

- Arenotinterestedtobeapartofstudy.
- DoesnotunderstandEnglishorKannada.
- Areworkinginhighschool.

SELECTIONANDDEVELOPMENTOFTOOL:

Basedontheobjectivesofthestudy,aself-administeredquestionnaire waspreparedIordertoassesstheknowledgeoftheschoolteachersregarding Dyslexiaanditsmanagementinchlidren.Themainstrengthsbehinddeveloping thetoolwas,relatedreviewofliterature,basedontheopinionsandsuggestionof experts,discussionswithcolleaguesandpersonalexperienceinclinicalsettings, book,journals,internetetc.Allofthem provided releventdatanecessaryto constructthetoolondyslexiaanditsmanagement.

DISCRIPTIONOFTHETOOLUSEDINTHESTUDY:

DEVELOPMENTOFSELFINSTRUCTIONALMODULE

SelfinformalmoduleregardingDiabeticfootulcerwithdiabeticmellites patintsanditsmanagementwasdevelopedbasedonreview ofliterature.The self-instructionalmodule was given forDiabetic footulceritincludes the defination,types,causes,clinicalfeatures,assessment,managementand preventionofDiabeticfootulcer,Attheendofsession,clarificationwasdone.

- Preparationoffirstdraftofinformationbooklet.
- Contentvaliditybyexperts.
- Editingofinformationbooklet.
- Preparationoffinaldraftofinformationbooklet.

TESTINGOFINSTRUMENT:

Contentvalidity:

Contentvalidityofthetoolobtainedonthebasisofopinionfrom different experts inthefieldofdiabeticfootcarepatientsmedicinepaediatricnursing and othernursing department.Necessary changes were made in the structured knowledgequestionnerieandthenthetoolwasfinalized.

Reliability:

Reliabilityoftheresearchinstrumentisdefinedastheextenttowhichthe instrumentyields the result on repeated measures.It is consistency,accurancyprecisionstabilityaquilineandhomogeneity.Thereabelity ofthetoolwasestablishedbyusingsplit-halfmethodandthetoolwasfoundto

footulcerwithdiabeticmellitespatientswererandamelyselectedfrom selected from hospitalandthepre-testisadministeredusingstructuredquestionnarieon knowledgeregardingdiabeticfootulcerwithdiabeticmellitesisadministred usingstructerdquestionnaireonknowledgeregardingDiabeticfootulcerwith diabeticmellitesqualitymanagement.ThentheselfInstructionalModuleisgiven onevaluatethesameday.After7daysthepost-testwasconductedbyusingthe samequestionnarietoevaluatetheeffectivenessofself-Instructionalmodle. Thesubjectedselectedforthepilotstudywerenotincludeinthemainstudy.

PROCEDUREFORDATAANALYSIS:

Inthepresentstudy.dataobtaniedwereanalysedonthebasisofthe objectivesofthestudyusingdescriptiveandinferentailstatististics.Amaster datasheetwaspreparedwithresponsesgivenbysubjects.Descriptivestastics suchasmean,meanpercentage,Standareddeveiationandinferentalstastics suchaspariedt'testandChisquaretestwereusedtoanalyseandinterpretthe data.

SI.NO	STATISTICALANAYSIS		DESCRIPTION
1. DATA	ANALYSIS	METHOD	
	Descriptivestat frequency stastistics	percentage distribution, mean and standard Devitation	Distribution ofDiabeticfoot ulcerpatientsaccording to thedemographivariabelesto assess the knowledge level ofDiabeticfootcarequality anditsmanagement.

		Chisqure	Association of pot-test knowledgescoreofDiabetic footcareulcerwithdiabetic mellitusanditsmanagement their selected demographic variabeles.

SCORE-INTERPRETATION

Eachitem hasanoptionwithonlyonecorrectresponse.Thescoreofone (1)wasallottedtoeachcorrectresponseandascoreofzore(0)wasgivento wrongresponse.Thusthetotalknowledgequestionnariehasaminimum of scorezoreandamaximum ofscore35anditusedfortheassessmentof knowledgeinpreandpost-test.

FINALSCORING

Knowledgequestionnariearesubdivideunderfollowingaspects:

Levelofknowledge	Score
Inadequateknowledge	
Moderateknowledge	
Adwquateknowledge	

ETHICALCONSIDARATION:

Consentwasobtainedfrom thesamplethosewhoarewillingto participateinthestudy.

SCORE-INTERPITATION
Eachitem has

SAMPLINGCRITERIA

Inclusivecriteria:Theclients

1. Whoarediagnosedasdiabeteswithfootulcerbetweentheagegroup35to65 years.

2. WhocanunderstandKannadaandEnglish

3.Whoarewillingtoparticipateinthestudy.
Exclusivecriteria:

1. Whoarelessthan35andmorethan65years.

2.Whohaveotherco-morbidities.

3. Whoarenotwillingtoparticipateinthestudy

CHAPTER-VI
RESULTS

Analysis is the process of categorizing,orderingmanipulating and summarisingthedatainanswerstoresearchquestions.Thepurposeofanalysis istoreducedatatoindelibleandinterpretablefrom therelationsofreserarch problemsofresearchproblemscanbestudiedandtested.

Thechapterdealwiththesystematicpresentationoftheanalyseddata followedbytheintrpretionofthedata.Thecollectedinformationisorganized, tabulated,analysedandintrpretedusingdescriptiveandinferentialstatistics. Basedontheobjectivesoftheobjectivesofthestudy,thefindingwereorganised inthefollowingsections.

OBJECTIVES

- To associate the levelofknowledge regarding qualityoflife among diabeticpatientswithdiabeticfootulcerwiththeirselecteddemographic variables

Prasentationofdata

Theanalyseddatahasbeenorganisedandpresentedinthefollowingsections.
Section1:Dealtwithsociodemographicvariabelsofdiabeticpatients

Section2:Dealtwithlevelofknowledgeregardingqualityoflifeamongdiabetic patientswithdiabeticfootulcer.

Section3:Dealtwitheffectivenessofinformationalbookletregarding qualityof lifeamongdiabeticpatientswithdiabeticfootulcer.

Section4:Dealtwithassociationbetweenpost-testknowledgescoresofdiabetic patientswithdiabeticfootulcerwiththeirselectedsociodemographicvariables.

SECTION-A

SOCIODEMOGRAPHICVARIABELSOFDAIBETICPATIENTSWITHDIABETIC FOOTULCER

Distributionofsampleofaccordingtoage.

N=40

Sl. No	Variable	Frequency(F)	Precentage%
1	Ageinyears		
	a.35-45years	22	55%
	b.45-5years	14	35%
	c.55-65years	04	10%

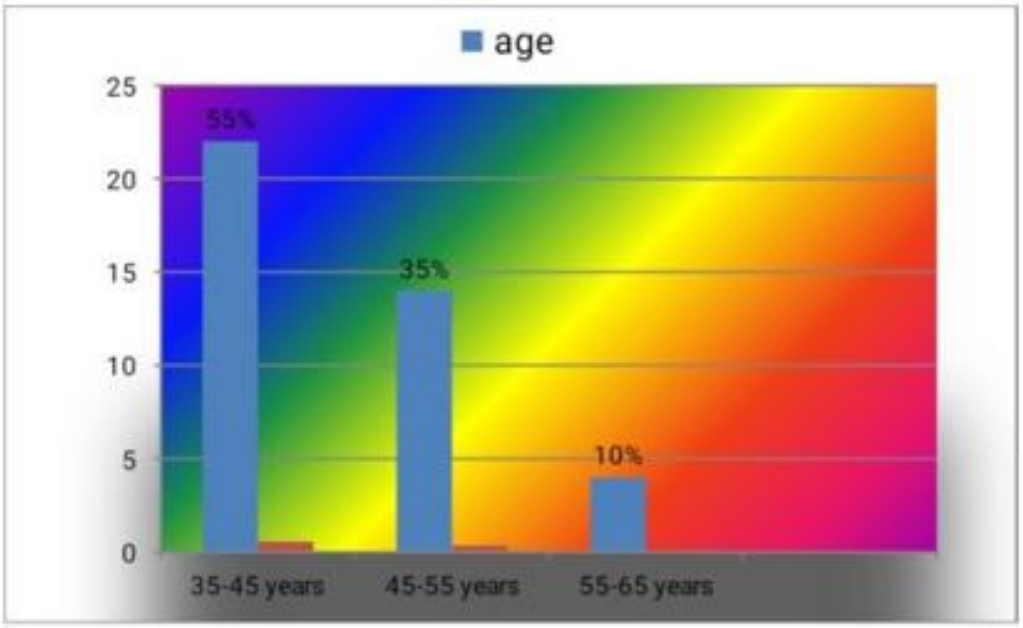


Figure2:Bardiagram showingthedistrubutionofsampleaccordingtoage

Distrubutionofsampleaccordingtogender

N=40

Sl.NO	Variable	Frequency(F)	Percentage(%)
2	Gender		
	a.Female	12	30%
	b.Male	28	70%

Table2:Theabovetableshowsthegenderofdiabeticpatientswithdaibeticfoot ulcermajority28(70%)weremaleand12(30%)werefemales

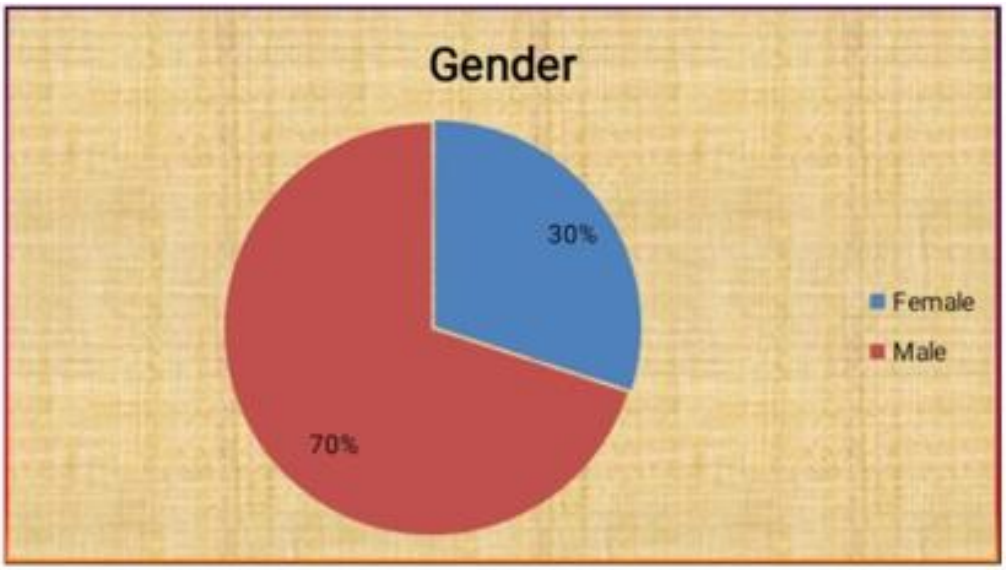


Figure:PaiDiagram showingthedistributionofsampleaccordingtogender

Distrubutionofsampleaccordingtoreligion.

N=40

Sl.NO	Variabels	Frequency(F)	Percentage%
3	Religion		
	a)Hindu	10	25%
	b)Muslim	17	42%
	c)Christian	13	32%

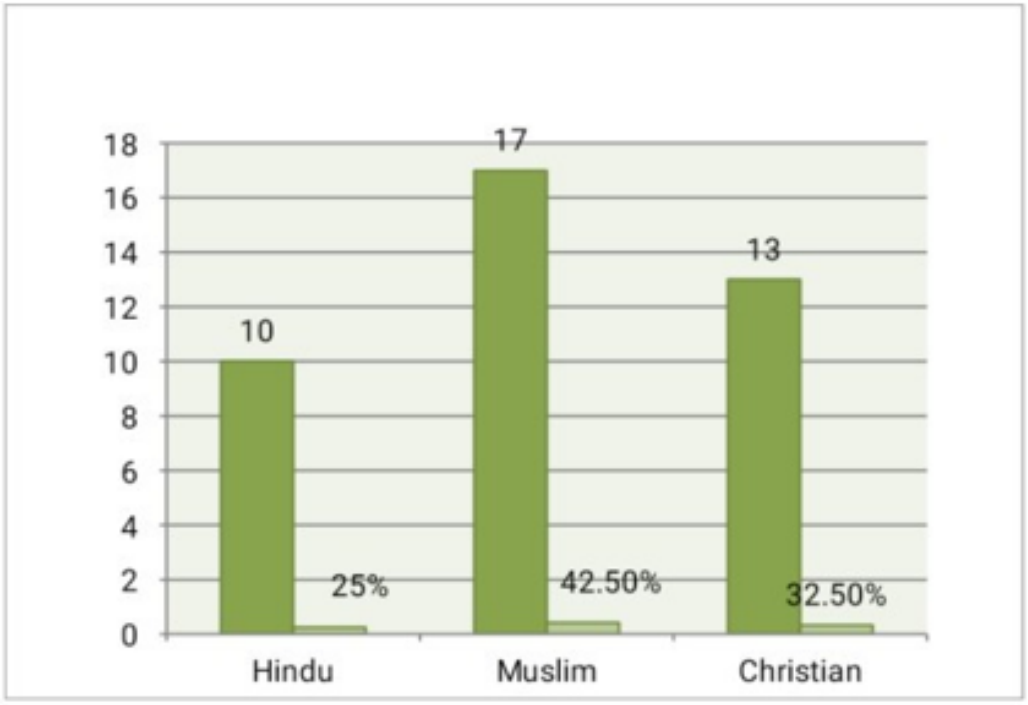


Figure3:Bardiagram showingthedistrubutionofsampleaccordingtoreligion.

DistrubutionofsampleaccordingtoPlaceofliving

N=40

Sl.NO	Variabels	Frequency(F)	Percentages
4	Placeofliving a. Urbanaera	20	50%

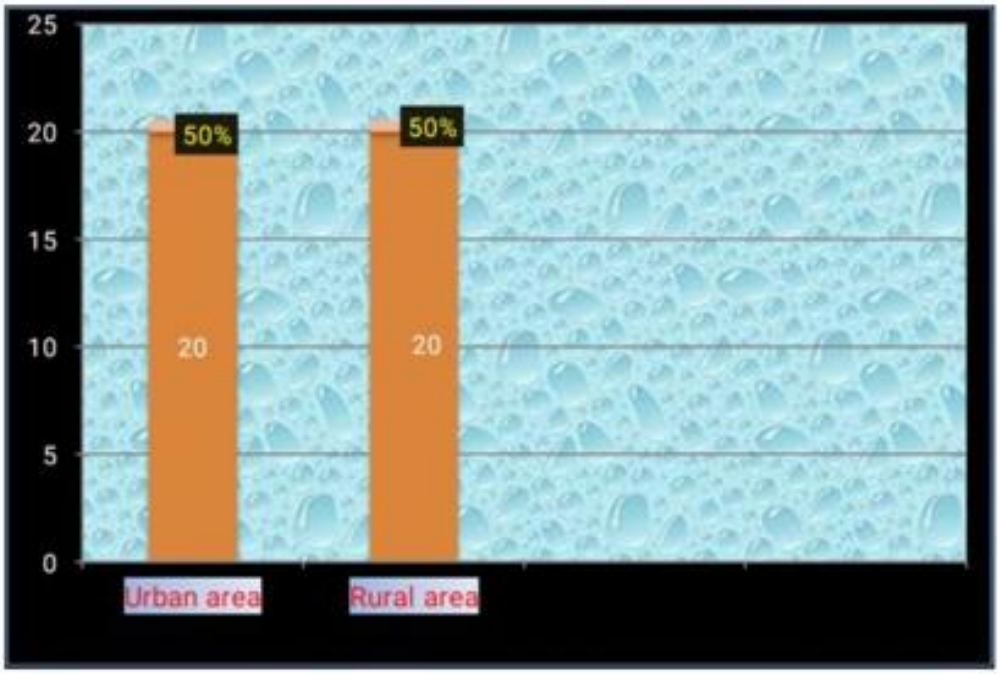


Figure3:Bardiagram showingthedistrubutionofsampleaccordingtoplaceof living

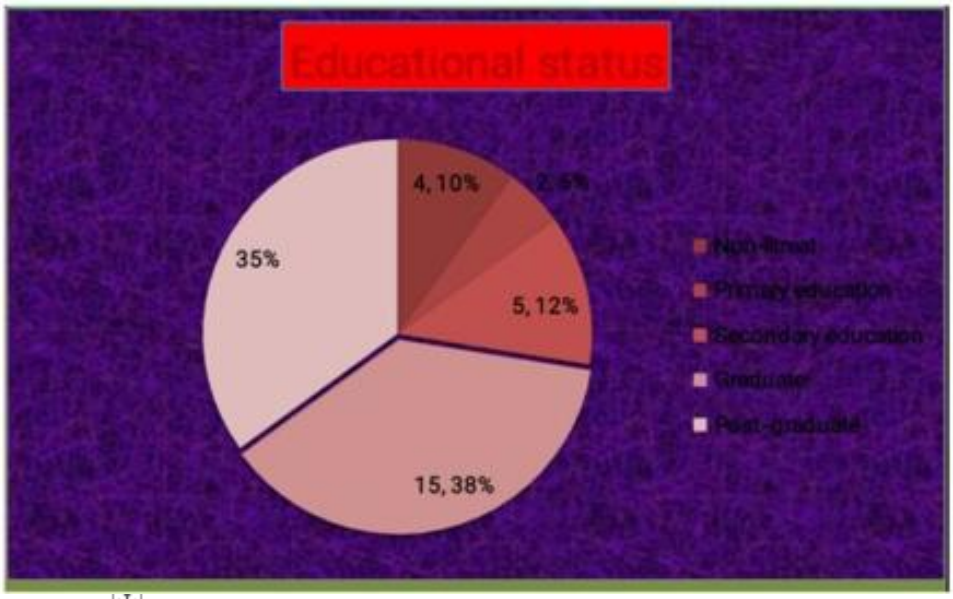
DistributionofsampleaccordingtoEducationalstatus.

N=40

Sl.NO	variables	Frequency	Percentage%

5	Educationalstatus		
	a.Nonliterate	04	10%
	b.Primaryeducation	02	5%
	c.Graduate	05	12.5%
	d.Post-graduate	15	37%

Table6:showsthedistrubutionofsampleaccordingtotheir EducationalStatus, majority15(37%)completed Post-graduationnonlitreat04(10%)12(5%)4(10%) werenonliteratesand 02(5%)completedprimaryeducation.



N=40

Sl.NO	variable	Frequency(F)	Percentages(%)
6	Occupationalstatus		
	a.self-employeed	8	20
	b.Private-employee	8	20
	c.Govt-employee	12	30
	d.Bussiness	12	30

Table7: showsthedistrubutionofsampleaccordingtotheir occupational Status ,majority12(30%),12(30%), belongs to governmentand bussiness employees,and8(20%),8(20%)belongstoselfandprivateemployees.

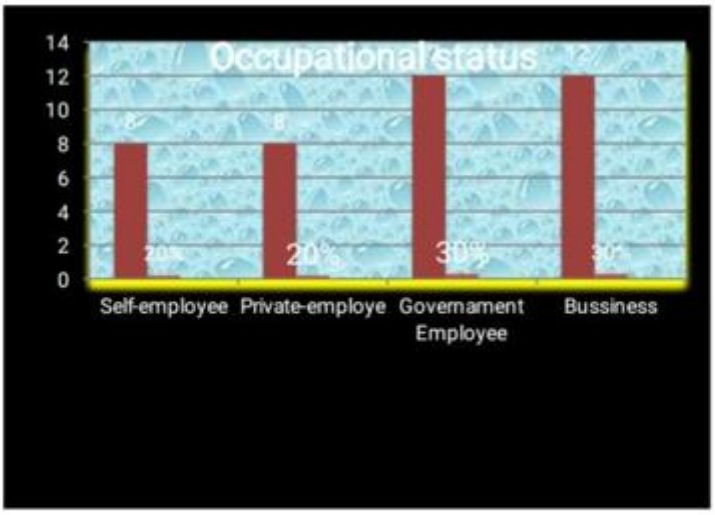


Figure 7:cone diagram showing the distrubution ofsample according to their occupationalStatus.

DistrubutionofsampleaccordingtothedurationofDiabeticmellitus

S.NO	variable	Frequency(F)	Percentag%
7	DurationofDiabeticmellitus		
	a.Lessthan5years	19	47.5%
	b.Morethan5years	21	52.5%

Table8:showsthedistrubutionofsampleaccordingtodurationofDiabetic mellitus, majority21(52%)hadhistoryofdiabetesmorethan5yearsand19(47%)hadhistoryof diabeteslessthan5years.

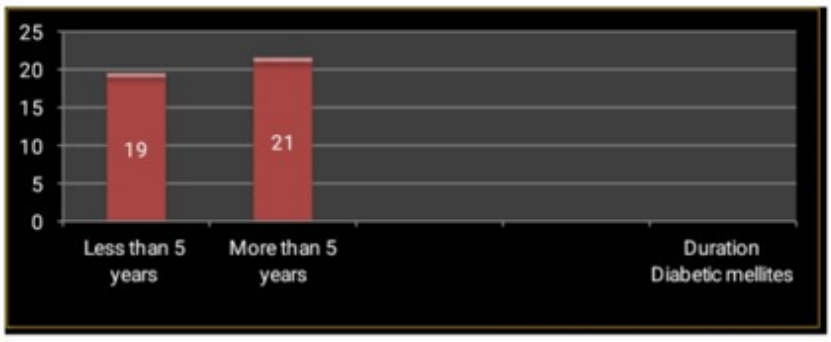


Figure8:cone diagram showingthedistrubutionofsampleaccordingtodurationof Diabeticmellitus.

Distributionofsampleaccordingtosourceofinformationabout Diabeticfootulcerand itsmanagement.

s.no	variable	frequency	Percentage(%)
8	Sourceofinformation		
a.	Familyandfriends	06	15%
b	Massmedia	13	32.5%
c	Healthpersonnel	21	52.5%

Table9:showsthedistrubutionofsampleaccordingtosourceofinformation,majority 21(52%)had received information from Health personnel,13(32.5%)had received information from Massmedia,06(15%)had received informationfrom Familyand friends.

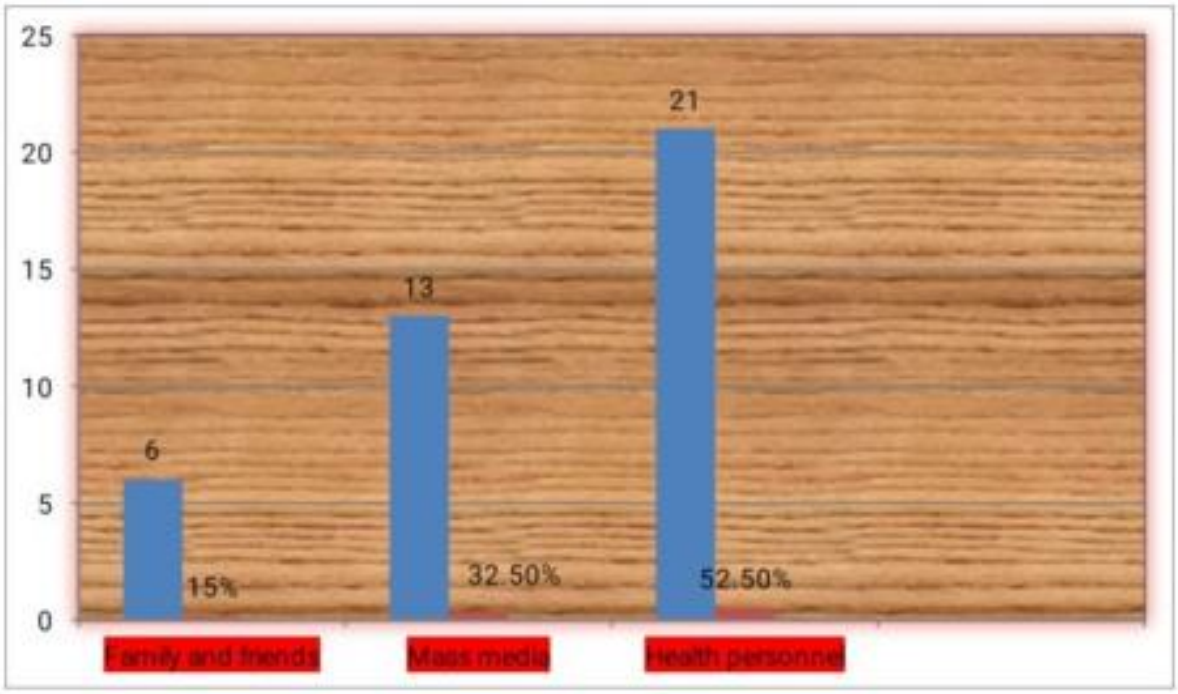


Figure9:Bar diagram showingthedistrubutionofsampleaccordingtosourceof informationaboutDiabeticfootulceranditsmanagement.

CHAPTER VI
DISCUSSION

The discussion section devoted to the thoughtfulinsightfulanalysis ofthe finding,leadingtoadisscussionoftheirclinicalandtheoreticalutility.Thepresentstudy was designed to "assess the effectiveness ofself-introductionalmodule on the knowledgeandqualityofdiabeticfootulceranditsmanagementinselectedhospital".

OBJECTIVES:

- Toassessthelevelof knowledgeregardingdiabeticfootulcerandits managementinamongdiabeticpatients.
- To evaluate the effectiveness ofselfinstructionalModule regarding scoresofamongdiabeticfootulceranditsmanagement.
- To find outthe association between post-testknowledge scores of Diabeticfootulcerregardingitsmanagementamongpatientswiththir selected.

Inthisstudyanevaluativeresearchapporchwasused.Theresearchdesign selectedforthestudywaspreexperimentalonegrouppre-testdesign.Theindependent variable was self-intructionalmodule and dependentvariable was knowledge of primarydiabeticfootulcer.Thesampleofthisstudycomprisedof40from selected hospital.Nonprobabilityconvientsamplingtechniquewasusedtodrawthesamplefor thestudy.Theobtaineddatawasanalysedintermsofusingdescriptiveandinferential statistics.

Thefindinghavebeenorganisedunderthefollowingsections:

Section 3:Association between pos -testknowledge score and seleccted demographicvariablesofdiabeticfoottulcer.

Section1:Diabeticfootulcervariablesofsamples:

Thedistrubtionofsamplesaccordingstothediabeticfootulcer

-Theageofdiabeticfootulcermajority26(43.3)wereinthegroupof35-45years 18(30%)wereinagegroup45-55years10(16%)wereinagegroup55-65years6(10%) wereintheagegroup andaboveandabove.

-Regardingthediabeticfootulcermaority48(80%)werefemalesand 12(20%) weremales.

-Regarding the DIABETIC FOOT ULCERmajority 34(56%)were from nucler family,24(40%)werefrom thediabeticfootanditsmanagementextended.

-RegardingtheDiabeticmellitusfootulcermajority34(56.7)belongstoHindu Religion13(21.7%)belongstoChristianand7(11.7%)belongstoMuslim religionand 6(10%)belongstootherreligion.

-Regarding the Educationalstatus of Diabeticmellitusfootulcer24(40%) completedGraduateandpost-graduate.

-Regardingthesourceofinformationon Diabeticfootulceranditsmanagement indiabeticmellitus42(70%)majoritrecivedinformationfrom electronicmediaand 14(23.3%)receviedinformationfrom theprintmediaand4(6.7%)recivedinformation from thehealthpersonnel.

-Regarding the Diabetic footulcerconducted among the patients 30(50%) respondedYesand30(50%) respendedYes.

Section2:KnowledgeofDiabeticfootulcerandqualityanditmanagement regardingdiabeticmellitus.

Itsrevealsthatthemajority35(58.3%)had moderatelyadequateknowledge 25(41.6%)had inadequateknowledgeandnoneofthem hadadequateknowledgeinpre-testandafterthedeliveryofself-instructionalmoduleondiabetic footulcerandits managementthere isanincreseinthelevelofknowledgeamongDiabeticmellitus footcareinpost-testmajority57(5%)hadadequqteknowledge3(5%)hadmoderate knowledgeandnoneofthem hadinadequateknowledge.

Section3:Associationbetweenpost-testlevelofknowledgescoresandselected demographicvariabelesofDiabeticfootulcercareandqualitymanagement.

Thestudyshowsthatthereisasignifientassociationbetweenpost-testlevelof knowledgeregardingDiabeticfootulcerwithdiabeticpatientsanditsmanagement amongtheirselecteddemographicvariabelssuchasage(3.18*)familytype(4.30*), religion(3.18*),educationalstatu(4.30*).However,itsisfoundthereisnosignificant associationbetweenpost-testlevelofkmowledgeregardingdiabeticfootulcerwith diabeticmellitus amongwiththereselecteddemographicvariabelssuchassourceof information(4.30),gender(12.17)malepatients(12.71)andfemela(12.71)at0.005 levelofsignificance.

Thereforethepresentstudyissupportedwithsimilarstudy"Astudytoassess theeffectivenessofstructuredteachingprogram onlerningdisabilitiesamongDiabetic footulcerwithdiabeticmellituscareknowledgequalityinselectedhospitalBangalore.

Thesampleselectedforthisstudyareteachingworkinginselectedhospital.The sampleofthisstudyconsistsof 40who intheage35-45years inthepresent 39.53 respectively with the obtained t'value of25.779 was found to be highly significantatthelevelofp<0.001.Itmeansthereissignificantdifferencebetweenpre-testandpost-testknowledgeofschoolteachersregardinglearningdisability.Findings revealedthattherewasastatisticallysignificantassociationbetweentheknowledge scoresofwitheducationalstatus,numberofchildrenatthelevelofp<0.05.Andnot significantassociation atthe levelofp<0.05.Hence,as a whole,the research hypothesisstatedthattherewillbesignificantassociationbetweentheknowledge scoresofDiabeticfootulcerregardinglearningdisabilitieswithselecteddemographic variableswasaccepted.

CHAPTER VI
DISCUSSION

The discussion section devoted to the thoughtfulinsightfulanalysis ofthe finding,leadingtoadisscussionoftheirclinicalandtheoreticalutility.Thepresentstudy was designed to "assess the effectiveness ofself-introductionalmodule on the knowledgeandqualityofdiabeticfootulceranditsmanagementinselectedhospital".

OBJECTIVES:

- Toassessthelevelof knowledgeregardingdiabeticfootulcerandits managementinamongdiabeticpatients.
- To evaluate the effectiveness ofselfinstructionalModule regarding scoresofamongdiabeticfootulceranditsmanagement.
- To find outthe association between post-testknowledge scores of Diabeticfootulcerregardingitsmanagementamongpatientswiththir selected.

Inthisstudyanevaluativeresearchapporchwasused.Theresearchdesign statistics.

Thefindinghavebeenorganisedunderthefollowingsections:
Section1:DemographicvariablesofDiabeticfootulcers.

Section 2:levelof knowledge of Diabetic foot ulcer regarding and its managementinHospital.

Section 3:Association between pos -testknowledge score and seleccted demographicvariablesofdiabeticfoottulcer.

Section1:Diabeticfootulcervariablesofsamples:

Thedistrubtionofsamplesaccordingstothediabeticfootulcer

-Theageofdiabeticfootulcermajority26(43.3)wereinthegroupof35-45years 18(30%)wereinagegroup45-55years10(16%)wereinagegroup55-65years6(10%) wereintheagegroup andaboveandabove.

-Regardingthediabeticfootulcermaority48(80%)werefemalesand 12(20%) weremales.

-Regarding the DIABETIC FOOT ULCERmajority 34(56%)were from nucler family,24(40%)werefrom thediabeticfootanditsmanagementextended.

-RegardingtheDiabeticmellitusfootulcermajority34(56.7)belongstoHindu Religion13(21.7%)belongstoChristianand7(11.7%)belongstoMuslim religionand 6(10%)belongstootherreligion.

-Regarding the Educationalstatus of Diabeticmellitusfootulcer24(40%) completedGraduateandpost-graduate.

-Regarding the Diabetic footulcerconducted among the patients 30(50%) respondedYesand30(50%) respendedYes.

-Regardingtheexposuretodemographicdataof Diabeticfootulcerandits managementmajority32(56.3%)respondedNoand28(46.7%)respondedYes.

Section2:KnowledgeofDiabeticfootulcerandqualityanditmanagement regardingdiabeticmellitus.

Itsrevealsthatthemajority35(58.3%)had moderatelyadequateknowledge 25(41.6%)had inadequateknowledgeandnoneofthem hadadequateknowledgeinpre-testandafterthedeliveryofself-instructionalmoduleondiabetic footulcerandits managementthere isanincreseinthelevelofknowledgeamongDiabeticmellitus footcareinpost-testmajority57(5%)hadadequqteknowledge3(5%)hadmoderate knowledgeandnoneofthem hadinadequateknowledge.

Section3:Associationbetweenpost-testlevelofknowledgescoresandselected demographicvariabelesofDiabeticfootulcercareandqualitymanagement.

Thestudyshowsthatthereisasignifientassociationbetweenpost-testlevelof knowledgeregardingDiabeticfootulcerwithdiabeticpatientsanditsmanagement amongtheirselecteddemographicvariabelssuchasage(3.18*)familytype(4.30*), religion(3.18*),educationalstatu(4.30*).However,itsisfoundthereisnosignificant associationbetweenpost-testlevelofkmowledgeregardingdiabeticfootulcerwith diabeticmellitus amongwiththereselecteddemographicvariabelssuchassourceof information(4.30),gender(12.17)malepatients(12.71)andfemela(12.71)at0.005 levelofsignificance.

Thesampleselectedforthisstudyareteachingworkinginselectedhospital.The sampleofthisstudyconsistsof 40who ---- intheage35-45years.inthepresent studyconsists of40diabeticfootulcerwho teachaged35-45years.Inthepresent study,non-probabilitypurposivesamplingtechniqueisused.Findingsrelatedtothe effectivenessofstructured programmeregarding diabeticfootulcerhad thetotal differenceinthemeanofoverallpre-testandpost-testknowledgescorewas19.38and

39.53 respectively with the obtained t'value of25.779 was found to be highly significantatthelevelofp<0.001.Itmeansthereissignificantdifferencebetweenpre-testandpost-testknowledgeofschoolteachersregardinglearningdisability.Findings revealedthattherewasastatisticallysignificantassociationbetweentheknowledge scoresofwitheducationalstatus,numberofchildrenatthelevelofp<0.05.Andnot significantassociation atthe levelofp<0.05.Hence,as a whole,the research hypothesisstatedthattherewillbesignificantassociationbetweentheknowledge scoresofDiabeticfootulcerregardinglearningdisabilitieswithselecteddemographic variableswasaccepted.

CHAPTER-VIII
CONCLUSION

The chapterdeals with conclusion and implicationsand recommendations and limitationsdrawnforthestudy"Astudytoassesstheeffectivenessof Self-instructional Moduleonknowledgeregarding Diabeticfootulcerinpatientswithdiabeticmellitus".

The present study evaluated the effectiveness of self-instructionalmodule on knowledge regarding---------- and followingconclusionsweredrawnonthebasisoffindingsofthestudy.Thefindings showedthatinpre-test----% ofsampleshadmoderatelyadequateknowledge -- % of sampleshadinadequateknowledgeregardingdiabeticfootanditsmanagement.

Inpost-test---% ofsampleshadadequateknowledge ---------- % of samplesmoderately adequateknowledgeand---- ofthem haveinadequateknowledge.Itshowsthatthere issignificantimprovementinknowledgeaftertheself-instructionalmodulewith a mean difference-----.Thepaired t'value obtained was --- atthelevelofp<0.05 significance.

Thenursingpersonnelshouldbepreparedasstakeholdertotakeleadership roleinall levelsofpreventionpromotionandtreatment.Nursesactiveparticipationin---------- byprovidingdirectandindirectcarehelpstoachievethesegoalsofhealthservices.-----

---deficitinknowledgeregarding ---------- indicatetheneedforarrangingsectionsin relatedtopics.

NURSINGADMINISTRATION

Themajorresponsibilityofnurseadministratorsinnursingservicedepartmentisto planandimplementhealthawarenessandeducationprogrammesregarding-------- and itsmanagementinpatientswithdiabetesmellitus.

NURSINGEDUCATION

Nuursingcurricuulum isameasureformotivatingthestudentstohuntforknowledge equips nurses with essentialknowledge ,skillforprevention ,promotion ,early detectionandmanagementofillness.----------areimportantin----------

---------. ----------clavanimportantinthecareofsuchpatients ----------should begivennecessarytheoreticalandpracticalknowledgeon-------- andhow toutilize otherprofessionalslike---------in healthcare.Curriculum shouldgiveadditionalin developingcommunicationskillofthe ---------- nursesforthebetterutilizationofavailable resources.

NURSINGRESEARCH

Researcherfound ----------.So the investigatorrecommendsconductingperiodicresearchonchildhooddisordersandrole ofnurses.

SUGGESTIONSFORFURTHERSTUDY

- Asimilarstudycanbeundertakenonalargerscaleformakingamorevalid generalisation.
- Acomparativestudycanbearrangedamong ---------- -.
- Astudycanbedonetoanalysethepracticeof ------ towardsdiabeticpatients.

theinclusionofmorepracticalknowledgeregarding ---------- andits managementindiabeticpatieents.

- Periodiccassessmentof --------- sknowledgeregardinghealthrelatedproblems tobeconducted.
- A studycanbecarriedouttoevaluatetheefficiencyofvariousteaching strategies like pamphlets,learning module,leaflets and computerassisted instructionon ---------- anditsmanagement.
- Astudycanbeconductedamong----------on----------
- Aconcentratedstudyshouldbemadetoincreasetheawarenessamongthe------ ---------regardingtheirrolein ---------- programmes.
- Arrangeanorientationprogrammefor----------in---------- PROJECTEDOUTCOMES

Thepresentstudyshowsthatthrough----------possessed ---------- knowledge,skilland practiceinmanagingdiabeticpatients.Basedontheassessment,theresearchers preparedalearningmodulewhichexplainsthemeaning,---- ,andcauses,management andpreventionofdiabeticfootandidentificationofdiabeticfoot.Thiscanbeusefulto allthosewhoarehandlingdiabeticpatients.

CHAPTER-VIII

SUMMARY

Themainaim ofthestudywastoassesstheknowledgeofprimaryschool teachersregardingdyslexiaanditsmanagementinchildren.italsoaimedfindingout theassociationbetweenknowledgescoresofprimarychoolteacherswithselected sociodemographicvariables.themainstudywasconductedinthreeselectedschools inBangalore.

Theresurchdesign adoptedforthestudywaspre-experimentaldesign.the instrumentdevelopedandusedforthepresentstudyisselfadministeredquestionnaire, consistof2actions.

Section1demographicvariablesconsistof08items.

Section2structuredknowledgequestionnaireconsistof30items.

Non-probabilityconvenientsamplingtechniquewasusedtodrawthesamplefor thestudy.Aconceptualframeworkisan analogoustoframeofahouse,justasthe foundationsupportahouseatheoriticalframeworkprovidesarationalforpredictions abouttherelationshipamongvariabelesofareserchstudy.Aconceptualframework usedinthestudyisbasedonmodifiedLudwigVonBertalanffygeneralsystem theory.

The tool developed and used for data collection was self-administred questionnarie.The toolvalidated by experts from differentmedicaland nursing deparmentsanditswasfoundtobereliableandfeasible.Pilotstudywasconductedas apart of major study and the tool prove to be comprehensivefeasible and acceptable.Datacollectionprocedurebeganafterobtainingpermissionfrom hospital andconsentfrom hospital.Theinvestigatorpersonallyexplinedtheneedandassyred theconfidentialityoftheirresponses.

The data gadared was analysed and interpreted according to objectives.Descriptivestasticswereandstandreddeviationandinferentialstastistis

includepairedttest,Chisqure(X^2)Testtotesthypothesisatdifferentlevelofsinificace anddataobtainedarepresentedingrahhicalfrom.

Findingrelatedtodemographicvariabeles

- Regardingthetypeofreligionmajority---Diabeticfootulcerwithdiabetic mellituspatientsfrom religion.

- RegardingtheEducationalstatusmajority --- completedgraduateand post-graduate.

- Withregardtothesourceofinformationstatus --- onDiabeticfootulcer withdiabeticmellituspatients

- Regardingtheoccupationalstatusconductedamongthe Diabeticfoot ulcerwithdiabeticmellitus------

- Regarding theDurationof Diabeteticmellitusaming theDemographic variabels-----respondedyesand ----respondedNoDiabeticfootulcerwith diabeticmellituspatients

- Among40Diabeticfootulcerwithdiabeticmellituspatientsmajority---- responded no the exposure to the exposureDiabetic footulcerwith diabeticmellituspatientsanditsmanagement.

Findingrelatedtoknowledgescoresof Diabeticfootulcerwithdiabetic mellitus:

Itrevelsthatthemajority --- Diabeticfootulcerwithdiabeticmellitus patientsmajorityhadadequateknowledge----hadinadequateknowledge inpre-testandafterthedeliveryofself-instructionalmoduleonDiabetic footulcerwithdiabeticmellituspatientsanditsmanagementthereisan increseinthelevelofknowledgeamongDemographcvariabelesinpost-testmajority----hadadequateknowledge ---hadmoderateandthem had inadequateknowledge.

selected demographic variables such as age ---gender----religion---- educationalstatus ----- astheirobtainedChisqurevalueisgreaterthan tabulatedt'value.However,itisfoundthereisnosignificantassociation between post-test knowledge score regarding knowledge scores regardingDiabeticfootulcerwithdiabeticmellitusqualityknowledgeand its management among patients with their selected demographic variablessuchsourceofinformation---genger -- Dibeticmellituspatients

---andexposureto ---------- astheirobtainedChi-squrevalueislesserthanthe tabulatedt'value.

EdinburghLivingstonecompanyPhiladelphia,1995.page.805-815.

3. A.K.JAIN (2002)ANOTOMYANDPHYSIOLOGY.ARYAPublisherssecondedition page191-192.213-215.

4. Brunnerandsuddharths"TEXTBOOKOFMEDICALANDSURGICALNURSING,9th edition,LippincottCompany,Philadelphia,2004.page1285-1286.

5. Joyce M Black.MEDICAL AND SURGICAL NURSING.clinicalmanagementfor positiveoutcomes.A HalcourtHealthsciences,W.B.sounderscompany.142-146.

6. WilmaJPhipps,BarbaraCLong,Nancyfugatewoods.ShaffersMedicalsurgical nursing,7thedition,2000,B.I.publicationsPvtltd,NewDelhi.:511-525.

7. FloodLisa,Constance,Ann.AmericanJournalofNursing:Features:Continuing Education,Diabetes&ExerciseSafety,June2002-Volume102-Issue6:47-56

8. www.rnao.org/Storage/11/536_BPG_Assessment_Foot_Ulcer.pdf

9. F.A Davis (2005) text book of medical surgical nursingJ.B.Lippincott publications,6thedition.Pageno135-136.

10. Sureka RaniH,MadhaviG,Ramachandra Rao.Risk factors ofcoronaryheart diseaseintypeIIdiabetesmellituspatients.Indianjournalofclinicalbiochemistry. 2005,Feb20(2):75-80.

11. World health organization fact sheet. Diabetes. Available from URL:http://www.who.int.

12. MelbaSheiladesouza,K.subrahmanyanairy.Healthpromotingbehavioursand qualityoflifeamongadultswithDiabetesmellitus(Improvedafternursedirected interventions).NightingaleNursingtimes.2008March;3(12):17.

13. DavisTM,PhilD,StrongJA,Bloom SR.Complianceindiabetesmellitus:Aself-assessmentstudy.Journalofpracticaldiabetes.2006July75(7):84-85.

14. JagdishTK,ShettyKJ.studyofNeuropathiccomplicationsindiabetesmellitus. Medicaljournalarmedforcesindia.1990oct.46.

typeIIdiabetesmellitus.JournalofDiabetesUK.2001Nov48(11):281-283

17. AgrawalRP,SharmaP,PalM,KocharA,KocharDK.Magnitudeofdyslipedemia anditsassociationwithmicroandmacrovascularcomplicationsintypeIIdiabetes. JournalofDiabeticResearchandClinicalPractice.2006Aug73(2):211-4.

18. RachmaniR,LeviZ,AvinM,RavidM. Teachingofpatienttomonitortherisk factorsandretardtheprogressofvascularcomplicationsinhighriskpatientswith typeIIdiabetesmellitus.JournalofDiabetesUK.2001Nov48(11):281-283.,

19. http://www.emedicinehealth.com/anatomy_of_the_endocrine_system/article_em.

20. LakerveldJ,BotSD,Chinapaw MJ,vanTulderMW,vanOppenP,DekkerJM. Primarypreventionofdiabetesmellitustype2andcardiovasculardiseasesusinga cognitivebehaviorprogram aimedatlifestylechangesinpeopleatrisk:Designofa randomizedcontrolledtrial. BMCEndocrine Disorders.2008June24;8:6

21. VangA,SinghPN,LeeJW,HaddadEH,BrinegarCH.Meats,processedmeats, obesity,weightgain and occurrenceofdiabetesamong adults:findingsfrom AdventistHealthStudies.AnnalsNutritionandMetabolism.2008;52(2):96-04.

22. .http://en.wikipedia.org/wiki/Pancreas

23.http://en.wikipedia.org/wiki/Diabetes_control_and_complications_trial

24. American Diabetes Association.Nationaldiabetes factsheet.Available at: http://www.diabetes.org/utils/printthispage.jsp?PageID=STATISTICS_233193. AccessedMarch14,2005.

25. http://www.who.int/topics/diabeticcomplications

26. http://www.nat14.RemaM,PonnaiyaM,MohanV.Prevalenceofretinopathyin noninsulindependentdiabetesMellitusatadiabetescentreinsouthernIndia. DiabetesResearchandClinicalPractice.196;34:29-36

27. http://my.clevelandclinic.org/disorders/diabetes_mellitus/hic_preventing_the_com plicatns_of_diabetes.aspx

30. ShaibiGQ,GoranMI.Examiningmetabolicsyndromedefinitionsinoverweight Hispanicyouth:afocusoninsulinresistance.TheJournalofPediatrics.2008 Febuary;152(2):171-76.

31. RayJG,MohllajeeAP,vanDam RM,MichelsKB.Breastsizeandriskoftype2 diabetes mellitus.Canadian MedicalAssociation Journal.2008 January 29; 178(3):313-15.

32. Maty SC,Lynch JW,Raghunathan TE,Kaplan GA.Childhood socioeconomic position,gender,adultbodymassindex,andincidenceoftype2diabetesmellitus over34yearsintheAlamedaCountyStudy.AmericanJournalofPublicHealth. 2008August;98(8):1486-494.

33. T.Haas,S.Svacina,J.Pav,R.Hovorka,P.Sucharda,J.Sonka.Riskcalculationof type2diabetes.ComputerMethodsandProgramsinBiomedicine. 1994January; 41(3-4):297-03.

34. SayeedMA,MahtabH,Khanam PA,LatifZA,BanuA,KhanAK.Prevalenceof diabetes and impaired fasting glucose in urban population ofBangladesh. BangladeshMedicalResearchCouncilBulletin.2007April;33(1):1-12.

35. Um HD,LeeDC,LeeSY,Kim YS.Aprospectivecohortstudyofexerciseandthe incidence oftype 2 diabetes in impaired fasting glucose group.Journalof PreventiveMedicineandPublicHealth.2008January;41(1):45-50

36. AshleyM Ford.(2006)TrendsinDiabetesResearch.NewYork:Novapublication

37. BareGBrenda.,&SmeltzerCSuzanne.(2008).BrunnerandSuddharthsTextbook ofMedicalandSurgicalNursing.Philadelphia:J.B.LippincottCompany.

38. Basavanthappa,B.T.(2007).MedicalSurgicalNursing.NewDelhi:JaypeeBrothers MedicalPublishers.

42. BettyM Johnson.,& PamelaB Webber.(2005).Anintroductiontotheoryand reasoninginnursing.USA:LippincottWilliamsandWilkins.

43. Black M Joyce. (2009). Luckmann and Sorensons Medical Surgical Nursing-psychophysiologicapproach.Philadelphia:W BSaundersCompany.

44. BarnettHAnthony.(2006).Obesityanddiabetes.LondonElsevierpublication

45. BraunWaldE.,Fauci.,Kasper.,Hauser.(2007).HarrisonsPrinciplesofInternal Medicine.Vol1.NewYork:McGrawHill.

46. ChristensenLBarbara.,&KockrowElaine.(1995).FoundationofNursing.St.Louis: MosbyCompany.

47. CravenRuth.,&HirnleConstance.(2003).FundamentalsofNursing:Humanhealth andfunction.Philadelphia:LippincottWilliams&Wilkins.

48. 13.Dimariofridi.,leonetijohn.(2001).Diabetesinthenewmillennium.USA:wiley& sonslimited.61

49. Doris Smith Suddarth.(1991).The Lippincott Manualof Nursing practice. Philadelphia:J.B.LippincottCompany.

50. Edwards,R.W.,Christopher.,etal.(1991).DavidsonPrinciplesandPracticeof Medicine.HongKong:ELBSedition.

51. FawcettJacqueline.(1984).Analysisand Evaluation ofConceptualmodelsof Nursing.Philadelphia:T.A.DavisCompany.

52. GeriLeBindoWood&JudithHaber.(1990).Nursingresearchmethods,critical appraisalandutilization.Toronto:CVMosbyCompany.

Application.Maryland:ApprenticeHallPublisher.

56. John pickup & Gareth William.(2003)TextBook ofDiabetes.UK:black well publication.

57. KozierBarbara.,etal.(2000).FundamentalsofNursingConceptsandProcess. NewYork:AddisonWesley.

58. .Kumar&Clark.(2009)ClinicalMedicine.NewDelhi:JayPeePublication.

59. Lewis L.Sharon.,etal.(2007).MedicalSurgicalNursing -Assessmentand managementofclinicalproblems.St.Louis:MosbyCompany.

60. Levin&O'Neal's.(2008)Thediabeticfoot.USA:MosbyElsevier.

61. Mahajan.B.K.(2005).Methods in Biostatistics.New Delhi:Jaypee Brothers Publishers.

62. .NancyBurns.(2009).ThePracticeofNursing Research.Missouri:Saunders publication.

63. NickRColledge.(2010).DavidsonPrinciplesandPracticeofMedicine.USA:Mosby Elsevier.

64. Phipps.(2007).MedicalSurgicalNursingConceptsandClinicalPractice.Baltimore: Mosby62

65. Pollit.F.Denise.,&Hungler,P.Bernadette.(2011).NursingResearchPrinciplesand Methods.Philadelphia:J.BLippincottCompany.