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1. A study to Assess the Knowledge Regarding the Care of Patients on Mechanical Ventilation and Prevention of VAP among Nursing Students of a Selected Nursing College ............................................... 1
   A S Saritha

2. A Study on Job Satisfaction among Employees in Quick Service Restaurants ............................................ 5
   A. Arun, J. Yuvaraj, A. Wilfred Lawrence

   Binsy Mathew, Abi M Thomas, Rajesh kumar

4. A Study on Determinants of Agricultural Productivity in Tamilnadu ............................................................. 14
   C. K. Gomathi, S. N. Sugumar

5. Susceptibility of Gender Entrepreneurship Gap in India–A Preview ............................................................. 18
   Chandrachud. S, S. N. Sugumar, S. Thangamayan, S. Sudha

6. Analysis of Medical Tourism and its Economic Impact ............................................................................. 21
   MS. J. Revathi, S. Jansi Rani

7. Occurrence of Menstrual Irregularities among Adolescent Girls in Selected Area, Dehradun, Uttarakhand 27
   Jyoti Kandpal, Mugdha Devi Sharan Sharma, Upma George

8. Mother’s Knowledge on Nutrition and Incidence of Malnutrition ............................................................. 32
   Kalpana Sawane, Sheetal Barde

9. Mortality Pattern amongst Patient Admitted in Tertiary Health Care Center, Rajnandgaon (C.G.) ............... 35
   Harshal Mendhe, Kiran Makade, Dhiraj Bhawnani, Daneshwar Singh

10. Effectiveness of Self-Instructional Module on Knowledge Regarding Post-Partum Psychiatric Disorders 41
    Leeja Bonny Thomas, Anusha Pradhan

11. A Study to Evaluate the Effectiveness of Structured Teaching Programme on Obesity & its Consequences among Adolescents in Selected Private High Schools in Pune ................................................. 47
    Mangesh V. Jabade, Manu Acha Roy

12. Assessment of the Awareness about Effects of Cell Phone Radiations amongst Students at Symbiosis International (Deemed University) Hill Base Campus ........................................................................... 51
    Anshika Nikita Singh, Neeti Sharma, Abhay Saraf, Samir Barve, Yatin Pimple

13. A Study to Estimate the Level of Physical Activity and Perceived Benefits and Barriers to Exercise among Women in Coastal Karnataka ................................................................. 57
    Sneha Deepak Mallya, Pawan Kumar, Sravan Kumar Reddy T, Beulah Sarah James, Asha Kamath
   Ranju Lal, Praamod Pathak, K. R. Chaturvedi, Payel Talukdar

15. Confocal LASER Scanning Microscopy (CLSM) for Evaluation of Endodontic Microflora-A Review ... 69
   Laxmish Mallya, Kundabala M, Vinod Jathanna

16. Effective Recruitment and Selection System for the IT Software Industry in India ............................ 74
   Ramkumar A., Rajini G.

17. A Study on Innovative Recruitment Techniques and It’s Impact on Job Seekers ............................... 79
   Ramkumar A., Rajini G.

18. Emotional Intelligence and Performance of Manager in Manufacturing Industries
   (With special reference to Automobile Industry) ................................................................................ 85
   S. Chandrachud, M. Thaiyalnayaki

19. Mechanically Induced Stump Dermatoses: High Prevalence Concern and Measures of Prevention ........ 88
   Salman Shaikh, Akshay Malhotra

20. A Study on Universal Precautions and Needle Stick Injuries among Nursing Staff in a
    Tertiary Care Hospital, Davangere ........................................................................................................... 93
    Sandhya Rani Javalkar, Sanjana S N

21. Pattern of Employment and Consumption Expenditure in India ......................................................... 98
    S. Jansirani, S. Sudha

22. A Study on Women Domestic Workers in M.g.r.nagar in Kanchipuram District ............................... 103
    S. Jansirani, S. Janifar Vinnarasi

23. Influence of Emotional Intelligence on Employee Performance among Selected Restaurants, Chennai .. 106
    V. Krishna Priya

24. Preferences and Problems of Agri-Based Enterprises of Guntur (A.P., India):
    An Empirical Study of Farmers Advisory Committees Under Atma .................................................. 111
    Vineet Pandey, Fate Bahadur Singh

25. Effects of Strength Training Exercises on Physical Parameters and Quality of Life among Older
    Adults in Selected Geriatric Homes in Kerala, India ............................................................................... 116
    Nisha B S, Dhanyamol K S, Devika Shaji, Rebecca Seguin

26. Study of MRSA and ESBL Organisms Isolated from Infected Wounds .............................................. 121
    Suresh P., V. Sreenivasulu Reddy, V. Praveen Kumar, P. Vamsimuni Krishna

27. Prevalence of Angles Malocclusion Traits in 7-16-Year-old School Children of Mewar Region, India .. 125
    Pradeep Vishnoi, Tarulatha R Shyagali, Prabhuraj Kambalyal, Deepak P Bhayya, Rutvik Trivedi, Jyoti Jingar

28. A Study on Marketing Prospects in Promoting Cultural Tourism in Tamil Nadu ............................... 131
    A. Arun, J. Yuvraj, A. Wilfred Lawrence, Chittaranjan Srivastava

29. An Objective and Subjective Evaluation of Dental Implant Impressions using Vinylsiloxanether and
    Polyether Impression Materials—An in Vivo Study .............................................................................. 135
    Divya Raigangar, Mahesh Mundathaje, Puneeth Hegde, Umesh Pai, Thilak Shetty, Sharon Saldanha, Shobha J Rodrigues
<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Comparison of Serum Calcium Levels in Euthyroid, Subclinical and Overt Hypothyroid Women in the Tribal Belt of West Midnapore, West Bengal</td>
<td>139</td>
</tr>
<tr>
<td>Sanjay Vashisth, Alpana Chhetri</td>
<td></td>
</tr>
<tr>
<td>31. Role of Whistle Blowers in Health Care Industry: An Empirical Study</td>
<td>142</td>
</tr>
<tr>
<td>Aseervatham Achary, Amit Kumar Pandey, Suneel Mago, Jaya Yadav, Sanjeev Bansal</td>
<td></td>
</tr>
<tr>
<td>32. Management of Talons Cusp in a Primary Maxillary Central Incisor: A Rare Case Report</td>
<td>147</td>
</tr>
<tr>
<td>Ellana Jermiah Joseph, Anupama Nayak P, Arathi Rao</td>
<td></td>
</tr>
<tr>
<td>33. Two Way Analysis of GST : With Reference to Healthcare and Pharma Sector</td>
<td>151</td>
</tr>
<tr>
<td>Arun Gautam, Saurabh Sharma</td>
<td></td>
</tr>
<tr>
<td>34. Comparison of Serological Tests in the Diagnosis of Leptospirosis in a Tertiary Care Hospital at Chidambaram, Tamilnadu, India</td>
<td>156</td>
</tr>
<tr>
<td>Balamuruganvelu Singaravelu, Sreenivasalu Reddy V, Saleel V. Maulingkar, Geethavani Babu, S. Kamala kannan</td>
<td></td>
</tr>
<tr>
<td>35. Traditional Use of Medicinal Plants in Puducherry for Treatment of Urinary Tract Disorders</td>
<td>160</td>
</tr>
<tr>
<td>C. Kishore Kumar, R. Vijaya Kumar, R. Sridharan</td>
<td></td>
</tr>
<tr>
<td>36. Awareness of Cervical Cancer among HIV Positive Women in Southern India</td>
<td>165</td>
</tr>
<tr>
<td>Deepak Madi, Parul Gupta</td>
<td></td>
</tr>
<tr>
<td>37. Correlates of Hope and Depression among People Living with Human Immunodeficiency Virus in Chhattisgarh State</td>
<td>170</td>
</tr>
<tr>
<td>Bansh Gopal Singh, Deepak Pandey</td>
<td></td>
</tr>
<tr>
<td>38. Vitamin C Intake Improve the Anthropometric Measurements, Lipid Profile and Atherogenic Indices in Obese and Non Obese Females</td>
<td>177</td>
</tr>
<tr>
<td>Ganesh H. Ghanwat, Ajit V. Sontakke</td>
<td></td>
</tr>
<tr>
<td>39. Effect of Vitamin C Supplementation on Insulin Resistance, β-cell Function and Insulin Sensitivity in Obese and Non Obese Individuals</td>
<td>183</td>
</tr>
<tr>
<td>Ganesh H. Ghanwat, Ajit V. Sontakke</td>
<td></td>
</tr>
<tr>
<td>40. Serum VEGF and TNF-α Correlate Bacterial Burden in Pulmonary Tuberculosis</td>
<td>189</td>
</tr>
<tr>
<td>Harish Bhat, Jeevan G Ambekar, Anand Kumar Harwalkar, Nilima Dongre, Kusal K Das</td>
<td></td>
</tr>
<tr>
<td>41. Online Sales Promotions of Herbal Products and Its Effectiveness towards Tanisha.com</td>
<td>195</td>
</tr>
<tr>
<td>M.Anbarasi, S. Praveen Kumar</td>
<td></td>
</tr>
<tr>
<td>42. Effects of Strength Training Exercises on Physical Parameters and Quality of Life among Older Adults in Selected Geriatric Homes in Kerala, India</td>
<td>201</td>
</tr>
<tr>
<td>Nisha B S, Dhanyamol K S, Devika Shaji, Rebecca Seguin</td>
<td></td>
</tr>
<tr>
<td>43. Impact of Quality of Work Life Dimensions on Organizational Performance: With reference to Jute Industry in Andhra Pradesh and West Bengal, India</td>
<td>206</td>
</tr>
<tr>
<td>K. Hymavathi, K. S. Sekhara Rao</td>
<td></td>
</tr>
<tr>
<td>44. A Study on Customer Preferences on Green Marketing</td>
<td>211</td>
</tr>
<tr>
<td>S. Sayeeda Jabeen, M. Kavitha</td>
<td></td>
</tr>
</tbody>
</table>
45. Why Physician’s Keep Coming Back to Telemedicine: Predicting Using Unsupervised Learning .......... 216
   Preeti Y Shadangi, Manoranjan Dash, Sunil Kar

46. Practicing the Strategies of Interpersonal Conflicts Management in Business Organisations to
   Accede Development and Effectiveness in Personal Health .......................................................... 222
   Mitashree Tripathy, Itishri Sarangi

47. Comparative Performance Analysis of Selected Large Cap Mutual Funds in India ....................... 227
   Mohammed Mujahed Ali

48. Study of Morbidity Pattern among Women Beedi Rollers Residing in Urban Area of Mangalore .... 233
   Nanjesh Kumar S, Sanjeev Badiger, Avin B. R. Alva, Pavan Kumar, Rahul Hedge

49. Perception, Attitude and Practices Regarding Climate Change among College Students in
   Coastal South India ..................................................................................................................... 236
   Rekha Thapar, Bhaskaran Unnikrishnan, Nithin Kumar, Prasanna Mithra, Vaman Kulkarni, Ramesh
   Holla, Darshan Bhagawan

50. Evaluation of Thyroid Hormone Levels Before and After Thyroidectomy ................................ 242
    Arunachala D Edukondalu, Chakradhar. S, Yamuna devi V. R., Prabhakar Reddy E.

51. Impact of Ambidextrous Leadership on Firm Performance: A Study on IT Sector in Hyderabad, India . 247
    Sahyaja Ch., K. S. Sekhara Rao

52. Prevalence of Halitosis among Preclinical Medical and Dental Students .................................... 253
    Runki Saran, Saurabh Kumar, Bharath Rao K, Arul Amalan

53. The Effectiveness of Information, Education and Communication on Knowledge, Attitude, Practice
    Regarding Obesity among Adolescents at Selected Government Schools in Kancheepuram District .... 257
    Shanthi M., C. Kanniammal, Jaideep Mahendra, G. Valli

54. Various Online Marketing and Promotions Strategies to Improve the Validation Towards the
    Organic Products in the Pharmaceutical Sectors ............................................................................. 263
    M. Anbarasi, S. Praveen Kumar

55. Effect of Bidirectional Dyadic Association on Anxiety and Self Esteem among
    Patients Undergoing Mastectomy ................................................................................................. 270
    Sruthi. M, Sr. Nirmala FCC

56. An Empirical Study to Improve the Service Quality for Geriatric Patients in a Tertiary Care Hospital .. 276
    Swathi T M, Khyathi G V

57. Effects of Nudge and Purchase Intention in Online Purchasing of Electronic Products ................... 282
    A. Binu Christeena, S. Preetha

58. Discharge Planning Model with Approach of Method in Improving Patients’ Readiness for
    Discharge in Hospitals .................................................................................................................... 288
    Nurul Jannah, Tintin Sukartini, Abdul Aziz Alimul Hidayat

59. Study of Model Climate Maps Using Geographic Information System (G.I.S) ............................... 293
    Ali Karim Mohamed, Mahmoud Mohammed Al-Shammari, Ali Jabbar Abdullah

60. Impact of Terrorism Act on Child Psychology and Post-Traumatic Stress Disorder .................... 298
    Afkar Fadhil Kareem Al-izzawi
61. The Sociopragmatics of Preaching in an American Christian Sermon ..................................................... 303
   Ahmed Sahib Mubarak, Hawraa Jabbar Rahi

62. The Effectiveness of Extract Klika Sreculiuapopulifolia Cream on the Collagen of Albino
   Mice against Ultraviolet B Radiation ........................................................................................................ 309
   Nur Khairi, Suryani As’ad, Khairuddin Djawad, Gemni Alam

63. *Polymerase Chain Reaction (PCR) Method* for Identification Gene *Escherichia coli* and
   Officer Depot Behavior in Drinking Water Refill ...................................................................................... 315
   Alfina Baharuddin

64. Assessment of Eu-152 Nuclide Contaminated from Radioactive lightning Rods in Soil Samples at
   Kasra and Atash in Baghdad .................................................................................................................... 321
   Suha Hadi Kadhim, Inass Abdulah Zgair, Rukia Jaber Dosh, Leith Hani Rasheed, Ali Abid Abojassim

65. Increased Expression of Interleukin 13 in Iraqi Patients Suffer from Ulcerative Colitis ....................... 326
   Ali J. Eidan, Haider M. Haloob, Kalid N. Alazawy, Ali M. Hasan

66. The Protective Role of Hydatid Cyst against Colorectal Cancers ....................................................... 332
   Asmaa Murtadha Mohammed, Dhamiaa Makki Hamza, Sabah Neamah Mohammed

67. Pulp Response Capped by Brain Derived Neurotrophic Factor (BDNF) ............................................. 337
   Athraa Y. Al-Hijazi, Mukhaleed L Ali, Dhuha M Hasan, Abdulla MW Al-shamma

68. Quality of Food Bacteria in School Snacks and Canteens in East Jakarta Health Office Working
   Area in 2017 ............................................................................................................................................... 341
   Bukroanah Amir Makkau, I Made Djaja, Budi Hartono

69. Borax Content in Foods Sold in a Campus and Its Trader Characteristics ........................................ 346
   Fany Saymona Fauzi, Dewi Susanna

70. The Condition of Sanitation Facilities with *Escherichia coli* Contamination on Food at
   University Cafeteria 2015 .................................................................................................................... 350
   Bellini Simangunsong, Dewi Susanna

71. Method and Frequency of Stethoscope Cleaning among Respiratory Therapists in
   Intensive Care Units at KAMC, Riyadh ........................................................................................................ 354
   Fayz S. Al-Shahry, Fahad Holil Al-Enazi, Nawaf Abdul-alkarim Al-Naam, Saleh Aloraibi

72. Hepatoprotective Effect of Bromelain against Gentamicin-Induced Hepatic Damage in Rats .......... 358
   Hawraa M. Murad, Jawad Kadhim Faris, Hawraa H. Naji, Firas Hussein Kadhim al-bawi, Nadya
   Jamal Ibrahim

73. Acute Appendicitis Versus Ruptured Ovarian Cyst in Female Patients Presented as Acute Abdomen Pain 364
   Wisam Mahmood Aziz, Hayder Adnan Fawzi

74. Effects of Health Promotion Behavior, Self-Esteem and Social Participation Activities on
   Life Satisfaction of Elderly Men ............................................................................................................... 368
   A Reum Lee, Hee Kyung Kim

75. Change of Brief Psychiatric Rating Scale (BPRS) Value with Spiritual Qur’anic Emotional
   Freedom Technique (SQEFT) Therapy on Mental Disorder Patient ...................................................... 374
   Lilin Rosyanti, Indriono Hadi, Jayalangkara Tanra, Asadul Islam, Rosdiana Natzir, Muhammad Nasrurn
   Massi, Faizal idrus, Burhanuddin Bahar
   Il-Hyun Yun

77. A Study on the Effect of Job Performance on Emotional Labor, Career Turnover Intention, Job Stress, Growth Need ................................................................. 385
   Il-Hyun Yun

78. Application of Digital Rubbing Massage in Pain Level, Comfort, and Duration of Labor Phase .......... 391
   Sudirman, Sumarni, Hartati, Hendra M., Ismi Rajiani

79. Using Propensity Score Bootstrapping on Determining the Model of the HIV/AIDS Patients’ Assistance 396
   Mahdalena, Mahpolah, Ismi Rajiani

80. ARCS Module (Attention, Relevance, Confidence, Satisfaction) to Increase Classroom Motivation for Pregnant Women at Public Health Center ........................................ 401
   Agustine Ramie, Mahdalena, Hammad, Ismi Rajiani

81. Interprofessional Education Module in Achieving Ethics/Values, Roles, Responsibilities, Professional Communication Competencies, and Team Collaboration among the College of Health Students ........ 406
   Neny Triana, Ismi Rajiani

82. Anxiety Level of Dental Care among Adolescents in Kepulauan Selayar District  ......................... 409
   Lilies Anggarwati Astuti, Nurnaeni, Faiqah Umar, Hasanuddin Tahir, Asmawati Amin

83. Baby Massage With Common Cold Massage Oil on Temperature Change, Pulse Rate, Frequency of Breath, Sleep Quality and Number of Streptococcus Bacteria in Toddlers with Acute Respiratory Infection ..... 413
   Melyana Nurul W, Fatatu Malikhah, Kusmini Suprihatin, Sutarmi

84. Risk Factors Affecting Attention Deficit Hyperactivity Disorder among Early Childhood in the Agricultural Area in Indonesia .................................................. 417
   Istiklali F., Suwandoono A., Suhartono S., Widyorini E., Saputro D.

85. Maternal and Neonatal Outcomes of Elective and Emergency Cesarean Sections .......................... 422
   Esraa Abdulkareem Mohammed

86. Comorbidities of Phototherapy Used in Neonatal Jaundice in Diyala Governorate, Iraq ................. 428
   Saif Hakeem Tofiq, Kareem Assi Obaid, Mazin Razooqi Mohammed

87. Effect of Thyroid Disorder on Liver Function and Some Immunological Parameters ...................... 433
   Jamela Jouda, Majida G. Maghtoof, Alia Essam Mahmood Alubadi, Youns Atiyah Kamil

88. The Presence of Pathogenic Leptospira sp. in Water Bodies in Klaten District ............................. 439
   Novia Tri Astuti, Mateus Sakundarno Adi, Yuliani Setyaningsih, Martini, Lintang Dian Saraswati

89. Dialectic Unity between Threat and Division Sociological Study .................................................. 444
   Majida Shaker Mahdi

90. Job Demands, Low Back Pain, and Job Crafting Behaviors: A Proposed Framework .................... 449
   Malek Ahmad Al-Natour, Nor Azimah Chew Abdullah

91. “Educational-Staff Knowledge and Attitude towards Antibiotic Use in Technical Institute of Karbala”. 455
   Maytham Salim AL-Nasrawii, Ali abd Al–Latif. G. Mohammed, Mohammad Abdul Baqi Abdul Mohsin, Mohammed A.Merzah
92. Intervention of Sexual Abuse Prevention for Mother of Children with Mental Retardation in Payakumbuh Indonesia 2016 ................................................................. 461
   Meri Neherta, Esthika Ariany Maisa, Yulvika Sari

93. Prenatal Tobacco Exposure and Neonate Birth Weight ........................................... 467
   Mery Ramadani, Budi Utomo

94. Influence of Firm’s Intangible Assets Intensity on Stock Prices Volatility: Evidence from Emerging Market of Pakistan ......................................................... 472
   Muhammad Ramzan Mehar, Huda Tahir, Mariam Nazeer

95. Perception of Job Characteristics and Internal Motivation in Medical Records Staff .................. 478
   Khadije Sadeghi, Roxana Sharifian, Zahra Mahmoodzade Sagheb, Nasrin Shokrpour

96. Influencing Factors and Microbial Agents Which Contribute to Acne among Students from Pathological Analysis Department/Kufa Technical Institute/Al- Najaf Government ......................................................... 484
   Noor Ismeal Nasser, Ahmed Abdul Hasan Mohsin, Thuraya Aamer Hakeeb, Maysoon Khudair Al-Hadrawi

97. Analysis of Factors on Reward System in the Hospital ................................................. 490
   Nursalam Nursalam, Berlian Yuli Saputri, Yanis Kartini, Tintin Sukartini

98. Model Development of Nursing Service Loyalty .......................................................... 495
   Ahsan Ahsan, Pratiwi Y, Nursalam Nursalam, Ferry Efendi

99. Occupational Health Issues Faced by Women in Spinners .......................................... 500
   R.Vetriselvan, Antony Jesu Rajan FSA., Arunkumar N.

100. Association of HLA-DRB1 Alleles with Allergic Asthma and Total Serum IgE Levels in Iraqi Adults Patients ................................................................. 505
    Ali J. Eidan, Raad A. Al-Harmoosh, Zainab J. Hadi

101. The Role of Serum and Follicular IL-1Beta in Predicting the ICSI Outcome in Infertile Women ....... 511
    Rihab Abbas Ali, Sahib Yahya Hasan Al-Murshidi, Dalal Mahdi Al-jarah

102. Factors Related to the Satisfaction of BPJS Participants on Outpatient Services in the Regional General Hospital Dr. H. Moch Ansari Saleh Banjarmasin ......................................................... 517
    Risa Fariyana, Roselina Panghiyangani, Bahrul Ilmi, Husaini, Meitria Syahadatina Noor

103. Increasing of Nutrition Status of Pregnant Women after Supplementation of Moringa Leaf Extract (Moringa Oliefera) in the Coastal Area of Makassar, Indonesia ......................................................... 521
    Nadimin, Venni Hadju, Suryani As’ad, Agussalim Buchari, Irmawati Haruna, Rudy Hartono

104. Assessment of the Effect of Diyala River upon the Quality of Tigris River in Baghdad Province by National Sanitation Water-Quality Index (NFS-WQI) ......................................................... 526
    Luma H. Alazawii

105. Determination of the Radiation of Alpha Particles in the Air of Primary School Buildings in the City of Karbala ................................................................. 531
    Abdalsattar Kareem Hashim, Sara Salih Nayif

106. The Influence of Organizational Pride on the Performance of Lecturers in Health at the Nahdlatul Ulama University in Surabaya ......................................................... 538
    Ima Nadatien, Seger Handoyo, Widodo J. Pudjirahardjo, Yusti Probowati
107. The Effectiveness of Using Direct Composite Veneer Template System in Restoring Anterior Teeth ..... 543
   Sri Wahyuni, Saluna Deynilisa, Ismalayani

108. A Study on Breast Cancer Awareness in Female Students of Begum Rokeya University, Rangpur:
      A Cross-Sectional Study ............................................................................................................................ 547
      Sukanta Das, Mst. Sirajum Munira, BK Chakraborti

109. Failure of Speed oligo Mycobacteria to diagnose Mycobacterium tuberculosis Complex
      Directly from Sputum Samples .................................................................................................................. 553
      Tarig MS Alnour, Faisal Abuduhier, Eltayib H Ahmed Abakur, Fahad MA Albalawi, Khalid AS Alfifi,
      Bernard C. Silvala

110. Body Fat Composition as a Determinant of Cognition Functions in Elementary School Students ........ 557
      Tria Wahyuningrum, Lida Khalimatus Sakdiyah, Rina Mardiyana

111. Factors Associated with the Knowledge and Attitude Towards Breastfeeding in Thai Grandmothers of
      Pregnant Adolescents ............................................................................................................................... 560
      Wilasinee Bootsri, Surasak Taneepanichskul

112. Cross-Sector Collaboration Indicators Development of HIV-AIDS Prevention Program in Indonesia ...
      566
      Balqis, Hasbullah Thabrany, Kemal N Siregar

113. The Relationship between Ventilation with Excess Cancer Risk (ECR) of Benzene at the Shoe
      Home Industry in Romokalisari Surabaya ............................................................................................... 572
      Bachtiar Chahyadhi, Abdul Rohim Tualeka

      577
      Bagus Soebadi, Adiastuti Endah Parmadiati, Hening Tutu Hendarti, Desiana Radithia, Diah Savitri Ernawati

115. Evaluation of the Health Policy Implementation of Indonesian Social Insurance Administration
      Organization in Primary Health Care Facilities .......................................................................................... 581
      Supriyana, Edy Susanto, Irmawati, Bernadus Rudy Sunindya, Asep Tata Gunawan, Ismi Rajiani

116. The Relationship between Environmental Sanitation to the Incidence of Hepatitis A in Rural
      Areas of Central Java, Indonesia .............................................................................................................. 585
      Teguh Widyanto, Marsum, M. Choerul Anwar, Subinarto, Ahmad Fikri, Asep Tata G, Ismi Rajiani

117. The Correlation between Green Open Space with Carcinogen Toxicity Score of Benzene in Shoes
      Home Industry Surabaya .......................................................................................................................... 589
      Nima Eka Nur Rahmania, Abdul Rohim Tualeka

118. Frequency of Cardiac Troponin T (TNNT2) Polymorphism, a Dilated Cardiomyopathy Gene in
      Tabuk Population .................................................................................................................................. 594
      Muhammad Tariq, Khalid Fandi, Rashid Mir, Yassir Birema, FM Abuduhier

119. SLC2A2 Gene (Glucose Transporter 2) Variation is Associated with an Increased Risk of Developing
      T2d in an Ethnic Population of Saudi Arabia .......................................................................................... 600
      Fahad M Almutairi, Rashid Mir, Faisal Abu-Duhier, Roaid Khan, Khalid Harby, Imadeldin Elfaki

120. A Content Analysis of Original Research Articles on Public Health Published in an International Journal:
      The Case Study of Thailand ..................................................................................................................... 606
      Sunanta Wongchalee, Orapin Laosee, Ratana Somrongthong
121. Study of Mental Health and Attitude towards Psychological Help Seeking among Management and Science University Students ................................................................. 612
   Bavani A/P Raman, Venkata Pavan Kumar Sriperumbuduru, Hasanain Faisal Ghazi, Fazna Saleem, Nava Jyothi Dalayi

122. Acute Lung Rejection: An Important Factor for Long Term Survival in Lung Transplantation ............ 617
   Zulkifli Amin, Ignatius Wuryantoro, Ceva Wicaksono Pitoyo, Elvina Johanna Yunasan

123. The Incidence of Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis in Dr. Saiful Anwar General Hospital Malang, Indonesia from 2012-2017 ................................................................. 622
   Safrina Dewi Ratnaningrum, Diana Lyrawati, Sinta Murlistyarini, Nurdiana, Tommy Alfandy Nazwar

124. Dynamic Transmission of Dengue Hemorrhagic Fever and Climate Variability Patterns in Jakarta ...... 628
   Haryoto Kusnoputranto, Margareta Maria Sintorini, Suyud Warna Utomo, Nurusysyarifah Aliyyah, Epi Ria Kristina Sinaga, Okky Assetya Pratiwi

125. Knowledge about Lung Cancer and Awareness of its Risk Factors among the University Students ...... 633
   Ashok Kumar Jeppu, Nur Atikah Binti Mohamed Jailani, Kavitha Ashok Kumar

126. Community Treatment Security Index in Makassar City ................................................................. 638
   Rusli, Chatarina U. Wahyuni, Suharjono, Hari Basuki Notobroto, Agust Dwi Djajanti, Rudy Hartono

127. Early Detection of Risk Factors and Severity of Airway Obstruction Through Measurement of Critical Values of FVC and FEV\(_1\) on Bus Terminal Officers ................................................................. 642
   Sudiro Sudiro, Martono Martono, Nursalam Nursalam, Ferry Efendi
Discharge Planning Model with Approach of Method in Improving Patients’ Readiness for Discharge in Hospitals

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ABSTRACT

Background: Discharge planning is one form of nursing service that is still a problem in Indonesia. That is because its implementation has not shown the patients’ readiness when returning from a hospital. One solution is to develop a discharge planning approach to Medication, Environment, Treatment, Health teaching, Outpatient referral, Diet (METHOD).

Aim & Objectives: This study aimed to analyze the discharge planning model with the METHOD approach in improving the readiness of patients returning from hospitals in Surabaya, Indonesia.

Method: The study used a quasi-experimental design with 40 patients whom were diagnosed with diabetes mellitus and were selected by purposive sampling. The data was collected with observation and interviews to assess the implementation of discharge planning and patients’ readiness models. There were 18 questions using a Likert scale with answers 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree. Moreover, patients’ readiness was measured using 16 questions consisting of questions about readiness for control, treatment, diet, activity and rest.

Results: The Mann-Whitney test results showed p value = 0.000 (p < 0.05). The intervention group that applied the discharge planning model with METHOD approach had a greater influence on the patients’ readiness behavior to go home compared to the control group.

Conclusion: The readiness of patients treated in hospitals in Surabaya, Indonesia before going home can be improved by applying a discharge planning model that used the METHOD approach.

Keywords: Discharge planning, medication, environment, health, treatment, outpatient referral, diet

INTRODUCTION

Discharge planning is a dynamic process to assess current and advanced care needs that are aimed to make patient independence. The current discharge planning implementation and provision of health education are still given for several hours before the patient returns home from a hospital. This can cause patient’s anxiety about the care or activity done related to his condition after going home. Discharge planning is also still fragmented because nurses only carry out routine activities in the form of return control information. Moreover, nurses’ compliance with policies and standard procedures are still low.

Discharge planning is very necessary in providing nursing care to patients in the hospital. Therefore, it needs to be prepared by the nurses and done as early as possible. Doing this earlier can reduce the length of hospital care, the cost of care, and the recurrence rates, also allow intervention home plans to be done on time. An important aspect of education and care coordination is to prepare patients and families to successfully manage themselves after hospital discharge.¹,²

The results of the study in the hospital wards of Islamic Hospital Surabaya showed that discharge planning was not carried out immediately when the patient was hospitalized. Thus, the length of treatment
could not be confirmed. So far, the education that would be delivered in the discharge planning process has never been formulated before. The provision of health education was carried out on the day the doctor decided that the patient can go home. Evaluation on the patients’ level of understanding is rarely done. The format of health education planning is incomplete. Hence, patients going home are less focused on METHOD. During this time, health education provided to patients during the hospital stay was not planned and documented because planning was only verbal.

The implementation of discharge planning has not been well implemented, causing the quality of service not in line with expectations. Besides that, there is no clear standard regarding discharge planning, which causes each hospital to have different discharge planning forms. The concept of the solution developed in this study is to develop discharge planning itself with the METHOD approach. METHOD is an abbreviation of aspects that need to be taught in the provision of health education. They aim to improve knowledge and understanding, also support for health conditions and follow-up care that must be done after patients go home. The purpose of this study is to analyze the effect of the discharge planning model with the METHOD approach in improving the readiness of patients returning home from hospitals in Surabaya, Indonesia.

**METHOD**

This is a quasi-experimental study. The research sample consisted of 40 patients whom were diagnosed with diabetes mellitus; there were 20 in the treatment group (Group A) and 20 in the control group (Group B). The sampling technique of purposive sampling was used to recruit respondents. The data were collected from participants who met the following inclusion criteria: (1) patients who need health education (2) patients who need continuity of care in Islamic Hospital of Surabaya, Indonesia, with a medical diagnosis of diabetes mellitus.

The data were collected by 18 questions using a Likert scale with answers 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree to assess the implementation of the discharge planning model. METHOD approach was used as measured by functionality, efficiency and usability. Meanwhile, patients’ readiness was measured by using 16 questions about readiness to control, treatment, diet, activity and rest with yes = 1, no = 0.

Data analysis was used to determine the effect of discharge planning development with the METHOD approach on patients’ readiness behavior using the Mann-Whitney test. The level of significance was set at p < 0.05.

**RESULT**

Table 1 shows the characteristics of respondents in the intervention and control group. Most of the respondents in the intervention group were aged between 40-59 years old (70%), women (80%), had primary school as the highest education (40%), and being hospitalized for the first time (55%). Whereas, age of the respondents in the control group were equally distributed between 40-59 and 60-79 years old. Most of the respondents in the control group were female (60%), had primary school as the highest education (50%), and being hospitalized for the second time (50%).

Table 1: Characteristics of respondents based on age, gender, latest education, hospital admission experience with the same disease

<table>
<thead>
<tr>
<th>Characteristics of Respondents</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-59 Years</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>60-79 Years</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Junior High School</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Senior High School</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Undergraduate</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Experience of being hospitalized with the same disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Once</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Twice</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>3 Times</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>More than 3 Times</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 2 shows that there was an effect of discharge planning model with METHOD approach on patients’ readiness behavior to go home. The mean rank value among the intervention group was 27.75, while among the control group was 13.25. The Mann-Whitney test results showed p value = 0.000 (p < 0.05). The results showed that the intervention group which was implemented with the METHOD approach as the discharge planning format, had a greater influence on the patients’ readiness behavior to go home compared to the control group. It was concluded that statistically there were significant differences in the patients’ readiness between the intervention group and the control group.

Table 2: Effect of discharge planning with the METHOD approach on the patients’ readiness behavior to go home

<table>
<thead>
<tr>
<th>Patients’ readiness behavior to go home</th>
<th>Group</th>
<th>N</th>
<th>Median (Min-Max)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td>20</td>
<td>93 (75-100)</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>20</td>
<td>75 (70-93)</td>
<td></td>
</tr>
</tbody>
</table>

Mann-Whitney Test. Mean rank intervention group= 27.75; control group=13.25

**DISCUSSIONS**

The implementation of the discharge planning model with the METHOD approach causes the patients to have a good readiness behavior in facing repatriation. The implementation of discharge planning with the METHOD approach was carried out since the patient was hospitalized. The discharge planning model with the METHOD approach contributed to the patients’ willingness to go home. The METHOD aspects can provide an overview to the patients and families about drugs given. They also gave a good environment for patients, therapies and exercises necessary for patients’ health, information on re-control and service in the community and diet.

The discharge planning helped the transition process of patients from one environment to another. The process can be seen with several indicators. Indicators of the results obtained should be aimed at the success of the patients’ discharge planning, namely: (a) patients and families understand the diagnosis, anticipate the level of function, medication and treatment measures after the patients go home, advanced nursing, and the response taken in the emergency condition, (b) special education is given to patients and families to ensure proper care after the patients go home, (c) support systems in the community are coordinated to enable patients to go back to their homes, help patients and families coping with changes in the patients’ health status, (d) conduct patients’ relocation and coordination of support systems or move patients to other health services.

Discharge planning is a systematic process that is aimed to prepare patients to leave the hospital to continue ongoing care programs at home or with community care. According to Almborg, giving discharge planning before being discharged can improve patients’ progress, and help patients achieve optimum quality of life. Patients who are not ready to face repatriation tend to return to the hospital (readmission), die or return to the emergency room within 30 days after discharge. The factors that caused unpreparedness of patients are lack of knowledge, low quality of service, low provision of health education and persistent symptoms. According to Harrison, unpreparedness of patients in facing repatriation was due to lack of treatment plans and daily activities to be carried out at home.

The strategies that can improve patients’ readiness to go home and patients’ health are language use, use of leaflets or pictures. These are done to increase understanding, limit the provision of health information at one time, repeat instructions, use the teach back method, and have a respectful and sensitive attitude towards patient needs. A simple strategy that can be implemented in a hospital is to improve repatriation planning. By developing a flexible planning that provides relevant information to anticipate future needs, it also tends to increase discharge planning and reduce long-term needs that are not met.

The discharge planning was successful in improving patients’ readiness in facing repatriation. It was a form of professional work from nurses because the implementation of good discharge planning was the duty of nurses. They played an important role in providing understanding and knowledge to patients and increasing patients’ motivation to undergo the
optimal rehabilitation process. The patients’ readiness to go home is an indicator of the success of discharge planning. Knowledge, understanding and skills of nurses in carrying out discharge planning affected the patients’ readiness behavior to go home because nurses were educational providers and people who accompanied patients for 24 hours. Therefore, nurses were required to provide information needed by patients. Patients’ readiness behavior to go home cannot be formed in a short time with short education. When individuals did not understand the health information, the consequences did not only affect the patients’ perceived readiness for discharge, but can also lead to worse health outcomes, dissatisfaction, and medical errors.  

The level of readiness and awareness of patients and families in the involvement of patient care was an important factor in the discharge planning process. All things beyond the capacity of patients were the responsibility of health workers to communicate to be understood by patients or families. Communicating health information could be a challenge because health workers had to share complex information and included a lot of contents. The characteristics of patients with unique linguistic preferences, skills, cultural, physical and cognitive differences were related to changes in age, disability, and emotions. All these could influence the process of receiving education.

Less communication occurred in situations when health workers were in a hurry or patients were afraid, sick, and/or in various matters related to their disease problems. Combining the readiness scale of patients back into the discharge planning process can add alternatives to assess the risk of readmission events. This could be done by better identifying related characteristics of patients who tend to affect their ability to be involved in self-management at home. The ability included symptoms reported, contacts that can be contacted, and control time.

The discharge planning implementation was carried out immediately when the patient was hospitalized. This could be one of the factors to improve the patients’ readiness behavior to go home. Besides that, there were benefits obtained from the process of involvement and good coordination between nurses and patients in the planning activities. Ensuring that all patients understand and maintain actions for advanced home care was an important step in improving the patient’s experience and reducing the incidence of readmission. The discharge planning was needed by patients to ensure the smooth process of transferring patients from hospital to another environment. This was done so that the care provided while in the patients were in the hospital can be sustainable. The main key in the discharge planning process was communication between nurses and patients/families in health education during the process. This would facilitate patients in receiving or understanding the instructions given while at home, so that the patients were able to independently maintain or improve their health.

CONCLUSION

The discharge planning implementation in Indonesia hospitals was still not effectively applied in the field as shown by the lack of patients’ readiness to go home. The discharge planning model available in the hospital was complete, but the education aspect has not been planned and explained in detail to the patients. The intervention group that applied the discharge planning model with the METHOD approach had a greater influence on the patients’ readiness behavior to go home compared to the control group. It was concluded that there were significant differences in the patients’ readiness behavior to go home between the intervention group and the control group.

Recommendation: The METHOD approach can be used as an alternative to carry out discharge planning in hospitals, which focuses on the planning, implementation and evaluation stages.

Relevance of the study: Research findings have highlighted the problem of discharge planning whereby discharged patients were not well informed before they go home, so the incidence of recurrence is frequent.

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