NURSE MV

ISSUE | 6

THE MALDIVES NATIONAL UNIVERSITY

SCHOOL OF NURSING | THE MALDIVES NATIONAL UNIVERSITY | MAY 2023

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EDITOR'S NOTE

Dear Readers!

Welcome to the 6th issue of NURSE MV. It gives my team and I great pleasure to invite the nursing community and others to read our magazine. A digital copy of this issue will also be available from www.mnu.edu.mv

I take this opportunity to congratulate the Maldives National University (MNU) on the occasion of its 50th anniversary. We are proud to announce that the School of Nursing enrolled the highest number of students at the Maldives National University for the past two years.

The NURSE MV continues to bring you diverse perspectives of the profession and also other personal reflections from the experienced nurses who have contributed to the profession. This issue contains: *Death and Dying: A Cultural Perspective in the Maldivian Health care Context*. The article provides an overview of the cultural practices related to death and dying in the Maldives. It is followed by *Massage therapy as a healing touch for pre-term babies: A Review*, which brings insight into the massage therapy for pre-term babies. Next in the Issue is, *My Nursing Story*- An interesting article relating the rich nursing experience by the former Dean of Faculty of Health Sciences. The next article, *Diploma in Nursing and Midwifery 1st batch in the Maldives*, recounts a personal history of the first batch of Diploma in Nursing and Midwifery (DNM) training in the Maldives. Lastly, this issue presents two interesting research abstracts. "Emotional intelligence and associated factors among nursing students at School of Nursing/MNU, Maldives: A Descriptive Cross-Sectional Study, "Clinical Experiences of Nursing Students Studying at School of Nursing/MNU, H. Dh Kulhudhuffushi Campus."

My heartfelt thanks and appreciation goes to all those who have contributed to this edition of NURSE MV and special thanks to the hard-working editor's team!

Enjoy reading!

Death and Dying: A Cultural Perspective in the Maldivian Health care Context

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Introduction

Death and dying is an inevitable part of life and a proceeding that every living being will face in this world. The practices among different cultures related to death and dying may vary from the beliefs to the rituals. "Every soul shall taste death "is a well-known and well-understood "ayah" from the Muslim Holy Scripture, Quran 3:185 (Ahamed, 1996). Muslims believe that everyone dies but not their soul (Sarhill et al., 2001). For a Muslim, death symbolizes the transition from one state of existence to the next as the religion of Islam teaches that life on earth is an examination-the life after in the eternal residence where one will gain the fruit of one's actions on earth (Sheikh, 1998).

In the Maldivian context, cultural practices associated with death and dying are mostly based on Islamic religious teachings. Similarly, health care practices must be based on Islamic principles and values at end-of-life care. Current literature suggests that death, dying, and bereavement are characterized by uniformity, culture, and nation-specific variations (Pentaris & Thomsen, 2020).

Culture related to death and dying

Muslims define death as the separation of the soul from the body, followed by the complete stopping of breathing. It is understood as an unconditional belief in an omnipotent God, who governs life and death. Muslims also describe the dying process as accompanying physical signs such as losing consciousness and speech, speaking about deceased people, turning the eyes, and experiencing thirst (Ahaddour et al., 2019). A family member's death is one of the most stressful experiences a family may face (Casey et

al., 2020). Along with death, the bereavement process may take days or even months for families to accept the loss. There are certain rituals that they need to practice to respect the deceased and accept the loss. However, following death, Muslim customs are minimal and simple; that is, wash, bathe, and shroud the deceased body, emphasizing burying quickly after family and friends have offered funeral prayers. (Ahamed, 1996). The literature on Maldivian history shows many rituals and practices related to the culture of death and dying. In the present day, some of these rituals and practices continue with minor to moderate cultural adaptations as per Islamic values.

Historical perspective

According to Francois Pyrard de Laval (n.d) cited in Ismail Didi Mohamed, (1995) who spent five years from 1602 to 1607 in the Maldives, described the cultural practices related to death and dying. People of the Maldives gave great importance and respect to the deceased, with priority given to the last bath performed for the deceased. For the male deceased body specially assigned, six men will give a bath, and similarly, six females were assigned to attend the female deceased. According to the religious beliefs, the men and women assigned for this purpose should be free from any crime, unethical behaviour, or sexual offenses. The deceased body would be washed by giving importance to keep the body turned on the right side. The last bath for the deceased will be performed using more than 40 gallons of water, followed by the body being covered and shrouded in two sets of white cotton clothes called "kafun." This procedure would be done by turning the body to the right side first and then to the left. Next, the body would be placed in a coffin made with unique wood called "kandhu filaa" to be buried as per religious rituals. Bathing of the deceased was done at home, and during the preparation for burial, the Holy Quran's recitation was performed by assigned people. In the past, female family members and friends grieved over the loss by crying aloud and shouting for many hours. Nevertheless, at the same time, they would talk about all the good characteristics and good deeds of the deceased, during the grieving process.

The deceased body would be taken for burying by relatives or close friends. The place selected for burying the body would have been sometimes chosen by the deceased person when he/she was alive. In the earlier days, the custom followed was to save money and material to be used for their burial process. People would also save their best two dresses to be placed

over the coffin. In normal circumstances, these dresses would be worn during the Muslim festival season known as “Eid." when the deceased was buried, the dresses would be gifted to the Muezzin (the person assigned to call for prayers) in the mosques. Sea shells would be thrown on the ground while the deceased is being taken for burial, later collected by the poor for their use.

When the whole process is over, friends and relatives will serve food to those involved in the care of the deceased. The Quran recitation would continue at the graveyard for three consecutive Fridays since the burial, and during the time of recitation, food and drinks would be served. A special dinner or lunch would also be prepared and served to the friends and relatives for three consecutive Fridays. The third Friday is considered very special, where a tombstone would be placed at both ends of the grave. The size of the tombstone depends on how wealthy the deceased was.

Current religious and cultural practices

Even though the cultural practices of dying and death from generations are still carried out even today, some cultural practices have changed over the years, yet the Islamic practices are strictly followed. In today's current practices, all death, irrespective of dying in their homes and elsewhere, need be taken to the hospital to certify the death. Present day patients in their death bed will be mostly in a hospital or any other healthcare facility. Therefore, they will be taken care of by the nurses and doctors. Additionally, irrespective of how severe or seemingly unbearable a person’s pain and suffering may be, Islamic jurisprudence does not recognize a right to die voluntarily, which stems from the belief that life is a divine trust and is sacred (Choong, 2015). Furthermore, in Muslim countries, where the Islamic law and regulations are exercised, withholding or withdrawing treatment under certain conditions or end-of-life decisions, especially those related to euthanasia and physician-assisted suicide, is not ethically acceptable or allowed (Abu-El-Noor & Abu-El-Noor, 2014). However, the practices that follow with death and dying involve vital cultural and religious aspects that need to be considered.

Most locally trained nurses are equipped with importance of culturally and religiously appropriate death care. However, with an increased number of multinational healthcare providers with different cultural and religious background working in the Maldives,

Conflicts on how to carry out the procedure of death care and cultural disparities at times occur while taking care of the deceased. For instance, for a dying patient nurses are expected to recite the "Shahadah" (Sahih, 1996). The expatriate non-Muslim nurse may not be able to do this very vital religious step. Such actions will usually result in dissatisfaction, apprehension, and anger of the relatives. This type of activity may be seen as a violation of cultural expectations from the health care provider (Thomas, 2001).

In Islamic culture, the family, relatives, and close friends are strongly encouraged to visit the sick and those patients experiencing end of life to honour the patient, praying for their welfare, seeking of forgiveness for wrongdoings that have been knowingly or unknowingly committed in the past (Choong, 2015). Besides the Islamic teachings from several verses of the Quran (2:83, 4: 34, 17:23) states the physical presence of the near and dear ones is essential to the patient's physical, emotional, and spiritual wellbeing while they are on their death bed. Furthermore, when the person is nearing death, the relatives will be asked to be with the patient and not leave the person alone (Philips, 1996).

Nurses will try to console the family members and give psychological support as death may seem inevitable. The way death notification is given, or the doctors and nurses' behavior may affect the family members' acceptance and the transition of the grieving process (Hassankhani et al., 2018). Different people from different cultures may mourn differently and may depend upon the degree of relationship with the family members (Esmaeilpour & Bakhshalizadeh Moradi, 2015; as cited in Hassankhani et al., 2018). In most local hospitals, if the patient is very sick, at least one relative will be allowed to stay with the patient. During the stay, they may recite the Holy Quran near him/her, or recorded verses of the Quran will be played on audio, softly near the patient. According to the Muslim custom when a person dies, the eyes and mouth should be closed, arms folded on the chest as in for prayer (right hand over left), and lower limbs straightened. The body should ideally face in the direction of Mecca, Saudi Arabia (Sheikh, 1998).

According to the Islamic practices the death care should be performed as soon as possible, including the removal of all the tubes and catheters, cleaning the body and keeping the body in the required alignment. This is to aid in alignment before rigor mortis sets in (Potter & Perry, 2017). Next, the procedure is to tie the body in five different and specific places;

all the orifices will be packed with cotton balls. It is also a legal requirement for a police officer to inspect the dead body to rule out any unnatural causes. After the death care procedure, the deceased body will then be handed over to the relatives, to be taken to the burial ground for the unique bathing, cleaning, and burial that is required in the Muslim custom.

Conclusion

Death is an inevitable event in the life course of any human and a phenomenon related to healthcare services and healthcare professionals. Culture plays a vital role in the death and dying process. Therefore, healthcare professionals need to be culturally competent to provide satisfying and fulfilling care to the dying patients and their family members. It is imperative for nurses and other healthcare professionals to deliver death care in a sensitive and culturally acceptable manner.

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Massage Therapy as a Healing Touch for Preterm Babies: A Review

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The World Health Organization (WHO) defines the preterm baby as a baby born alive before 37 weeks of gestation. Annually, 15 million babies are born prematurely every year, which presents the leading cause of death for under five years (WHO, 2018). Birth conditions influence mortality; hence, effective interventions reduce the mortality of the preterm (Ayuningrum, 2019). In 2018, infant death because of preterm birth and low birth weight was 17% (Centre for Disease Control (CDC), 2020). In the Maldives, the neonatal mortality rate was 4.8 deaths per 1000 live births in 2018 (WHO, 2020). Prematurity is associated with multiple complications, needing extensive treatment for survival (Lincetto & Banerjee, 2020).

Intensive survival treatments lead to long-term preterm hospitalization, leaving them unsecured concerning the sensory-rich environment of the uterus (Montaseri et al., 2020). Therefore, to improve the quality of life of the preterm and address associated complications, medical interventions are essential. The probability of long-term complications for preterm babies who survive the neonatal period depend on the success of quality care provision (Lincetto & Banerjee, 2020). Among many of the interventions used in preterm care, massage therapy has gained attention in the literature. Massage therapy is somatic stimulation of preterm by using mild-to-moderate stroking.

Literature support with evidence of preterm care

Massage therapy enhances weight gain, which is an essential criterion for the discharge of a preterm baby from a health care facility (Álvarez et al., 2019; Liao et al., 2021). Furthermore, this effect on the preterm implies to be more significant when used in combination with oils or other emollients. According to Liao et al

(2021), when “massage with oil groups” compared with “massage alone” and control group, the massage with oil group showed an increased weight gain (P= 0.05), showing a statistically significant difference (Liao et al., 2021).

Other areas massage therapy has a positive impact on growth and development of preterm include, it affects head circumference and height (Álvarez et al., 2019; Zhang & Wang, 2018). In a prospective quasi-experimental study, preterm head circumference and height increased on given massage therapy (Álvarez et al., 2019). Also, a prospective open-label randomized trial further supported this. It evidenced an increase in lean body mass, bone mineral density, and body fat distribution, showing improvement in growth quality (Elmoneim et al., 2021).

In addition, this study has shown massage therapy to be favorable in maintaining physiologic parameters of preterm. In a randomized controlled trial by Maharani et al., (2017), statistically significant difference in body weight (p = 0.047), body temperature (p = 0.021), and pulse rate stability (p = 0.001) resulted in preterm babies who underwent massage. Researchers used Kangaroo Mother Care (KMC) for one treatment group and massage therapy for the other group. The result shows that massage therapy is more effective in measured parameters than KMC, a currently established treatment in preterm care.

Moreover, a literature review by Ayuningrum in (2019), summarizing the benefits of massage therapy, highlights its positive effect on the quality of sleep and stress of preterm. They observed an increase in sleep state score after providing massage in a quasi-experimental study done in southeast Iran (Baniasadi et al., 2019). In this study, participants had significant differences after providing massage regarding sleep state (P = 0.003), awake state (P = 0.04), fidgeting/crying (P = 0.03) and motor activity (P = 0.001) between pre and post-massage. In a randomized controlled trial conducted in Iran, to evaluate the effects of massage therapy on transcutaneous bilirubin level on preterm, the evaluation after providing massage therapy for 4 days showed a positive effect (Basiri-Moghadam et al., 2015). The mean stool frequency was high in the experimental group, and the bilirubin level notably reduced with a significant difference within groups. However, there was no difference in bilirubin level in another study, but stool frequency increased, indicating gastrointestinal function

improvement (Karbandi et al., 2015). On evaluating the effect of massage therapy on feeding intolerance in preterm in a systematic review, evidence reported a mean reduction in gastric residual volume, vomiting, and abdominal circumference in massage groups comparatively (Seiiedi-Biarag & Mirghafourvand, 2020). A systematic review by Álvarez et al., (2017), reports that massage therapy on preterm exerts a beneficial effect on better neurodevelopment, a positive effect on brain development, reduced risk of neonatal sepsis. Researchers also reported increased serum insulin levels.

In a randomized controlled trial evaluating the efficacy of coconut oil with a sample of 2294 preterm, the result showed fewer incidences of hypothermia and apnea, better skin maturity, and neurodevelopmental outcome (Konar et al., 2020). In this study, the preterm who received coconut oil massage was 0.31 (95% CI: 0.24–0.39) and 0.59 (95% CI: 0.45–0.74) times less likely to suffer from decreased skin maturity and adverse neurodevelopmental outcome, respectively. Shaikh & Patil (2017), reported statistically significant improvement in physiological and behavioral status ($p<0.001$) in a randomized controlled trial whereby massage therapy adjunct to KMC was provided to preterm infants compared with a group receiving KMC alone.

The preterm baby spends most of their time in NICU under the care of health professionals, limiting the development of parental attachment and bond. Massage therapy is an intervention that can address this emotional attachment between parents and preterm (Field, 2018). As Neonatal Intensive Care Unit (NICU) environment impedes the bond between parents and infants, nurses are the person who often take the role in bridging this gap (Hopwood, 2010). Hence, nurses' knowledge and expertise in the intervention will help successfully implement massage therapy (Abdallah et al., 2020). An experimental study involving 52 mothers of preterm infants, examined using the Profile of Mood States questionnaire showed a significant improvement in mothers' mood with a mean score in the intervention group before massage 152.42 ± 4.56 and 118.92 ± 3.45 after the massage while in the control group was 153.76 ± 5.5 first, which reduced to 141.73 ± 6.1 (Lotfalipour et al., 2019). Evidence is present on the fact that parents are hesitant to continue with massage therapy for fear of hurting the fragile preterm (Abdallah et al., 2020). These emotionally challenged parents require professional help and support to maximize intervention for them and preterm.

Provided with multiple benefits of massage therapy to preterm, it leads to earlier discharge and better health outcomes for preterm. It is identified as a safe and cost-effective treatment for preterm (Li et al., 2016; Wang et al., 2013). Thus, besides shortening the stay, it cut out the hospital costs (Taheri et al., 2018). Therefore, along with benefits preterm gain through this, it is beneficial for hospital and staff in the long run. Massage therapy reduces the length of stay in the hospital, which further cuts hospital costs in terms of staff and resource utilization (Álvarez et al., 2017; Bayomi & El-Nagger, 2015; Iskandar et al., 2019; Niemi, 2017; Rad et al., 2016). In a study evaluating the effect of massage on weight gain and length of stay in the hospital, the average length of stay for the intervention group was 3 days while for the control group 5 days, with a statistically significant difference (p-value = 0.033) (Iskandar et al., 2019). Also, in another non-randomized blocking clinical trial, authors reported that length of stay was shorter (P = 0.007) in the intervention group. It leads reduction in hospital costs because of early discharge (Rad et al., 2016).

Therefore, having provided many benefits of massage therapy, it is essential to implement this into preterm care, which must be done systematically to achieve maximum outcome. In order to achieve this, a guideline for preterm massage must be prepared, defining the standards and side by side current practices, knowledge, and attitude of health care professionals and parents is essential to be known to proceed with implementing the intervention. It must provide training and education to experts in the area, covering all health sectors widely. Parents must be educated and coached about the process during the inpatient period for massage therapy to be continued post-discharge. A proper evaluation system must be established and timely. It must continue monitoring to uphold the standards.

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My Nursing Story

Aminath Faiz
RNM (Registered Nurse Midwife),
PCCN (Progressive Care Certified Nurse),
Master in Nursing (Advanced Nursing Practice),
Master of Science (Nursing Education)

Some highlights of my nursing career

Central Hospital, Male' Maldives.

My nursing career goes through a span of 40 years and I practiced in two countries, the Maldives and the United States of America (USA). I first graduated with Diploma in General Nursing & Midwifery in 1981 from School of Nursing, Lady Hardinge Medical College and Hospital, in New Delhi. After I graduated I got my first job as a Staff Nurse (Registered Nurse, RN), at Central Hospital, Male' Maldives. At the time professional nurses were few, and I was amongst the ten working RNs in the hospital. I felt special and proud to hold a job that was so much in demand by the community.

As a Staff Nurse I carried out all the procedures like managing labor and deliveries, resuscitation of new borns, placement of intravenous lines (IV) and initiation of IV drips. In the years from 1992-1995 I became the Nursing Supervisor. The biggest challenge I faced at the time was the huge shortage of nurses. So, more staff nurses were recruited from India. With the help of my fellow Staff Nurses, I conducted the Induction Program for the new nurses. I also participated in the transfer of the Central Hospital to Indira Gandhi Memorial Hospital

Faculty of Health Sciences:

Soon after, in 1995, I went to Perth, Australia to upgrade my nursing Diploma to a Bachelor's Degree. Upon completion I joined the Faculty of Health Sciences (FHS) to become a Nursing Instructor. I held positions as Nursing Instructor and Lecturer, teaching Medical Surgical Nursing to Diploma nursing students. In 1998, FHS became part of the Maldives College of Higher Education (MCHE). While on the job in 2000, with 9 other fellow nurse educators, I achieved Master

of Nursing Degree (Advanced Nursing Practice) offered by University of Newcastle, Australia.

During my last years at FHS from 2002-2005, I was the Dean of the faculty and with my love for teaching, I continued to teach Medical Surgical Nursing to the Diploma nurses.

Having taught to nursing students for over 9 years in the Maldives, I had a strong desire to study and work abroad and I decided to move to the USA. I needed to pass two board exams, CGFNS (Certification of Graduates from Foreign Nursing Schools) and the National Council Licensure Examination (NCLEX) for RNs, which provided the license to practice in the US. So I studied and passed both the exams.

2005: In the United States:

Barlow Respiratory Hospital, Los Angeles, California

My first job in the US was at Barlow Respiratory Hospital in Los Angeles, a small specialized hospital of 100 beds. I was trained to take care for patients on the ventilator, the weaning protocols, and cardiac monitoring. As required I got certified in Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS).

In Barlow Respiratory Hospital, I was introduced to Team Nursing. A team consisted of a Registered Nurse (RN), a Licensed Vocational Nurse (LVN), and a Nursing Assistant. As a Team Leader I had to make sure that other members were able to manage the care of their patients. In the two years I spent there I became confident to take care of ventilated patients and I was looking for a different job to learn more.

2007-2021: University of California, Los Angeles Hospital, Santa Monica (UCLA-SM)

In 2007 I started working at the University of California, Los Angeles, Santa Monica (UCLA-SM) which comprised of 280 beds. UCLA- SM is Magnet designated. At Magnet Hospitals the patient outcomes are excellent and nurses have a high level of job satisfaction, and a low staff nurse turnover rate.

I was very happy to be a nurse at UCLA. As a Magnet awarded and stroke certified hospital, the expectations were high. The hospital made sure we speak to its mission and vision and values in the work we do every day. To keep up with the standards, staff training and education on the job was a constant effort.

In the shoes of a Clinical Nurse at UCLA-SM

I worked on a Telemetry Unit with 36 beds. Besides cardiac patients this unit included stroke, COPD (Chronic Obstructive Pulmonary Disease), ESRD (End stage renal disease), ESLD (End Stage Liver Disease), oncology and alcohol withdrawal patients. To work on this unit, I had to have the right skills. I completed an EKG (Electrocardiogram) course to be able to identify the different cardiac rhythms. I obtained Oral Chemo certification so that I could medicate my Oncology patients. I was already certified for ACLS and I could intervene if a patient had a cardiac arrest. In addition, I also obtained the PCCN (Progressive Care Certified Nurse) certification to care for the acutely ill patients.

The NPH (Normal Pressure Hydrocephalus) patients were also admitted on this floor for CSF drainage. I assisted doctors to place lumbar drains. Once the drain was placed, nurses drained the fluid every hour. For stroke patients we were using the NIHSS (National Institute of Health Stroke Scale) to determine the severity of stroke. I advise new nurses to be thorough with their assessments because nurses will have to make clinical decisions during any emergencies and act fast if they are to save patient's life. We nurses are the people at the bedside watching patients all the time.

Clinical Nurse Manager

I worked on many Performance Improvement projects in the capacity of Team Champion and Team Leader and I chaired the Magnet Committee, which monitors the nursing quality. I was part of the team representing UCLA at the Magnet Conference held in Baltimore, Maryland in 2010.

As a leader and manager, I kept open communication and supported staff in their roles. Good relationship with staff helped me find strategies to solve problems. We have to listen and provide nurses with what they need and find ways to encourage them to stay at the bedside. Nurses burnout fast with the stress of the heavy workload and to nurture them is essential. They need ways to develop professionally and personally, be recognized and respected at work.

Clinical Instructor

In 2017, I went back to school and achieved Master of Science (Nursing Education) at Western Governors University, Utah. Thereafter I took a second job as a Nursing Instructor at West Coast University in California. I was assigned 10 students achieving Bachelors

in nursing. These students were posted at Beverly Hills Rehabilitation Center for their medical surgical experience. I had to follow the curriculum given to me by the West Coast University.

Every day as a Clinical Instructor, I start with a preconference where the plan for the day was discussed. The day ended with a post conference where students presented their cases. From my experience, I taught them how to prevent burn out, how to build resilience, and to practice mindfulness. I enjoyed working with young aspiring nursing students. It was important to understand the generational differences. While they were adept at modern technology their social and interpersonal relationship skills were often underdeveloped. However, they were motivated, creative, and eager to get immediate feedback on their work.

Experience through the Covid-19 pandemic

We had our first surge of Covid-19 patients on the Telemetry floor in January 2020. We were extremely stressed with the burden of this new disease as our workflow changed entirely. Every patient was placed on contact and respiratory isolation in a private room. Donning and doffing the personnel protective equipment (PPE) with the contact of every patient was taxing enough. It was emotionally and physically draining, it left us with exhaustion, anxiety and a lot of stress. This was the time when the treatment for Covid-19 was not clear, patient prognosis was poor and there was not enough personal protective equipment (PPE). No family members were allowed in the hospital and nurses were the only support for the patients. It was amazing how much we were appreciated by the public. On the national TV people broadcasted programs dedicated for the front-line health care workers. Various community groups made cloth masks and mask holders for us and the local restaurants were sending us food. It made us feel gratified of the work we were doing.

The pandemic also made me stronger personally and professionally. It was rewarding to be out there saving people's lives. With all the struggle I learnt new skills, knowledge, and found strength in working as a team. New experiences expanded my knowledge and I became more competent and confident on my job as an acute care nurse, manager, and a teacher.

I make sure each day that I put my best foot forward, "hoping for the best but prepared for the worst". Some days it will

be dealing with emergencies one after another. I feel I have achieved something special when my team work together and I know that we have made a difference, whether it is saving patients' lives, making them comfortable, or assisting patients to die peacefully, supporting them in their most vulnerable moments.

My advice to new nurses

I always tell my fellow new nurses *"Don't be afraid to be great!"* Your nursing school has given you a great foundation, so be confident and do not feel intimidated. You can become a wonderful nurse. Here, I offer you a few pieces of advice:

1. Always remember that our primary responsibility is towards our patients. Take care of every patient in a way you would expect to be cared for yourself if you were that patient. Most importantly, listen to your patients and their families. It makes your job a lot easier when you understand them and know what they need.

2. Nursing is a noble profession which is challenging and continuously evolving. So be ready to evolve with nursing, expect the unexpected every day and deal with the chaotic moments. For they teach you lessons to perform better especially in difficult situations.

3. Be prepared to be flexible and open to change, because without change you will not grow professionally or even personally. You have to be a lifelong learner to become that competent and knowledgeable nurse.

We were all new once, hang in there! Before you know it, all the difficult tasks will become second nature and you will be able to critically think and perform your job with much more ease.

Diploma in Nursing and Midwifery 1st batch in the Maldives

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Introduction

The Diploma in Nursing and Midwifery (DNM) course was inaugurated for the first time in the history of the Maldives in 1991. The course, in the beginning, was inaugurated with a total of 10 students. The successful start of this Diploma program led the Government refraining from sending Maldivian students overseas for nursing training and finally ending up all basic nursing studies and trainings from abroad.

This article aims to explore the experiences and challenges faced by the first batch of students. Inauguration of this course brought lots of uncertainties among senior officials from the country as it was the first of its kind. Hence change brings uncertainty and resistance among the service providers as well as from the recipients. However, this has become history now with a successful completion of the course by 6 Maldivian nurses.

The program

In the year 1991, the DNM course was inaugurated by the Minster of Health Hon, Ahmed Abdulla. It began with high hopes and dreams of 10 Maldivian students. The three-year Diploma in Nursing and Midwifery (DNM) course coordinator Ms. Mariyam Shafeeg, along with her the tutors from Maldives as well as from abroad did a great job in teaching and coordinating the first batch. During those days the duration of DNM course was 3 years with 6 months Midwifery component including domiciliary midwifery. Tutors from abroad and few locals took classes. Dr. Aminath Jameel, the former Health Minister and Dr. Christnan from India played a great role in developing the curriculum and bringing the program to life. All the theory classes were conducted in the Allied Health Services Training Center, Hakuraage class rooms. With the initiation of the course the

Institute's name was changed to Institute of Health Sciences (IHS).

During those days we had only two dummies in the nursing art lab and 3 beds to practice for the basic practical procedures and most of the non-invasive procedures like bathing, head shampoo, combing, nail care and positioning were practiced on one another which made it very realistic in teaching and learning. Hands on practice for bed making and other simple procedures were carried out in the Central Hospital Male. Students spent their whole day teaching and learning in the Institute. It was a very friendly, conducive environment for the students. At the end of first year, 3 of the students from the first batch got chances to go abroad to continue their nursing studies. However, the management decided to run the program even with only one student.

Chaos and unsettlement

The chaos and unsettlement began with the news of the three students leaving to go abroad to complete their nursing program, students showed their frustration and was unhappy which made students 99% of the students wanting to quit the nursing. However, with solid stance the management took made the rest of the students realize the importance to continue the program in the country.

Barriers and challenges for the students

It was expected for every new program or activities to have challenges and negative encounters. Similarly, students had to experience challenges and shortcomings during the clinical placement. This section will discuss about some of the barriers and challenges experienced by the students.

Clinical placement

After the class room sessions practical demonstrations were carried out in the nursing art lab where students do return demonstrations. the tutors were able check and give individual feedback to all students as there were only 10 students in a class back then. It was a huge advantage that teachers were behind the students mentoring, guiding almost whenever students were on duty. The students had to take all equipment and articles from the nursing art lab to the central hospital where there was not enough equipment for students to practice. However, everyday students take the articles to the clinical area to practice and bring it back to the faculty and clean, disinfect and kept ready to use for the next day. During the clinical placement it was common to get

bullied by the other nurses and some senior staff. We were mocked and belittled because we were doing the nursing training in the Maldives. Diploma in Nursing and Midwifery students were the first people to wear an identification card with a picture on it for which students were bullied and harassed by nursing colleagues.

Externship

The DNM curriculum had a component of an externship where students had to go abroad for their medical surgical nursing practical experience. There were limited specialized procedures carried out in the only hospital in the Maldives 29 years ago, unlike the current situation where many specializations are available for nursing students to observe and practice in the Maldives. However, the students found this experience very challenging for various reasons. Firstly, most students were travelling for the first time away from their families and out of the country for a very long time. We were sent to Christian Medical College Vellore, India for 3 months. Secondly, when the students were sent abroad, it was the beginning of the second year and all theory components were completed. In fact students didn't know what to expect and face difficulties trying to comprehend and apply the theory into practice. However, it was an excellent opportunity to get to know many aspects of patient care with varied cultural background. In addition, the other challenge was not being able to communicate directly with patients as many patients didn't know English and we were not able to speak the any of the local language such as Tamil or Telegu. Nevertheless, most students managed to talk in Hindhi which was an added advantage for students to communicate patients and their families.

Success and outcome

I graduated from the DNM course and won the Presidential Award for getting the first place in the program. Total of six students graduated from the first batch of Diploma in Nursing and Midwifery course. I am very proud to be a graduate of the Maldives National University, School of Nursing. Currently, I am a Senior Lecturer, course coordinator for Advanced Diploma in Midwifery. Additionally, a member of Maldivian Nursing and Midwifery Council (MNMC) representing academic institutions as well as the acting registrar of MNMC.

Note: since this is a reflection of the student's perspective there might be a recall bias.

ABSTRACT COLUMN:

Clinical Experience of Nursing Students Studying at School of Nursing, Maldives National University H. Dh Kulhudhuffushi Campus

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Background

Clinical experience is an integral part of nursing education programs which contributes to the overall preparation of the student for professional practice. Exposure in the clinical settings is significant in the development of professional skills, students' competence and professional socialization. The acquisition of skills and levels of competence depends upon the quality of clinical preparation and the degree to which students are satisfied with their clinical experiences. Fostering positive clinical experiences also helps in students' retention which is critical in a time where there have been projections indicating a forthcoming crisis of nursing shortage. Therefore, the provision of safe and quality care and sustaining the profession in the future depends on the current students.

Aim

This descriptive qualitative study aims to explore the clinical experiences and the factors affecting the clinical learning process of nursing students studying at Maldives National University, H. Dh Kulhudhuffushi Campus.

Method

Semi-structured in-depth individual interviews were conducted with 6, final year Diploma nursing students who were recruited from a purposive sampling strategy.

Results

After the thematic analysis, 5 themes emerged which consists of (1) Initial experience in the clinical settings (2) Mentors attitude towards supervision (3) Challenges in clinical learning environment (4) Encountering negative experiences and (5) Readiness for professional practice.

Conclusion

The findings yielded from this study have implications for establishing better mechanisms to prepare students psychologically, investing in preparation of adequate mentors for supervision, in providing appropriate resources and in building effective relationship between healthcare and educational staff to overcome several challenges that hinder clinical learning.

Emotional Intelligence and Associated Factors Among Nursing Students at The Maldives National University: A Descriptive Cross-Sectional Study

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Background

The healthcare environment is experiencing a significant change and numerous challenges for nurses as a result of increased workload, shortage of nurses, high nurse turnover rate, and an aging population with co-morbidities. To deal with these emotional complexities nursing students need to develop and enhance emotional intelligence as it helps

to control, understand and utilize their own and others' emotions effectively.

Aim

The aim of this study was to assess the levels of emotional intelligence and associated factors and to examine any relationship between levels of emotional intelligence and demographic variables among nursing students in the Maldives.

Method

A descriptive cross-sectional study was conducted among 302 nursing students from School of Nursing, the Maldives National University (MNU), who were recruited by stratified random sampling method. Data was collected using The Schutte Self Report Emotional Intelligence Test to measure the emotional intelligence.

Results

This study reported that (55%) of the students had higher level of emotional intelligence and (45%) had moderate level of emotional intelligence. There was a positive correlation between total emotional intelligence score and age ($p=0.003$). Emotion utilization had significant difference with gender while emotion expression had a significant association with mothers' educational level on independent t-test. However, there were no significant association with gender, academic achievement, levels of education and parents' level of education.

Conclusion

More than half of the nursing students at MNU, reported a higher level of emotional intelligence, indicating nursing students in the Maldives are emotionally intelligent. There needs to be regular training and interventions incorporated into the nursing curricular to enhance and strengthen the levels of emotional intelligence among student nurses.


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12 May 2023