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A STUDY TO ASSESS THE EFFECT OF PLANNED TEACHING ONKNOWLEDGE OF CAREGIVERS REGARDING PREVENTION AND MANAGEMENT OF AMNESIA AMONG ELDERLY INSELECTED RURAL AREA OF SINDHUDURG DISTRICT

BY

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ACKNOWLEGDEMENT

"*Gratitude makes sense of our past, brings peace for today, and creates a vision fortomorrow"*

-Melody Beatie

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MISS RIYA KHANOLKAR

RESEARCH ABSTRACT

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STATEMENT OF THE PROBLEM

A study to assess the effect of planned teaching on knowledge of caregivers regarding prevention and management of amnesia among elderly in selected rural area of Sindhudurg District.

OBJECTIVES

- To assess the knowledge of caregivers regarding prevention and management ofamnesia among elderly before and after planned teaching.

- To find out the comparison between knowledge of caregivers and selected demographicvariables.

RESEARCH APPROACH

A descriptive exploratory approach was used for this study.

RESEARCH DESIGN

One group pre-test and post-test design.

POPULATION

The population for this study consisted of all the caregivers involved in caring for the elderly aged 70 years and above of Sindhudurg district, Maharashtra.

SAMPLE AND SAMPLE SIZE

In this study the sample refers to the caregivers of elderly from selected rural area of Sindhudurg and the total sample size decided for the study was forty caregivers fulfilling the inclusion criteria

SAMPLING INCLUSION CRITERIA

- Caregivers who are able to understand, read and write Marathi or English.
- Caregivers willing to participate in the study
- Caregivers who are providing care to elderly aged 70 years and above.

SAMPLING TECHNIQUE

The sampling technique used in this study was non-probability convenience sampling.

TOOL AND TECHNIQUE

Based on objective of the following study tools were designed as:

1. Structured questionnaire
2. Planned teaching

Technique

Technique is the method of data gathering. The technique used in this study to collect the data was self-reporting.

VALIDITY AND RELIABILITY

The content validity of the tool developed for this study was done by giving it to twelve experts, four from the department of psychiatry and nine experts from the Nursing Department. Changes were incorporated in the tool as per their suggestions.

The reliability of the semi structured questionnaire was established by administering it to 30 college students who reside with their grandparents. The reliability was established by using Cronbach's Alpha formula. The value obtained was 0.74 and the tool was found to be reliablestatistically.

PILOT STUDY

The pilot study was carried out at Kudal, Sindhudurg district on four adult caregivers who stayed with their elderly. The pilot study helped the investigator to assess the feasibility and practicality of the research design and tool and helped her to gain more clarity about the data gathering process.

DATA GATHERING PROCESS

The investigator visited the elderly and their care givers at their residence and after introduction of self, got oriented to their problems. The investigator explained about her study and asked for their willingness and convenient date and time. For the data gathering the investigator arranged one assembly hall. The investigator visited to the gram panchayat and school and met the Sarpanch and school principal in advance and obtained the necessary permissions from concerned authorities. The investigator gathered all the caregivers for the pre-test followed by planned teaching. After seven days the investigator called all the caregivers again for the post-test. Thus, the investigator collected the data in a planned systematic manner.

MAIN FINDINGS OF THE STUDY

Demographic data of elderly:

Age:

More than half i.e. 55% elderly were aged 70-75years and 25% elderly between 76-80 years.Only 20%

were 80 years and above.

Gender:

As reported by caregivers, out of all the elderly 65 % were female and only 35 % male.

Education:

Most of the elderly had primary education that is 67.5 %, 12.5% elderly had secondary education and some percentage did not have any. Only 5% elderly were higher secondary andabove.

Type of family:

Almost 80% of elderly lived with their family in joint or extended system. Whereas 20% belong to a nuclear family norm.

Demographic data of Caregivers:

Age:

As per the findings 37.5 % caregivers were aged between 30 to 40 years, 32.5% caregivers were more than 50 years, 25 % care giver aged between 41 to 50 % and only 5 % care givers less than 30 years of aged.

Gender:

Out of all the caregivers 52% were male and 48% were female caregivers

Education:

With regards to the education of the care giver 42.5% completed secondary education, 22.5% care givers had completed primary education. Only 15% of caresgivers were educated up to graduation, 12.5 % care givers completed higher secondary education. 7.5% caregivers were post graduate

Relation with elderly:

Out of all the sample, majority of the caregivers were the children i.e. 40 % son and 32.5% daughter. Remaining 17.5% caregivers included granddaughter, grandson, daughter in law. 7.5% were sibling of the elderly and 2.5% mothers.

Duration of stay with elderly:

Majority i.e. 87.5% caregivers have been staying with their elderly more than 10 years. 10 % care givers have been staying with elderly for 5 to 10 years and 2.5 % care givers for less than2 years.

Effect of planned teaching regarding prevention and management of amnesia among elderly on pre and post-test knowledge scores of the samples.

With regards to knowledge about meaning of amnesia and memory, it was found that the mean mean

percentage during the pre-test was 7.5% that increased to 55% in the post-test. Similarly, knowledge regarding types of amnesia significantly improved from satisfactory (38.75%) to excellent (82.5%). There was an increase of only 7.5% in the mean percentage of knowledge regarding causes before and after planned teaching. Knowledge regarding symptoms of amnesia increased from 50.83 to 73.33% and knowledge regarding prevention and management of amnesia significantly increased from 43.5% to 75.5% after the teaching was implemented.

However, no change was found in the pre and post-test mean knowledge percentage of the sample with regards to diagnostic measures of amnesia.

The mean knowledge percentage improved from poor (33.33%) to average (47.5%) in relation to home care of clients with amnesia.

Comparison of knowledge with demographic variables

The comparison of knowledge score with selected demographic variables i.e. age, gender and relation with elderly were done. In each of the above, the calculated value of 't' obtained was less than the tabulated value at both 0.05 and 0.01 level of significance. Thus, the null hypothesis was accepted it can be concluded that there was no significant difference in the knowledge score with regards to age, gender and relation with elderly.

Conclusion:

The result of the above study clearly showed that the planned teaching had a positive effect on knowledge of samples regarding prevention and management of amnesia among elderly.

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CHAPTER 1

INTRODUCTION

"***Nothing can last forever. There isn't any memory, no matter how intense, thatdoesn't fade out at last"***

-Juan Rulfo

Langer (2019) states that memory has been viewed since antiquity through the lens of physical, emotional, and spiritual states of well-being. Biblical references to forgetting and memory abound. Concepts of memory and remembrance are recognized in the works of Hippocrates, Plato, Aristotle, Cicero, Avicenna, Averroes, and Maimonides, among others.

The term amnesia as per Langer (2019) derives from the Greek word, meaning loss of memory. The river of oblivion or forgetting in classical Greek mythology, Lethe (oblivion forgetting), was thus named. A very early appearance of the term amnesia has it as a synonym for 'amnesty' (etymologically related, as a noun: "Forgetfulness, oblivion; an intentional overlooking").

Galen credited his predecessors for the designation of "such conditions by different names, lack of memory, forgetfulness or the loss of memory, but also qualified them indistinctly as damage, affect or illness, or even symptom or infirmity". It appears that cases of forgetfulness or memory loss were well-recognized, but as can be seen, the term "amnesia" as a pathologic

clinical medical entity with substantive semi logical classifications did not develop until the late 18th century.

Raj (2017) defined amnestic disorders as a group of disorders that involve loss of memory previously established, the person is not able to develop new memories and also lose the ability to learn new information.

According to DSM-IV-TR, the amnestic disorders result from two basic causes, general medical condition that produce memory disturbance; and exposure to a chemical like drug abuse, some medication or some environmental toxins. There is a range of symptoms associated with the amnestic disorder, as well as difference in the severity of symptoms.

Some people experience difficulty to recalling events that happened or facts that they learned before the onset of amnestic disorder. This type of amnesia is called as retrograde amnesia. Other people experience the inability to learn new facts or retain new memories, which is called anterograde amnesia. People with amnestic disorders do not usually forget all of their personal history and their identity, although memory loss of this degree of severity occurs in rare instances in patients with dissociative disorders.

From four million Indians suffering from Alzheimer's currently, the number is set to reach 7.3 million by 2030. India ranks second in the world of dementia sufferers with an estimated 4.1 million patients. As research races to find a cure to these mystifying diseases, the answer may lie in the enigma of human memory. This article authored by Jain in 2018 states that the number of people with memory loss or forgetting will increase in tremendous way and there need to be some solution to avoid this situation.

Mild cognitive impairment (MCI) is an early stage of memory loss or other cognitive ability loss (such as language or visual/spatial perception) in individuals who maintain the ability to independently perform most activities of daily living.

The article in Alzeheimers Association, 2021 states that mild cognitive impairment causes cognitive changes that are serious enough to be noticed by the person affected, and by family members and friends, but do not affect the individual's ability to carry out everyday activities. Approximately, 12-18% of people aged 70 or older are living with mild cognitive impairment.

In some individuals, mild cognitive impairment reverts to normal cognition or remains stable. In other cases, such as, when a medication causes cognitive impairment, mild cognitive impairment is mistakenly diagnosed. It is important that people experiencing cognitive changes, seek help as soon as possible for diagnosis and possible treatment.

NEED OF THE STUDY

Cognitive health is an important component of performing everyday activities. Cognitive health means ability to think, learn and remember. Amnesia affects the cognitive health of elderly.

In the year 1990, there were more than 280 million people belonging to the age, 60 years or above in developing regions of the world, and 58% of the world's elderly were living in less-developed regions.

According to World Population Prospects (1950–2050), the proportion of elderly in developing countries is rising more rapidly, in comparison with developed ones. The report published by the US Department of Health and Human Services shows that more developed nations have had decades to adjust to this change in age structure.

Ageing is associated with many neurological disorders, as the capacity of the brain to transmit signals and communicate reduces. Loss of brain function is the biggest fear among elderly which includes loss of the very persona from dementia. Multiple other neurodegenerative conditions like Parkinson's disease or the sudden devastation of a stroke are also increasingly common with age. These disease cause nerve cell death and tissue loss throughout the brain, affecting nearly all its functions. The cortex in the brain shrivels up and these damages the areas involved in thinking, planning and remembering. The shrinkage in a nerve cell is especially severe in the hippocampus (an area of the cortex that plays a key role in the formation of new memories) as well as the ventricles (fluid-filled spaces within the brain) also grow larger, these causing memory loss, changes in personality and behaviour like depression, apathy, social withdrawal, mood swings, distrust in others, irritability and aggressiveness.

Nearly, 33 million Indians have neurological disorders, and these occur twice as often in rural areas. According to the World Health Organisation (WHO), nearly 5% of men and 6% of women aged 70 years and above are affected with Alzheimer's-type dementia worldwide. In India, the total prevalence of amnesia per 1000 elderly is 33.6%, of which dementia constitutes approximately 39% and Alzheimer's disease constitutes approximately 54%.

Caregiver burden is often experienced by caregivers for cognitively impaired family member, which is multifaceted involving physical, psychological, social and emotional problems. The care giver faces so many problems while dealing with the elderly having amnesia. There are different causes of amnesia, some may have amnesia because of aging, others have because of poor diet, accident etc. Elderly with amnesia face problems like forgetting house address, miss medication doses, forgetting about the placement of things where they are kept, name of known people or some past life events. All these things can impair the activities of daily living of elderly having amnesia. Elderly with amnesia, need directions to carry out activities of daily living and depend on the caregiver for the same. This further increases the caregivers stress and burden.

There is no specific treatment for amnesia, but techniques for enhancing memory and psychological support can help elderly people with amnesia and their families, to cope up with

such situations. Thus, there is a need to educate the care givers to manage and prevent amnesiaand improve the quality of the lives of the elderly.

CONCEPTUAL FRAMEWORK

The conceptual framework adopted for this study is based on System's theory that was developed by biologist Ludwig von Bertalanffy in 1930s. This theory provides a common framework for scientists from various disciplines to apply in research and communicate their findings.

A system is a collection of independent but interrelated elements or components organized in a meaningful way to accomplish an overall goal.

Open system is defined as a system that interact with its environment exchanging raw materials and energy for services and/or goods produced by the system. Health care facilities, hospitals, families, humans, banks, etc. are examples of open systems. A hospital produces health services through practice, health care professionals through training and knowledge through research. In return it receives money, raw materials, appreciation, and energy from itsenvironment.

Any system must have a goal. The goal is the overall purpose for existence of the system. The function of any system is to convert or process materials, energy, and/or information (inputs) into a product or outcome for use within the system, or outside of the system (the environment) or both.

Inputs include raw material, energy and resources processed to produce the outputs of the organization. In this study, input includes caregivers of elderly with amnesia, each attributed with knowledge, experience, age and education.

Transformation or throughput is the processes used by the system to convert raw materials or energy (inputs) from the environment into products or services that are usable by either the system itself or the environment. In this study the process includes pre-test conducted before planned teaching, planned teaching on prevention and management on amnesia among elderly, conducted using power point presentation, chart and pamphlet and post-test to evaluate the knowledge score after planned teaching.

Output is the product or service which results from the system's throughput or processing of technical, social, financial & human input. This includes the comparison in terms of gain knowledge score among caregivers. Thus, output refers to the change in knowledge of caregiver after planned teaching. The output could be positive or negative that is caregiver may or may not have an increase in the knowledge.

Feedback is information about some aspect of data or energy processing that can be used to evaluate & monitor the system & to guide it to more effective performance.

The lack of gain of knowledge of caregiver provides feedback that indicate the need for modification and reinforcement of planned teaching.

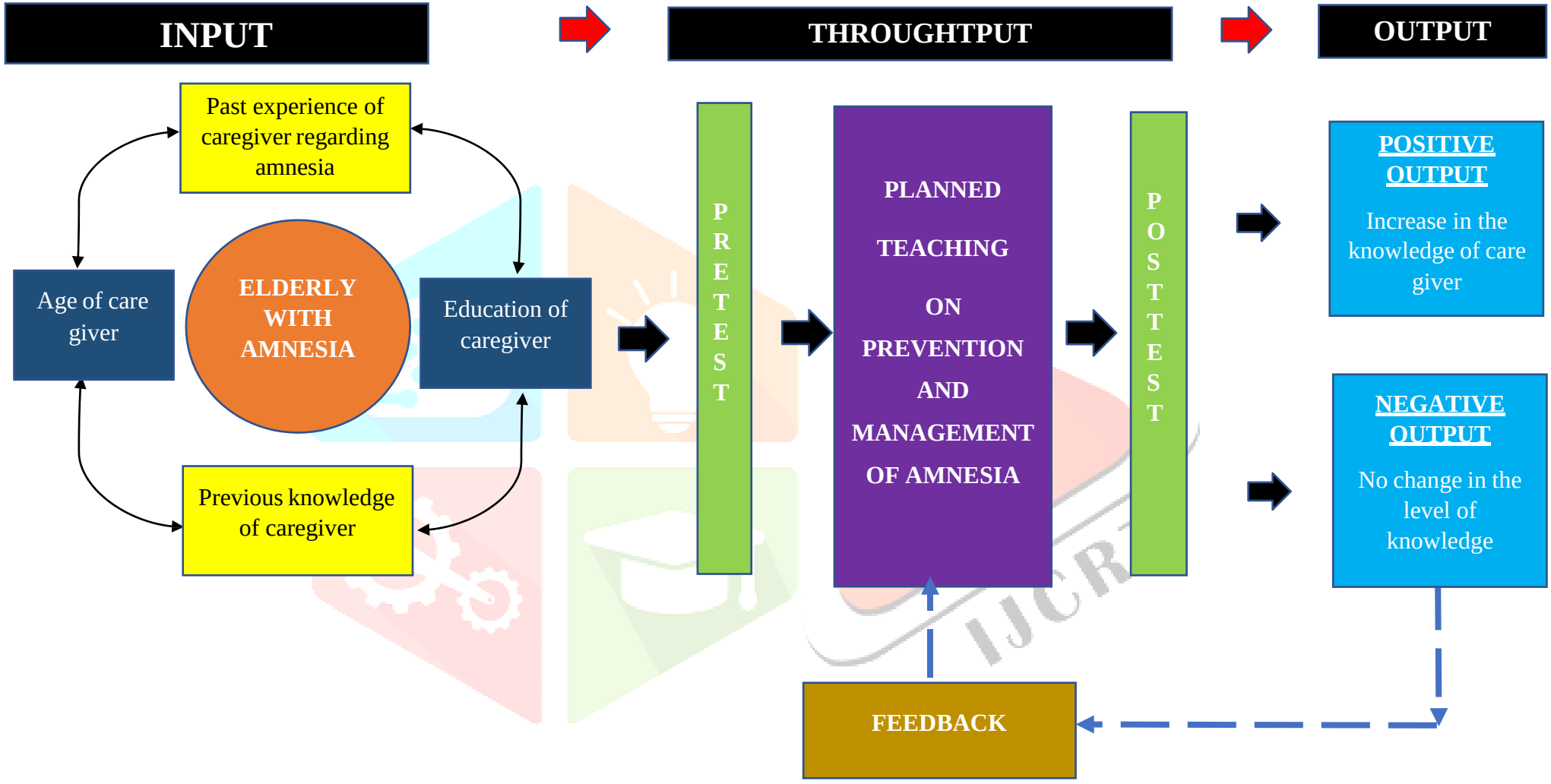

FIGURE 1

CONCEPTUAL FRAMEWORK BASED ON LUDWIG VON BERTALANFFY GENERAL SYSTEM'S THEORY

PROBLEM STATEMENT

"A study to assess the effect of planned teaching on knowledge of caregivers regarding prevention and management of amnesia among elderly in selected rural area of Sindhudurg District".

OBJECTIVES OF THE STUDY

- To assess the knowledge of caregivers regarding prevention and management ofamnesia among elderly before and after planned teaching.
- To find out the comparison between knowledge of caregivers and selected demographicvariables.

OPERATIONAL DEFINITION

Assess: -As per Collins dictionary, assess refers to judge the worth or importance of.

In this study assess means to find out the knowledge of caregivers regarding management and prevention of amnesia among elderly.

Effect: - As per Oxford dictionary, effect means change, that is a result or consequence of an action.

In this study, effect refers to the change in knowledge scores of caregivers regarding prevention and management of amnesia among elderly.

Planned: - As per Oxford dictionary, planned means detailed arrangement for something you want to do in future.

Teaching: - As per Oxford dictionary, teaching means to give lessons to students in a school, college, university to help somebody learn something by giving information about it.

In this study planned teaching means the meaningful and systematic interaction between researcher and caregivers using prepared teaching plan. The teaching plan includes the following aspects-

- ✓ Concept of amnesia
- ✓ Causes of amnesia
- ✓ Symptoms of amnesia
- ✓ Diagnostic measures of amnesia
- ✓ Treatment of amnesia
- ✓ Home care for elderly with amnesia
- ✓ Prevention and management of amnesia.

The planned teaching will be a single session of lecture-cum-discussion using audio visualaids, which will last for1and 1/2 hour.

Knowledge – As per Oxford dictionary knowledge means, the information, understanding and skill that you gain through education or experience.

In this study the knowledge implies the correct responses of caregivers which will be elicited using structured questionnaire. Each correct response will be given a score of one and incorrect response will be scored zero.

Knowledge will be arbitrarily graded as follows:

Above 75% - Excellent

60-74% - Good

59-45% - Average

44-36% - Satisfactory

Below 35% - Poor

Caregiver: - As per Oxford dictionary caregiver means a person who takes care of sick or old person at home.

In this study caregivers refers to individuals who are staying and giving care to the elderly aged70 years and above.

ASSUMPTIONS

- Caregivers may have some knowledge about the age-related changes in elderly.
- Planned teaching is an accepted method for imparting knowledge.

HYPOTHESIS

- H1: - There will be a significant difference in the mean knowledge score of caregiversbefore and after planned teaching.
- H2: - There will be a significant association between the mean knowledge score ofcaregivers and selected demographic variables.

DELIMITATIONS

- The teaching is delimited to the selected cognitive domain of elderly.
- The study is delimited to a single session of planned teaching.

SCOPE OF THE STUDY

- ❑ The study will empower the caregivers in providing care to elderly clients.
- ❑ The study will aid the caregivers to detect signs of amnesia at an early stage.
- ❑ The study can provide impetus for further study related to the practical aspects of careof clients with amnesia.

REFERENCES

1. Alzeheimers association. (2021). Retrieved from www.alz.org.
2. Deepak. (2019). Text book of Managment. Delhi: P V Publication.
3. Jain, a. (2018). Memories Mestrys. The New Indian Express.
4. Langer, K. G. (2019). Early History of Amnesia. A History of Neuropsychology.
5. Raj, D. E. (2017). Derbs Mental Health Nursing. Banglore: Emmess MedicalPublishers.
6. Pearsall J (2002). The Concise Oxford Dictionary. 10th edition. Oxford UniversityPress.
7. Polit D.F. and Hungler B.P. Nursing Research: Principles and Methods.4th Edition. Philadelphia.
8. Quotemaster. https://www.quotemaster.org

CHAPTER II

REVIEW OF LITERATURE

"***Literature is the art of discovering something extraordinary about ordinary people, and saying with ordinary words something extraordinary***"

-Boris Pasternak

Review of literature is an important step of development of research project. Literature review is a critical summary of research on the topic of interest generally prepared to put a research problem in context or to identify gaps and weaknesses in prior studies so as to justify new investigation. It relates to the findings from one study to another, with the hope to establish a comprehensive study of scientific knowledge in professional discipline way, from which valid pertinent theories may be developed.

It is important to think of knowledge in a given field as consisting of three layers. First, there are the primary studies that researchers conduct and publish. Second, are the reviews of those studies that summarize and offer new interpretations built from, and often, extending beyond the primary studies. Third, there are the perceptions, conclusions, opinions, and interpretations that are shared informally, that become a part of the field. An attempt has been made by the investigator to review and discuss the research literature and its findings related to the present study. It is intended to develop a deeper insight in the problem areas, development of conceptual framework and research design.

The Review literature for the study has been presented under the following headings:

1. Studies related to the prevalence, the causes and the types of amnesia.
2. Studies related to the diagnosis of amnesia.
3. Studies related to the management of amnesia.
4. Studies related to the caregiver's burden residing with the elderly.
5. Studies related to the knowledge of caregivers of the elderly and effect of plannedteaching.

1. Studies related to the prevalence, the causes and the types of amnesia.

Ray and Courtney conducted a study in Loma Linda University, California in 2016 on "Effects of Stress, Sex Differences, and Cognitive Reserve on Cognitive Decline in Healthy Elderly Subjects". The current study used data collected through the Walnuts and Healthy Aging (WAHA) Study. Three hundred and sixty-five healthy, elderly participants (aged 65-75 years old; mean=69.6 years old; 245 females) from the Southern California area were recruited via radio, newspaper and internet advertisements, as well as posted fliers. None of the subjects were residents of the assisted living or nursing homes—all lived independently within the community. The results concluded that, stress did not have a significant effect on any of the cognitive performance or decline scores. Sex was a significant predictor of performance and decline in verbal memory.

Gaël Chételat, Rik Ossenkoppele, Victor L Villemagne, Audrey Perrotin, and Brigitte Landeau, in the year 2016 explored the Atrophy, hypometabolism and clinical trajectories in patients with amyloid-negative Alzheimer's disease. They investigated clinical and demographic features, patterns of brain atrophy and hypometabolism and longitudinal clinical trajectories of these patients. Forty amyloid-negative patients, carrying a pre-scan diagnosis of Alzheimer's disease dementia from four centres were included (11/29 females/males; mean age = 67 ± 9). There were 21 amnestic, 12 non-amnestic, and seven non-specific amyloid-negative Alzheimer's disease cases. After the amyloid scan, clinicians altered the diagnosis in 68% of amyloid-negative patients including 48% of amnestic versus 94% of non-amnestic and non-specific cases. After the amyloid scan, clinicians altered the diagnosis in 68% of amyloid- negative patients including 48% of amnestic versus 94% of non-amnestic and non-specific

cases. In contrast, in the subgroup of amnestic amyloid-negative cases, the clinical presentationand follow-up usually remained consistent with Alzheimer's disease.

A study carried out by Barbara Vicini-Chilovi, Maddalena Riva, Marta Conti, Marina Zanetti, Salvatore Caratozzolo, Gulia Mombelli, et al, in the year 2010 on "Does age at observation time affect the clinical presentation of mild cognitive impairment?". (MCI). A total of 167 outpatients with a clinical diagnosis of MCI were consecutively enrolled and entered in the study. Clinical and demographic characteristics were carefully recorded. Each patient underwent a wide neuropsychological standardized assessment. The subjects were divided into 3 groups according to their age at observation time: 58 MCI patients were classified as young (≤ 69 years), 89 as old (70-79 years) and 20 as very old (≥ 80 years). The 3 groups did not differ in demographic characteristics, general cognitive functions and memory impairment. Very old MCI subjects showed a significantly greater impairment than younger MCI patients in cognitive domains involving executive functions. In particular, very old MCI patients were more frequently classified as having multiple-domain amnestic MCI.

A study carried out by Carrie B Peltz, María M Corrada, Daniel J Berlau, and Claudia H Kawas in the year 2011 on "Incidence of dementia in oldest-old with amnestic MCI and other cognitive impairments". The objective of the study was to examine the incidence of dementia among the oldest-old people with normal cognition and different types of cognitive impairment. This study included 395 participants without dementia (mean age 93.3 years) from the 90+ Study, a prospective, population-based study of aging and dementia in people aged 90 years and older. The participants had evaluations for dementia every 6 months, and their average follow-up was 2.5 years. The incidence of all-cause dementia was examined in participants after stratified them into 4 cognitive groups: normal, amnestic mild cognitive impairment (aMCI), non-amnestic mild cognitive impairment (naMCI), and other cognitive impairment (OCI). The result showed dementia incidence was highest for participants with aMCI (31.4% per year) and OCI (39.9% per year). Participants with naMCI had an incidence of 14.1% per year, and participants with normal cognition had an incidence of 8.4% per year.

Ming-Yen Tsai, Meng-Han Tsai, Shih-Chung Yang, Yu-Lung Tseng, and Yao-ChungChuang studied the effect of hypnotics on amnesia in elderly, in the year 2009. The study was

on “Transient global amnesia-like episode due to mistaken intake of zolpidem: drug safety concern in the elderly”. Older people who self-medicate often have a high risk for medication errors. A case study of a 65-year-old woman, who experienced recurrent transient anterograde amnesia, anxiety, bewilderment, and repetitive questioning that lasted for 2 to 3 hours after erroneously taking zolpidem. It was concluded that medication, particularly as regards to hypnotics, should be carefully reviewed when a patient presents with transient global amnesia-like symptoms.

Clémence Tomadesso, Audrey Perrotin, Justine Mutlu, Florence Mézenge, and Brigitte Landeau studied in the year 2015 on “Brain structural, functional, and cognitive correlates of recent versus remote autobiographical memories in amnestic Mild Cognitive Impairment” (aMCI). The study aims to understanding of this graded effect by investigating the cognitive and neural substrates of recent versus remote autobiographical memories in patients with amnestic Mild Cognitive Impairment (aMCI). Twenty aMCI patients and twenty-five Healthy elderly Controls (HC), underwent neuropsychological tests assessing remote (20-to-30 years old) and recent (the ten last years) autobiographical memory as well as episodic and semantic memory, executive function and global cognition. The brain regions related with the retrieval of events from the recent period showed greater atrophy/hypometabolism in aMCI patients compared to HC than those involved in remote memories. Recall of recent memories essentially relies on episodic memory processes and brain network, while remote memories also involve other processes such as semantic memory. This is consistent with the semanticization of memories with time and may explain the better resistance of remote memoryin AD.

Guha K Venkatraman 1, Andrew Bauerschmidt conducted the study in the year 2011 on “Two cases of delayed-onset transient global amnesia after saline-contrast transthoracic echocardiography”. Two cases of transient global amnesia (TGA) with delays of 1 and 2 hours after saline-contrast transthoracic echocardiography. The unique presentation in these cases may help elucidate the possible mechanisms underlying TGA. A 63-year-old woman admitted for lower extremity arterial thrombosis with TGA onset, 1 hour after saline-contrast echocardiography and a 75-year-old woman admitted to rule out myocardial infraction with TGA onset 2 hours after saline-contrast echocardiography. It can thus be concluded, that the presence of a delay after the trigger event as described in these cases is unique and informative and that it lends strength to some proposed mechanisms over others in this subset of TGA presentations.

Rosalie Boitet, Nicolas Gaillard, Eddine Bendiab, Lucas Corti, Caroline Roos, and Jacques Reynes et al studied in the year 2019 on "Concomitant reversible cerebral vasoconstriction syndrome and transient global amnesia". They retrospectively reviewed clinical and radiological features of patients, diagnosed with confirmed concomitant RCVS and TGA between 2012 and 2018 in two specialized institutions. Two women aged 67 and 53, and a 64-year-old man had a first thunderclap headache, triggered by an acute emotional stress, rapidly followed by TGA. Amnesia resolved within a few hours and RCVS was proven for all, with complete resolution of vasospasms within 3 months. All three patients had excellent outcome. After the result they conclude that RCVS and TGA can occur simultaneously, which suggests common mechanisms, such as aberrant responses to physical or emotional stress andcerebral vasoconstriction.

A study was conducted by Deselms, Jessica L. in Minnesota State University, Mankato, United States in 2012 on "Memory Priming in Elderly Individuals Diagnosed with Dementia". The purpose of this study was to examine the efficacy of a novel memory enhancement procedure for individuals with dementia named "memory priming." Each participant was administered the Modified-Mini-Mental Status Exam to obtain a global assessment of their level of cognitive impairment. The 3MS is a modified version of the Mini-Mental Status Exam (MMSE). The low-probability questions were questions that the participants answered correctly less than 30% of the time, participant 1 (M=20%), participant two (M=26.1%), and participant three (M=18.87%). These questions served as the target questions during the intervention phase, with one target question being designated to each of the three separate intervention conditions. Target questions were randomly assigned to each condition. Moderate- probability questions were those that the resident responded to correctly between 30% and 70% of the time or higher, participant one (M=66.6%), participant two (M=52.66%), and participant three (M=50.57%). Each question was asked four to six times. In conclusion, MP may comprise a variety of cognitively engaging activities that may need to be determined on an individual. Therefore, it is tentatively concluded that engaging in cognitively stimulating activity seems to be a useful technique in increasing recall of personally-relevant information.

A study conducted by Ambika B Khanna and Chandra S Metgud at Belgavi Karnataka in the year 2020 on "Prevalence of cognitive impairment (CI) in elderly population residing in an urban area of Belagavi". A cross-sectional study was carried out among 770 elderly aged ≥60 years residing in two Urban Health Centres of Belagavi District. Socio-demographic profile of the participants were collected using a predesigned and pretested questionnaire by

personal interview at the participants' residence. To assess the CI and burden of healthcare, Mini Mental State Examination and Zarit Caregiver Burden Scale were used, respectively. The result said that the overall prevalence of CI was 8.4%. The risk factors noted for CI were advancing age, female sex, unmarried or widow/widower, illiterate, not working presently, staying alone, and poverty. Out of 65 caregivers, 67.7% of them had mild or moderate burden of caring for the cognitively impaired elderly.

2. Studies related to diagnosis of amnesia.

Camilla Dyremose Jensen, Thomas Krøigård, Christoph Patrick Beier in Denmark explored the study in the year 2019 on "Transient epileptic amnesia diagnosed using long-term electroencephalography". Transient epileptic amnesia (TEA) is a distinct syndrome affecting middle-aged persons without concurrent brain disease or disposition to epileptic seizures. Seizures are characterized by amnesia, usually lasting less than one hour, and interictal memory deficits that are common. Effective antiseizure treatment is usually rapid in patients with TEA, which underlines the need for prompt diagnosis. Here, the report of a 58-year-old male patient, with recurrent episodes of antero- and retrograde amnesia. MRI was normal and diagnosis was made using long-term EEG (27 hours), revealing 10 right-sided temporal lobe seizures with subtle clinical symptoms lasting up to 86 seconds. Details of the video-EEG are presented. Treatment with levetiracetam resulted in complete recovery and seizure freedom that was confirmed on a second long-term EEG.

A study was done by Buschke H, Mowrey WB, Ramratan WS, Zimmerman ME, Loewenstein DA, Katz MJ, Lipton RB in the year 2017, on ability of Memory Binding Test, to distinguish Amnestic Mild Cognitive Impairment and Dementia, from Cognitively Normal Elderly. The aim was to assess the reliability and cross-sectional discriminative validity of the Memory Binding Test (MBT) to distinguish persons with amnestic cognitive impairment (aMCI) and dementia from cognitively normal elderly controls. The memory Binding Test was administered to 20 participants with dementia, 31 with an amnestic cognitive impairment and 246 controls. The result was total number of items recalled in the Paired condition (TIP) was elected the optimal index. TIP cut-score was ≤22 for differentiating aMCI alone (sensitivity = 0.74, specificity = 0.73) and aMCI and dementia combined (sensitivity = 0.84, specificity = 0.73) from controls. It was ≤17 for differentiating dementia from aMCI and controls (sensitivity
= 0.95, specificity = 0.87). Age and education adjustments did not materially improve

discriminative validity. The reliability of TIP was 0.77. Conclusion was MBT achieved moderate to good reliability. TIP had superior cross-sectional discriminative validity than the other MBT indices

3. Studies related to management of amnesia.

A study was conducted by Gautier Allouchery, Farès Moustafa, Jean Roubin, Bruno Pereira, Jeannot Schmidt, Julien Raconnat, et. al. in the year 2018, on "Clinical validation of S100B in the management of a mild traumatic brain injury: issues from an interventional cohort of 1449 adult patients". The aim was a reduction of cranial computed tomography (CCT) scans by 30%. The secondary goal was to investigate the influence of age and associated risk factors on the reduction of CCT. Out of the 1449 patients included in this study, 468 (32.3%) had S100B- with a sensitivity of 96.4% (95% CI: 87.5%-99.6%), a specificity of 33.4% (95% CI: 31%-36%) and a negative predictive value of 99.6% (95% CI: 98.5%-99.9%). No significant difference in serum levels or the S100B+ rate was observed if patients had retrograde amnesia (0.16 µg/L; 63.8%), loss of consciousness (0.13; 63.6%) or antiplatelet therapy (0.20; 77.9%). After this result they concluded that the clinical use of S100B in mTBI management reduces the use of CCTs by approximately one-third; furthermore, the percentage of CCTs reduction is influenced by the age of the patient.

Taeko Makino, Hiroyuki Umegaki, Masahiko Ando, Xian Wu Cheng, Koji Ishida, Hiroshi Akima et al. concluded the study in the year 2021 on, "Effects of Aerobic, Resistance, or Combined Exercise Training Among Older Adults with Subjective Memory Complaints: A Randomized Controlled Trial". The objective of the study was to investigate the differential effects of aerobic exercise training (AT), resistance exercise training (RT), and combined exercise training (CT) on cognition in older adults with subjective memory complaints (SMC). Community-dwelling older adults with SMC (n = 415; mean age = 72.3 years old) were randomly assigned to one of the four groups: AT, RT, CT, or control group. The study consisted of two phases: a 26-week intervention and a 26-week follow-up. The participants were evaluated at baseline, 26 weeks (postintervention), and 52 weeks (follow-up). This study suggests that AT intervention can improve delayed memory in community-dwelling older adults, particularly in individuals without objective memory decline.

A study was conducted by Takao Suzuki, Hiroyuki Shimada, Hyuma Makizako, Takehiko Doi, Daisuke Yoshida, et al. in the year 2012 on, "Effects of multicomponent

exercise on cognitive function in older adults with amnestic mild cognitive impairment: a randomized controlled trial" in Japan. The design was Twelve months, randomized controlled trial. Fifty older adults (27 men) with aMCI ranging in age from 65 to 93 years (mean age, 75 years) participants were present. Subjects were randomized into either a multicomponent exercise (n = 25), or an education control group (n = 25). Subjects in the multicomponent exercise group, exercised under the supervision of physiotherapists for 90 min/d, 2 d/week, for a total of 80 times over 12 months. The exercises included aerobic exercise, muscle strength training, and postural balance retraining, and were conducted using multiple conditions to stimulate cognitive functions. At the end the result of the mean adherence to the exercise program was 79.2%. Improvements of cognitive function, following multicomponent exercise were superior at treatment end (group × time interactions for the mini-mental state examination (P = 0.04), logical memory of immediate recall (P = 0.03), and letter verbal fluency test. So, they conclude that this study indicates that exercise improves or supports, at least partly, cognitive performance in older adults with aMCI.

Xiang-Lian Zhou, Li-Na Wang, Jie Wang, Ling Zhou, Xin-Hua Shen explored the study in the year 2020 on, "Effects of exercise interventions for specific cognitive domains in old adults with mild cognitive impairment (MCI): A meta-analysis and subgroup analysis of randomized controlled trials". Randomized controlled trials of exercise interventions in MCI patients, older than 55 years, with an outcome measure of cognitive function were included. The result was that eleven studies with sufficient data met the inclusion criteria for the meta- analysis. Exercise interventions significantly improved general function. At the end, they concluded that exercise improves performance in the 5 cognitive domains. Across cognitive domains, language ability was the domain most affected by exercise.

The study was conducted by Lawla L F Law, Vincent C T Mok, Matthew M K Yau in the year 2019 on, "Effects of functional tasks exercise on cognitive functions of older adults with mild cognitive impairment: a randomized controlled pilot trial". A four-arm, rater-blinded randomized controlled trial. Participants (N = 59) were randomized to either a functional task exercise group, a cognitive training group, an exercise training group, or a waitlist control group for 8 weeks. All outcome measures were undertaken at baseline and post-intervention using Neurobehavioral Cognitive Status Examination, Trail Making Test A and B, Chinese Version Verbal Learning Test, Lawton Instrumental Activities of Daily Living Scale, and Zarit Burden Interview. Results of the Kruskal-Wallis one-way ANOVA showed higher improvement in the functional task exercise group with significant between-group differences

in memory (p = 0.009) compared to the exercise group and cognitive training group, functional status (p = 0.005) compared to the cognitive training group and waitlist control group, and caregiver burden (p = 0.037) compared to the exercise group and cognitive training group.

A study was conducted by Soledad Ballesteros, Jennifer A Rieker, Julia Mayas, Antonio Prieto, Pilar Toril, María Pilar Jiménez et al. in the year 2020 on, "Effects of multidomain versus single-domain training on executive control and memory in older adults: study protocol for a randomized controlled trial (RTC)". In this study the randomized, single- blind, controlled trial, 144 participants will be randomly assigned to one of the four combinations of cognitive training and physical exercise. This RCT will investigate the short and long-term effects of multidomain training, compared to cognitive training and physical training alone, on executive control and memory functions in healthy older adults, in comparison with the performance of an active control group.

P. Srisuwan, D. Nakawiro, S. Chansirikarnjana, O. Kuha, P. Chaikongthong, and T. Suwannagoot concluded in the year 2020, a study on, "Effects of a Group-Based 8-Week Multicomponent Cognitive Training on Cognition, Mood and Activities of Daily Living among Healthy Older Adults: A One-Year Follow-Up of a Randomized Controlled Trial". The objective of the study was to assess the effectiveness of a multicomponent CT using a training program of executive functions, attention, memory and visuospatial functions (TEAM-V Program) on cognition, mood and instrumental ADL. Seventy-seven nondemented community-dwelling older adults (mean age 65.7±4.3 years) were selected for the study. The result said that Compared with the control arm, the TEAM-V Program was associated with reducing anxiety (P = 0.004). Compared with the baseline, participants receiving the TEAM- V Program were associated with significantly improved general cognition (MoCA, P < 0.001), immediate recall (word recall task, P = 0.01), retrieval and retention of memory process (word recognition task, P = 0.01), attention (number cancellation part A, P < 0.001) and executive function (maze test, P = 0.02) at 1 year.

Kazuki Uemura, Hiroyuki Shimada, Hyuma Makizako, Takehiko Doi, Daisuke Yoshida, Kota Tsutsumimoto, et al. explored the study in the year 2013 on, "Cognitive function affects trainability for physical performance in exercise intervention among older adults with mild cognitive impairment". Forty-four older adults diagnosed with mild cognitive impairment based on the Peterson criteria (mean age 74.8 years) consented to and completed, a 6-month, twice weekly exercise intervention. The Timed Up and Go (TUG) test was used as a measure

of physical performance. The Mini-Mental State Examination (MMSE), Trail Making Test Part B, Geriatric Depression Scale, baseline muscle strength of knee extension, and attendance rate of intervention, were measured as factors for predicting trainability. At the end the result said that, in the correlation analysis, the change in TUG showed modest correlations with attendance rate in the exercise program ($r = -0.354$, $P = 0.027$) and MMSE at baseline ($r = -0.321$, $P = 0.034$). A multiple regression analysis revealed that change in TUG was independently associated with attendance rate ($\beta = -0.322$, $P = 0.026$) and MMSE score ($\beta = -0.295$, $P = 0.041$), controlling for age and gender.

4. Studies related to caregiver's burden residing with elderly

Shweta Ajay, Arvind Kasthuri, Pretesh Kiran, Rahul Malhotra, M.P.H in 2016 explored the, association of impairments of older persons with caregiver burden among family caregivers in Karnataka. All impaired older persons (aged ≥60, with impairment in activities of daily living (ADL) or cognition or vision or hearing), residing in 8 villages in Bangalore district, Karnataka, India, and their primary informal caregivers were interviewed. Caregiver burden was measured using the Zarit Burden Interview (ZBI; higher score indicating greater perceived burden). The Linear regression models, adjusting for background characteristics of older persons and caregivers, assessed the association of type of impairment (physical [Yes/No], cognitive [Yes/No], vision [Yes/No] and hearing [Yes/No]) and number 1 or 2 or 3 or 4) of older person impairments with caregiver burden. A total of 140 caregivers, caring for
149 older persons, were interviewed. Relative to caregivers of older person with one impairment, those caring for an older person with all 4 impairments had significantly higher ZBI score. The findings concluded that caregivers of older persons with multiple impairments, especially physical impairment, are vulnerable.

A case control study was done by Kuljeet Singh Anand, Vikas Dhikav, Ankur Sachdeva and Pinki Mishra in New Delhi in the year 2015, to assess the perceived caregiver stress in Alzheimer's disease and mild cognitive impairment. Caregivers of patients diagnosed with Alzheimer's disease/Mild Cognitive Impairment were recruited at the Memory Clinic of Neurology Department of a Tertiary Care Hospital in Northern India. The controls included caregivers of patients with chronic medical and psychiatric disorders. Caregivers were interviewed using Perceived Stress Scale (PSS) and the patients were assessed using The

Blessed Activity of Daily Living (ADL), Mini Mental State Examination (MMSE) and Clinical Dementia Rating scale. Caregivers of a total of 31 patients of AD/MCI (Males = 24, Females = 7), and 30 controls (Males = 18, Females = 12) were interviewed. Caregivers of patients with MCI had lower PSS scores compared to AD caregivers, but significantly higher scores compared to caregivers of other chronic disorders. At the end they concluded that caregivers of patients with AD/MCI have a high perceived stress compared to caregivers of patients withother chronic illness.

P. Sinhaa, N. G. Desaia, O. Prakasha, S. Kushwahab, and C. B. Tripathic did a comparative study in New Delhi in 2017, to find out the Caregiver burden in Alzheimer-type dementia versus psychosis: A comparative study from India. Thirty-two caregiver-patient dyads of Alzheimer-type dementia were compared with thirty-two caregiver-patient dyads of psychosis. Cognitive assessment, abilities to perform activities of daily living and severity of dementia was assessed in the patients. Zarit Burden Interview was used to study the caregiver burden in both groups. The mean burden score in dementia caregivers was high at 47.7, whereas the mean burden score for elderly psychosis caregivers was lesser at 33.6. The study inferred that dementia carries a greater caregiver burden when compared with elderly patients with psychosis. Innovative interventions are needed to remove burden from caregiving, making it a meaningful practice integral to the Indian society.

A study conducted in Gujarat (2015) by Shobha Misra, Rajat Oswal and Mehul Patel to explore the Family Burden in Caregivers of Elderly with Cognitive Impairment residing in Rural and Tribal Population of a District in Western India. The cross-sectional study was conducted among adults residing in the rural population. A total of 240 households from 12 villages of the block were selected by multistage and random sampling method. Mini-mental state examination and Zarit Burden Interview tools were used to assess CI and burden. A total of 212 adults aged over 59 years were studied. The overall prevalence of CI was 42.92%. There was a statistically significant difference seen in CI among females as compared to males. Interview of primary care taker showed that 32 (35.16%) caregivers had little or no burden, 53 (58.24%) had mild-to-moderate burden, and 6 (6.59%) had moderate-to-severe burden, while none had a severe burden.

5. Studies related to knowledge of caregivers of elderly and effect of teaching.

A study conducted in Iran (2010) by Saeed Pahlavanzadeh, Fatemeh Ghaedi Heidari, Jahangir Maghsudi, Zahra Ghazavi, and Saeed Samandari to assess the effects of family education program on the caregiver burden of families of elderly with dementia disorders. This was a clinical trial, in which 50 family caregivers of the elderly patients with dementia who had referred to two referral centres for dementia in the city of Isfahan were selected with convenient sampling method and were randomized to experimental and control groups. The experimental group participated in a family education program but the control group did not. Data were collected by Zarit's caregiver burden scale, completed by caregivers of both groups before, right after, and one month after the family education program. Also, Mini-Mental Status Examination was conducted for elderly before the program. Caregivers' burden was gradually increased in the controls, but decreased in the experimental group during the study. The means of caregivers' burden before, right after, and one month after the family education program were 42, 35.44, and 33.56 in the experimental group, respectively, while the mean of control group were 43.28, 46.8 and 50.64 respectively. By conducting this program, it could reduce the caregivers' burden of families of elderly with dementia. Developing such programs and evaluating them within research projects are recommended.

A study was conducted by Perla Werne in 2001 on correlates of family caregivers' knowledge about Alzheimer's disease. Two hundred and twenty informal caregivers of an elderly person suffering from Alzheimer's disease were recruited from four large memory clinics across the country, and interviewed by trained research assistants. Overall, low levels of knowledge were found, especially in items related to the prevalence, causes and symptoms of the disease. Low education and being a spouse were the most important vulnerability factors associated with poor knowledge.

REFERENCES-

1. Ajay, S., Kasthuri, A., Kiran, P., & Malhotra, R. (2017). Association of impairments of older persons with caregiver burden among family caregivers: Findings from rural South India. Archives of gerontology and geriatrics, 68, 143-148.
2. Anand, K. S., Dhikav, V., Sachdeva, A., & Mishra, P. (2016). Perceived caregiver stress in Alzheimer's disease and mild cognitive impairment: A case control study. Annals of Indian Academy of Neurology, 19(1), 58.
3. Allouchery, G., Moustafa, F., Roubin, J., Pereira, B., Schmidt, J., Raconnat, J., ... & Bouvier, D. (2018). Clinical validation of S100B in the management of a mild traumatic brain injury: issues from an interventional cohort of 1449 adult patients. Clinical Chemistry and Laboratory Medicine (CCLM), 56(11), 1897-1904.
4. Ballesteros, S., Rieker, J. A., Mayas, J., Prieto, A., Toril, P., Jiménez, M. P., & Reales, J. M. (2020). Effects of multidomain versus single-domain training on executive control and memory in older adults: study protocol for a randomized controlled trial. Trials, 21(1), 1-15.
5. Boitet, R., Gaillard, N., Bendiab, E., Corti, L., Roos, C., Reynes, J., ... & Ducros, A. (2020). Concomitant reversible cerebral vasoconstriction syndrome and transient global amnesia. *Journal of Neurology*, 267(2), 390-394.
6. Buschke, H., Mowrey, W. B., Ramratan, W. S., Zimmerman, M. E., Loewenstein, D. A., Katz, M. J., & Lipton, R. B. (2017). Memory binding test distinguishes amnestic mild cognitive impairment and dementia from cognitively normal elderly. Archives of Clinical Neuropsychology, 32(1), 29-39.
7. Chételat, G., Ossenkoppele, R., Villemagne, V. L., Perrotin, A., Landeau, B., Mézenge, F., & Rabinovici, G. D. (2016). Atrophy, hypometabolism and clinical trajectories in patients with amyloid-negative Alzheimer's disease. Brain, 139(9), 2528-2539.
8. Deselms, Jessica L. in Minnesota State University, Mankato, United States in (2012). Memory Priming in Elderly Individuals Diagnosed with Dementia.
9. Jensen, C. D., Kr. igård, T., & Beier, C. P. (2020). Transient epileptic amnesia diagnosed using long-term electroencephalography. Epileptic Disorders, 22(2), 225-228.
10. Khanna, A. B., & Metgud, C. S. (2020). Prevalence of cognitive impairment in elderly population residing in an urban area of Belagavi. *Journal of Family Medicine and Primary Care*, 9(6), 2699.

11. Law, L. L., Mok, V. C., & Yau, M. M. (2019). Effects of functional tasks exercise on cognitive functions of older adults with mild cognitive impairment: a randomized controlled pilot trial. Alzheimer's Research & Therapy, 11(1), 1-10.

12. Makino, T., Umegaki, H., Ando, M., Cheng, X. W., Ishida, K., Akima, H., ... & Kuzuya, M. (2021). Effects of Aerobic, Resistance, or Combined Exercise Training Among Older Adults with Subjective Memory Complaints: A Randomized Controlled Trial. *Journal of Alzheimer's Disease*, 82(2), 701-717**.**

13. Misra, S., Oswal, R., & Patel, M. (2020). Family burden in caregivers of elderly with cognitive impairment residing in rural and tribal population of a district in Western India–A baseline study. Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine, 45(4), 445.

14. Peltz, C. B., Corrada, M. M., Berlau, D. J., & Kawas, C. H. (2011). Incidence of dementia in oldest-old with amnestic MCI and other cognitive impairments. Neurology,77(21), 1906-1912.

15. Polit O.F. and Hungler B.P. (1991), "Nursing Research: Principles and Methods", 4th Edition, Lippincott Publication, Philadelphia.

16. Quotemaster, https://www.quotemaster.org

17. Ray, C. (2016). *Effects of stress, sex differences, and cognitive reserve on cognitive decline in healthy elderly subjects*. Loma Linda University.

18. Sinha, P., Desai, N. G., Prakash, O., Kushwaha, S., & Tripathi, C. B. (2017). Caregiver burden in Alzheimer-type dementia and psychosis: A comparative study from India. *Asian journal of psychiatry*, 26, 86-91.

19. Srisuwan, P., Nakawiro, D., Chansirikarnjana, S., Kuha, O., Chaikongthong, P., and Suwannagoot, T. (2020). Effects of a Group-Based 8-Week Multicomponent Cognitive Training on Cognition, Mood and Activities of Daily Living among Healthy Older Adults: A One-Year Follow-Up of a Randomized Controlled Trial. *The journal of prevention of Alzheimer's disease*, 7(2), 112-121.

20. Suzuki, T., Shimada, H., Makizako, H., Yoshida, D., Tsutsumimoto, K., Anan, Y., ... & Park, H. (2012). Effects of multicomponent exercise on cognitive function in older adults with amnestic mild cognitive impairment: a randomized controlled trial. BMC neurology, 12(1), 1-9.

21. Tomadesso, C., Perrotin, A., Mutlu, J., Mézenge, F., Landeau, B., Egret, S and Chételat, G. (2015). Brain structural, functional, and cognitive correlates of recent versus remote

autobiographical memories in amnestic Mild Cognitive Impairment. NeuroImage: Clinical, 8, 473-482.

22. Tsai, M. Y., Tsai, M. H., Yang, S. C., Tseng, Y. L., & Chuang, Y. C. (2009). Transient global amnesia-like episode due to mistaken intake of zolpidem: drug safety concern in the elderly. *Journal of Patient Safety*, 5(1), 32-34.

23. Uemura, K., Shimada, H., Makizako, H., Doi, T., Yoshida, D., Tsutsumimoto, K. and Suzuki, T. (2013). Cognitive function affects trainability for physical performance in exercise intervention among older adults with mild cognitive impairment. Clinical interventions in aging, 8, 97.

24. Venkatraman, G. K., & Bauerschmidt, A. (2011). Two cases of delayed-onset transient global amnesia after saline-contrast transthoracic echocardiography. The Neurologist, 17(6), 338-339

25. Vicini-Chilovi, B., Riva, M., Conti, M., Zanetti, M., Caratozzolo, S., Mombelli, G., ... & Padovani, A. (2010). Does age at observation time affect the clinical presentation of mild cognitive impairment? Dementia and geriatric cognitive disorders, 30(3), 212-218.

26. Zhou, X. L., Wang, L. N., Wang, J., Zhou, L., & Shen, X. H. (2020). Effects of exercise interventions for specific cognitive domains in old adults with mild cognitive impairment: A meta-analysis and subgroup analysis of randomized controlled trials. Medicine, 99(31).

CHAPTER III

RESEARCH METHODOLOGY

This chapter deals with the description of research methodology adopted by the investigator. According to Polit and Beck (2004) methodology refers to ways of obtaining, systematizing and analysing data.

According to Creswell (2003) methodology is a coherent group of methods that harmonize one another and that have the capability to fit, to deliver data and findings that will reflect the research question and suits the researcher's purpose. The steps taken for gathering and organizing the collected data were: research design, settings, population, sample size and technique, criteria for selection of sample tool, validity and reliability, pilot study, data collection process and plan for data analysis.

RESEARCH APPROACH

The research approach refers to the way in which the investigator plans the research process. The study was based on a descriptive exploratory approach. Exploratory study is the primary stage of research and the purpose of this research is to achieve new insights into a phenomenon.

According to Burns and Grove (2003) descriptive research is "designed to provide a picture of a situation as it naturally happens". Descriptive research is the method that describes the characteristics of the population or phenomenon that is studied. This methodology focuses

more on the "what" of the research subject than the "why" of the research subject. Descriptive research is "aimed at casting light on current issues or problems through a process of data collection that enables them to describe the situation more completely than was possible without employing this method. It is an effective method to get information that can be used to develop hypotheses and propose associations.

Here the investigator explains, describes and evaluates the effectiveness of planned teaching on knowledge of caregivers in relation to prevention and management of amnesia among elderly using semi structured questionnaire with self-reporting techniques.

RESEARCH DESIGN

A research design incorporates the most important methodological decisions that an investigator makes in conducting a research study.

Burns and Grove (2002) define a research design as a blueprint for conducting a study with maximum control over factors that may interfere with the validity of the findings. A research design helps the investigator in the selection of subjects for the study and determines the types of analysis to be used to interpret the data. The selection of research design depends upon the purpose of the study, research approach and the variables under study.

In this study the research design used by the investigator was single group pre-test post-test design. The schematic representation of the research design is as follows:

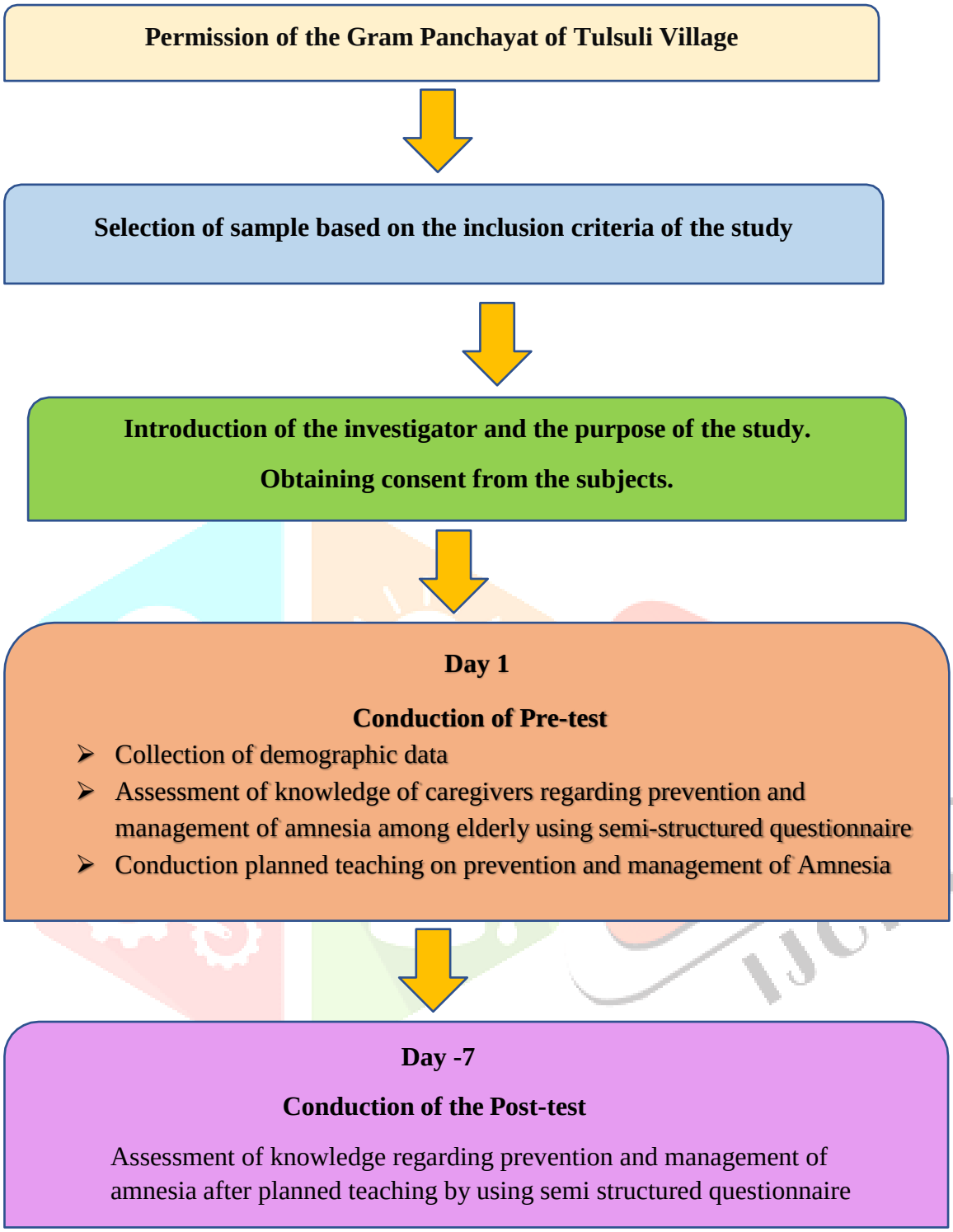

FIGURE- 2

SCHEMATIC REPRESENTATION OF THE RESEARCH DESIGN

VARIABLES OF THE STUDY

According to Polit and Hungler (1991) the concepts under investigation are referred to as variables. A single variable is something that varies and an investigator actively creates or manipulates variables.

In research, variables are any characteristics that can take on different values, such as height, age, temperature, or test scores.

Researchers often manipulate or measure independent and dependent variables in studies to test cause-and-effect relationships. The investigator has identified and differentiated the following variables of the study.

Independent variables

The independent variables are the conditions that the investigator manipulates in her attempt to ascertain their relationship to the observer.

Independent variable in this study was the planned teaching on prevention and management of amnesia among elderly.

Dependent variables

The dependent variables are the conditions that appears, disappears as the investigator introduces, removes or changes independent variables.

The dependent variable of this study is the knowledge of caregivers regarding prevention and management of amnesia among elderly.

SETTING OF THE STUDY

The community-based study was conducted in the Tulsuli village of Sindhudurg district, Taluka Kudal. The list of elderly population aged 70 years and above was retrieved from the Gram Panchayat of the selected village.

In order to accommodate the subjects at one place, the investigator had selected the Assembly Hall of Lingeshwar Vidyalaya and Junior College, Tulsuli. A prior permission was

sought from the principal of the school. The hall had a total capacity of 100, thus enabling to follow the norms of social distancing.

POPULATION

According to Polit and Hungler a population is the entire aggregate of the cases that meets a designed set of criteria.

A research population is also known as a well-defined collection of individuals or objects known to have similar characteristics. All individuals or objects within a certain population usually have a common, binding characteristic or trait.

It is for the benefit of the population that researches are done. However, due to the large sizes of population, researchers often cannot test every individual in the population because it is too expensive and time-consuming.

The population for this study consists of all the caregivers involved in caring for the elderly aged 70 years and above of Sindhudurg district, Maharashtra.

SAMPLE AND SAMPLE SIZE

In research terms a sample is a group of people, objects, or items that are taken from a larger population for measurement. The sample should be a representative of the population to ensure that the findings extracted from the research sample can be generalised to the populationas a whole.

According to Basvanthappa (2001) it is a subject of the population of interest.

In this study the sample refers to the caregivers of elderly from selected rural area of Sindhudurg and the total sample size decided for the study was forty caregivers fulfilling the inclusion criteria.

CRITERIA FOR SAMPLE SELECTION

Inclusion criteria:

The sample were selected according to the following criteria:

- Caregivers are able to understand, read and write Marathi or English.
- Caregivers are willing to participate in the study
- Caregivers are providing care to elderly aged 70 years and above.

Exclusion criteria:

Caregivers having hearing and visual impairment.

SAMPLING TECHNIQUE

Sampling refers to the process of selecting a portion of the population to represent the entire population.

According to Polit and Hungler convenient sampling entails the selection of the mostreadily available person as subject in the study.

The sampling technique used in this study was non-probability convenience sampling.

Convenience sampling is a type of non-probability sampling that involves the samplebeing drawn from that part of the population that is close to hand.

DEVELOPMENT OF TOOL

The tool means the instrument selected in research should as far as possible be the vehicle that would obtain best data for drawing conclusion pertinent to the study. The tool was developed after updating knowledge by reviewing the relevant literature regarding prevention and management of amnesia among elderly.

The investigator interacted with the family members of the elderly to gain insight regarding problems faced by the caregivers. She also contacted few experts in the field which added to the knowledge and guidance in developing the tool.

Based on the inputs the following tools were developed:

Tool I: A Semi structured Questionnaire to assess demographic data and knowledge of sample regarding prevention and management of amnesia among elderly.

Tool II: Planned teaching on prevention and management of amnesia among elderly.

DESCRIPTION OF THE TOOL

Tool I

A Semi structured questionnaire was prepared to determine the knowledge of samplewith regards to prevention and management of amnesia among elderly.

The tool was divided into two sections

Section I: deals with the demographic data. This section was further divided into two parts

Part A: Demographic data of elderly

Part B: Demographic data of caregiver.

Section II: This section comprised of items to elicit the knowledge of the caregivers with regards to prevention and management of amnesia. It has 20 multiple choice questions, each having four alternatives of which, one is a correct option. The correct option is scored as one.

Tool II: Planned teaching

The investigator developed the tool after reviewing the literature pertaining to prevention and management of amnesia. After which she interacted with the experts in the field of nursing and psychiatry in the process of preparation of the planned teaching.

The planned teaching included the following aspects:

- Meaning of the terms - memory and amnesia.
- Types of amnesia.
- Causes of amnesia
- Symptoms of amnesia.
- Diagnosis of amnesia.
- Treatment of amnesia
- Home care of elderly with amnesia.
- Measures to prevent and manage amnesia among elderly.

A pamphlet on guidelines for homecare of the elderly would be prepared and given to the caregivers for easy reference.

VALIDITY

According to Polit and Hungler (1999), Validity is defined as the extent to which an instrument measures what it is supposed to measure, or, to the extent to which it provides data which is compatible with the relevant evidence.

Validity means the extent to which the results really measure what they are supposed to measure. If research has high validity, that means it produces results that correspond to real properties, characteristics, and variations in the physical or social world.

The content validity of the tool developed for this study was done by giving it to twelve experts, four from the Department of Psychiatry and nine experts from the Nursing Department.

After receiving the opinion from the experts, certain modifications were made in the initial tool that consisted of 25 items. As per the inputs given, few questions were reframed, statements were changed into questions and few were deleted. Thus, the final tool which was prepared consisted of 20 multiple questions in the structured format.

VALIDITY OF PLANNED TEACHING

The validity of planned teaching was obtained by verifying it from various experts from the field of nursing, psychiatry and clinical psychologist. Few suggestions like organization of content matter, expressing it in simple form, and adding few points were incorporated. The planned teaching was prepared in English, which later was translated into Marathi language by the literature experts for better comprehension by the sample

RELIABILITY

Reliability of the tool is a major criterion for assessing the quality and accuracy. It is the degree of consistency with which it measures the attribute it is supposed to be measuring.

The reliability depends on the variation produced by the repeated use of an instrument, lesser the variation, higher is the validity. Reliability includes assessing for internal

consistency, equity and stability. Internal consistency assesses the correlation between multiple items in a test that are intended to measure the same construct.

The reliability of the semi-structured questionnaire was established by administering it to30 college students who reside with their grandparents.

The reliability was established by using Cronbach's Alpha formula.

$$\alpha = \frac{n}{n-1}\left(1 - \frac{\Sigma v_i}{vtest}\right)$$

n = Number of questions

Vi =variance of score on each question

V test= total variance of overall scores (not % 's) on the entire test.

The value obtained was 0.74 and the tool was found to be reliable statistically.

PILOT STUDY

According to Polit and Hungler, a pilot study is a small-scale version or trial run of the major study.

A pilot study is the first step of the entire research protocol and is often a smaller-sized study, assisting in planning and modification of the main study. The purpose of the study is twofold, firstly, to make improvement in the research project, and secondly, to delete problems that must be eradicated before the major study be attempted.

The pilot study was carried out at Kudal, Sindhudurg district on four adult caregivers who stayed with their elderly on 20th January 2022. Initially the investigator introduced herself and then explained the purpose of the study to the caregivers. After obtaining their consent, a pre- test was introduced followed by planned teaching on prevention and management of amnesia. Post-test was conducted after 7 days on the same group.

The pilot study helped the investigator to assess the feasibility and practicability of the design tool and helped her to gain more clarity about the data gathering process.

DATA GATHERING PROCESS

The data gathering process commenced on 28th January 2022. The investigator visited the elderly and their caregivers at their residence and after introduction of self, got oriented to their problems. The investigator explained about her study and asked for their willingness and convenient date and time. She finalized a day i.e., 7th February 2022, that was feasible for all caregivers to conduct the pre-test and planned teaching regarding prevention and management of amnesia.

For the data gathering the investigator arranged for one assembly hall. The investigator visited the Gram Panchayat and the school and met the Sarpanch and the school principal in advance, and obtained the necessary permissions from the concerned authorities.

The data gathering process was as follows:

1. Permission from Gram panchayat and school principal
2. Selection of the Sample
3. Conduction of Pre-test
4. Conduction of Planned teaching
5. Conduction of Post-test

The selection of sample was done as per the inclusion criteria laid down for the study. The list of elderly whose age is 70 years and above was obtained from the Gram Panchayat of Tulsuli.

The pre-test was conducted on 7th February 2022. The investigator gathered all the caregivers for the pre-test followed by planned teaching at Lingeshwar Vidyalaya school Tulsuli. The sample were guided towards the assembly hall. The investigator introduced herself and the topic of study to the caregivers. After the introduction, a written consent was taken from the caregivers. After obtaining their consent, pre-test was conducted to analyse the baseline knowledge of caregivers regarding prevention and management of amnesia.

Planned teaching was arranged in such a way that it did not interfere with the routine activities and work of the caregivers. Thus, pre-scheduled time-table of the planned teaching was prepared by the investigator. Planned teaching was a single session of lecture-cum-

discussion using audio visual aids, which lasted for 1 hour and 30 minutes. Caregivers were encouraged to asked questions in between. If they did not understand any aspect of planned teaching re-explanation was given and made sure that they understood.

The caregivers were contacted telephonically to be present on 7th day of teaching, dated 14th February 2022, on the same location for the post-test. After post-test, a pamphlet prepared on guidelines for home care of elderly was provided to the caregivers. This would be a quick reference for them. Thus, the investigator collected the data in a planned systematic manner.

PLAN FOR STATISTICAL ANALYSIS

The Statistical procedures enables the investigators to reduce, summarize, evaluate, interpret and communicate numerical information in meaningful ways. In this study descriptive and inferential statistics were used.

Statistical methods used in the present study were-

1. Frequency and percentage- to assess the demographic data of the sample, pre-test andpost-test knowledge of caregivers.
2. Paired and unpaired "t" test to compare the pre-test and post-test knowledge scores andknowledge scores with selected demographic variables.

The statistical analysis is dealt in detail in the next chapter.

CHAPTER IV

ANALYSIS AND INTERPRETATION

"It is the mark of a truly intelligent person to be moved by statistics"

-George Bernard Shaw.

This chapter deals with the analysis and interpretation of the data collected by the investigator for the study.

Data Analysis is the process of systematically applying statistical and/or logical techniques to describe and illustrate, condense and recap, and evaluate data. According to Shamoo and Resnik (2003) various analytic procedures "provide a way of drawing inductive inferences from data and distinguishing the signal.

Statistical procedure enables the investigator to reduce, summarize, organize, evaluate, interpret and communicate numerical information. Statistical methods are techniques for rendering quantitative information as meaningful and useful.

The data collected were classified tabulated and analysed based on the objectives of the studyunder the following sections:

Section-I This section deals with the analysis and interpretation of demographic data of the caregivers. Section I is further divided as follows:ss

Part A- Demographic data of elderly.

Part B- Demographic data of caregiver.

Section-II This section deals with the data pertaining to the analysis and interpretation of the knowledge scores of caregivers regarding prevention and management of amnesia among elderly. Section II is divided into three parts:

Part A: This part deals with the knowledge of sample regarding prevention and management of amnesia in relation to different areas.

Part B: Deals with the mean percentile of knowledge score of overall samples regarding prevention and management of amnesia

Part C: This section deals with the comparison of pre and post-test knowledge score with regards to prevention and management of amnesia.

Section-III This section deals with the comparison of knowledge of the caregivers with selected demographic variables.

SECTION- I

This section deals with the analysis of the demographic details of the elderly and their caregivers.

The data was analysed in terms of frequency and percentage

PART A- This section deals with the data pertaining to the analysis and interpretation of demographic data of elderly.

TABLE NO. I

DISTRIBUTION OF ELDERLY CLIENTS ACCORDING TO THEIRDEMOGRAPHIC VARIABLE

N=40

Sr. No.	Demographic Variable	f	%
1.	**Age of the elderly –**		
	70-75 years	22	55
	76-80 years	10	25
	81-90 years	6	15
	> 90 years	2	5
2.	**Gender of the elderly –**		
	Male	14	35
	Female	26	65
	Transgender	0	0
3.	**Education of the elderly –**		
	Primary	27	67.5
	Secondary	5	12.5
	Higher secondary	2	5
	Graduate	1	2.5
	Post- graduate	0	0
	No formal education	5	12.5
4.	**Type of family –**		
	Nuclear	8	20
	Joint	30	75
	Extended	2	5

The above table reveals the age of elderly clients whose caregivers were the subject of the study. More than half i.e., 55% elderly were aged 70-75 years and 25% elderly between 76-80 years. Only 20% were 80 years and above.

As reported by the caregiver, out of all the elderly 65 % were females and only 35 % males.

Most of the elderly had primary education that is 67.5%, 12.5% elderly had secondary education and same percentage did not have any formal education. Only 5% elderly were higher secondary and above.

It is evident from the above table that almost 80% of the elderly lived with their family in joint or extended system. Whereas, 20% belong to nuclear family norms.

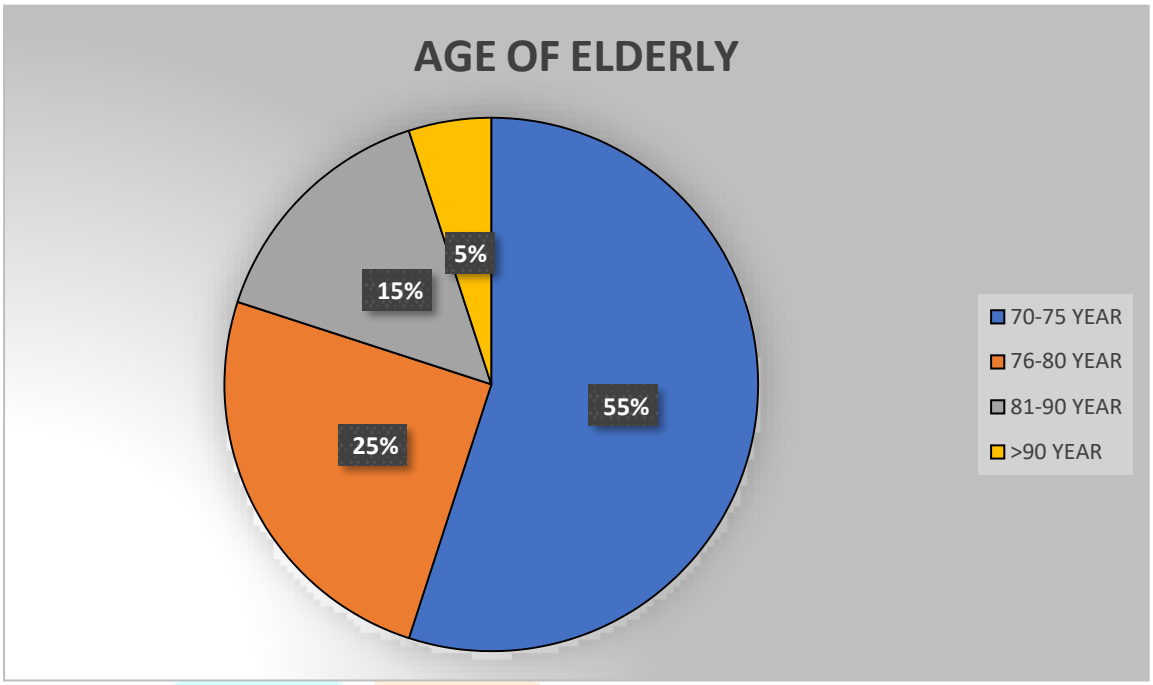

FIGURE. 3

DISTRIBUTION OF ELDERLY CLIENTS ACCORDING TO THEIR AGE

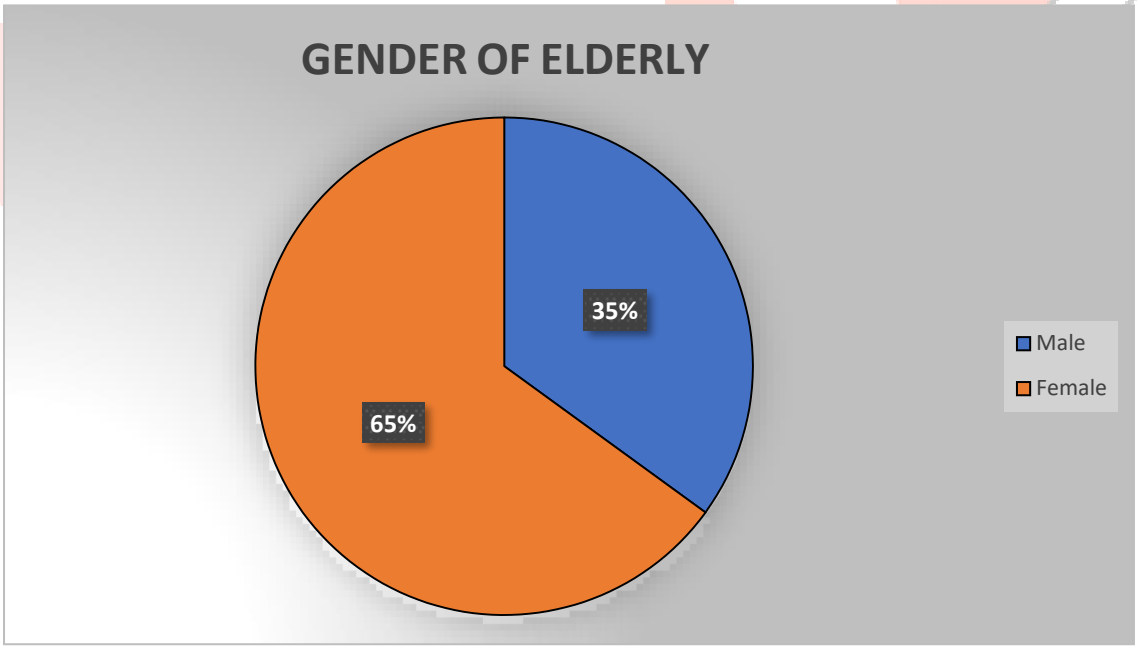

FIGURE. 4

DISTRIBUTION OF ELDERLY CLIENTS ACCORDING TO THEIR GENDER

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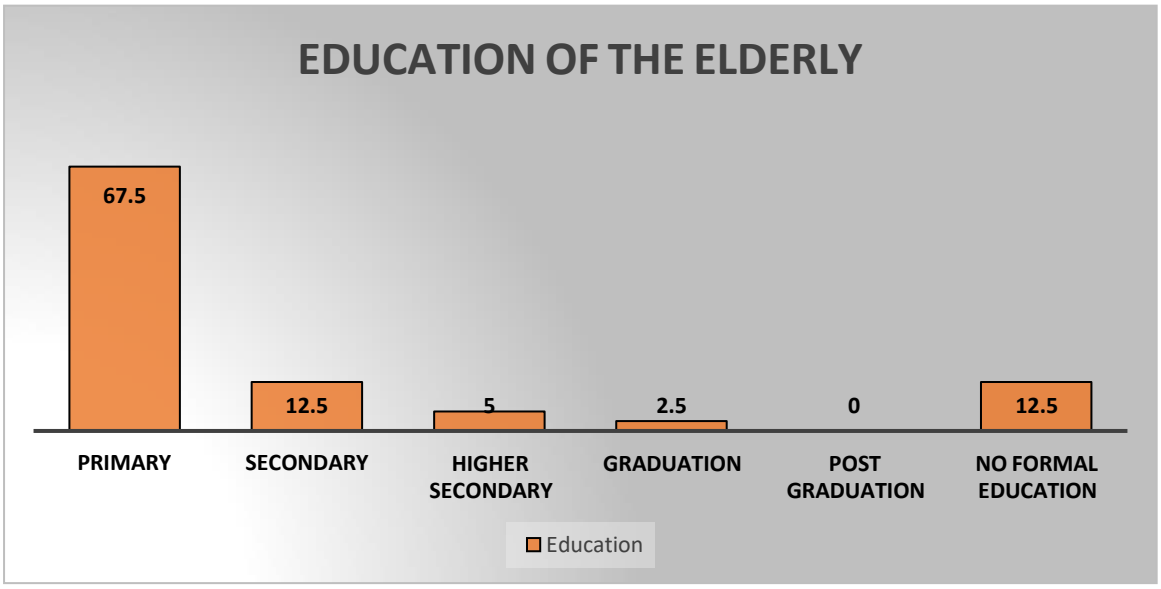

FIGURE. 5

DISTRIBUTION OF ELDERLY CLIENTS ACCORDING TO THEIR EDUCATION

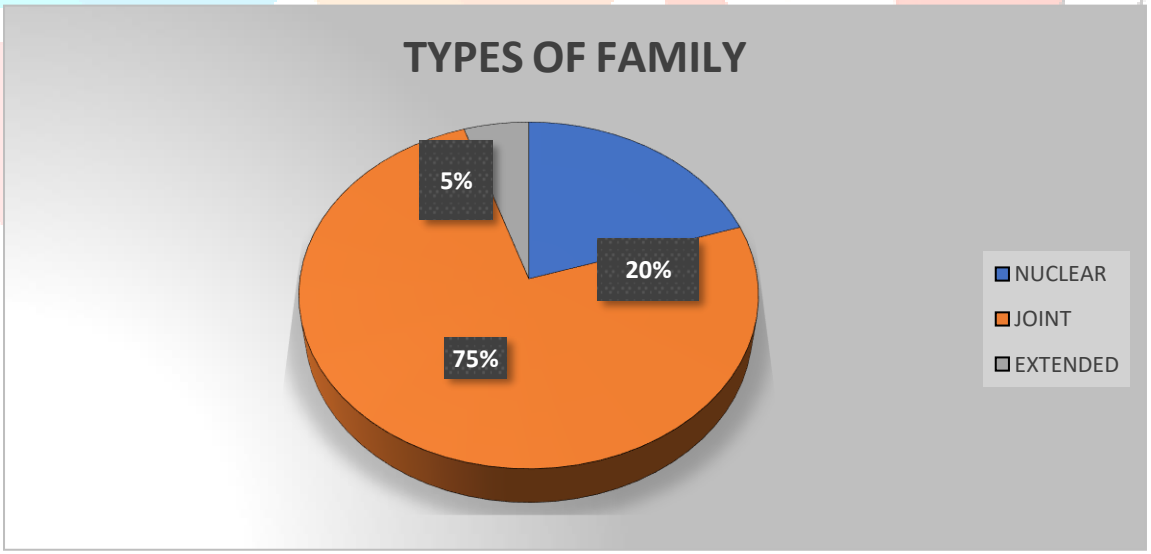

FIGURE. 6

DISTRIBUTION OF ELDERLY CLIENTS ACCORDING TO THEIR TYPES OF FAMILY

PART B- This part deals with the analysis and interpretation of demographic data of caregivers.

TABLE NO. II

DISTRIBUTION OF CAREGIVERS ACCORDING TO THE DEMOGRAPHIC VARIABLES

N=40

Sr. No.	Demographic Variable	f	%
2.	**Age of the caregiver-**		
	< 30 years	2	5
	30-40 years	15	37.5
	41-50 years	10	25
	> 50 years	13	32.5
3.	**Gender of the caregiver-**		
	Male	21	52.5
	Female	19	47.5
	Transgender	0	0
4.	**Education of the caregiver-**		
	Primary	9	22.5
	Secondary	17	42.5
	Higher secondary	5	12.5
	Graduate	6	15
	Post- graduate	3	7.5
	No formal education	0	0

(cont….)

TABLE NO. II (Cont….)

DISTRIBUTION OF CAREGIVERS ACCORDING TO THE DEMOGRAPHIC VARIABLES

N=40

Sr. No.	Demographic Variable	f	%
5.	**Relation with elderly –**		
	Spouse	0	0
	Mother	1	2.5
	Father	0	0
	Brother	1	2.5
	Sister	2	5
	Daughter	13	32.5
	Son	16	40
	Any other	7	17.5
6.	**Duration of stay with the elderly-**		
	<2 years	1	2.5
	2 to 5 years	0	0
	5 to 10 years	4	10
	>10 years	35	87.5

As per the above table 37.5% caregivers were aged between 30 to 40 years, 32.5% caregivers were more than 50 years, 25% caregivers were aged between 41 to 50% and only 5 % caregivers were less than 30 years of age.

Out of all the caregivers 52% were male and 48% were female caregivers.

With regards to the education of the caregivers, 42.5% had completed secondary education, 22.5% caregivers had completed primary education, 15% of caregivers were educated up to graduation, 12.5% care givers completed higher secondary education. Only 7.5% caregivers were post graduate.

Out of all the sample, majority of the caregivers were the children of the elderly, i.e., 40% sons and 32.5% daughters. Remaining 17.5% caregivers included granddaughter, grandson, daughter-in-law, 7.5% were siblings of the elderly and 2.5% mothers.

Majority i.e., 87.5% caregivers have been staying with their elderly for more than 10 years. 10% caregivers have been staying with the elderly for 5 to 10 years, and 2.5% caregivers for less than 2 years.

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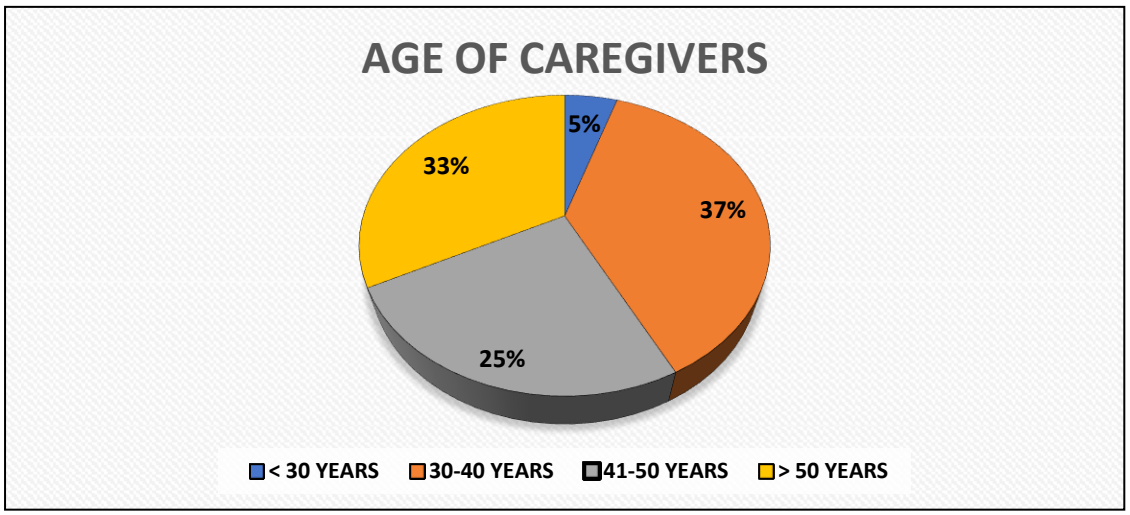

FIGURE. 7

DISTRIBUTION OF AGE OF CARE GIVERS

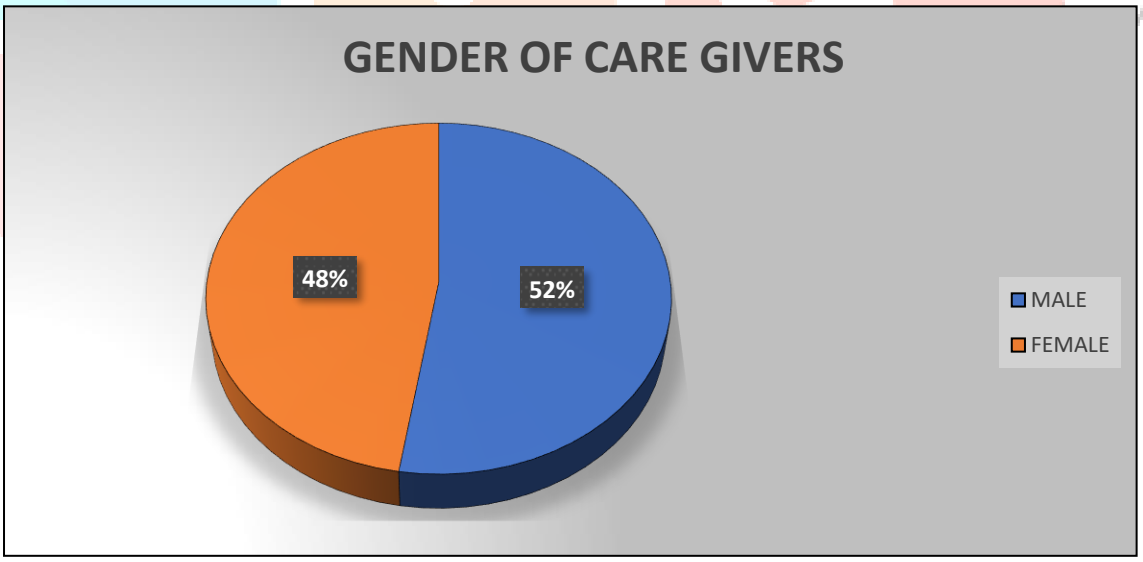

FIGURE. 8

DISTRIBUTION OF GENDER OF CARE GIVERS

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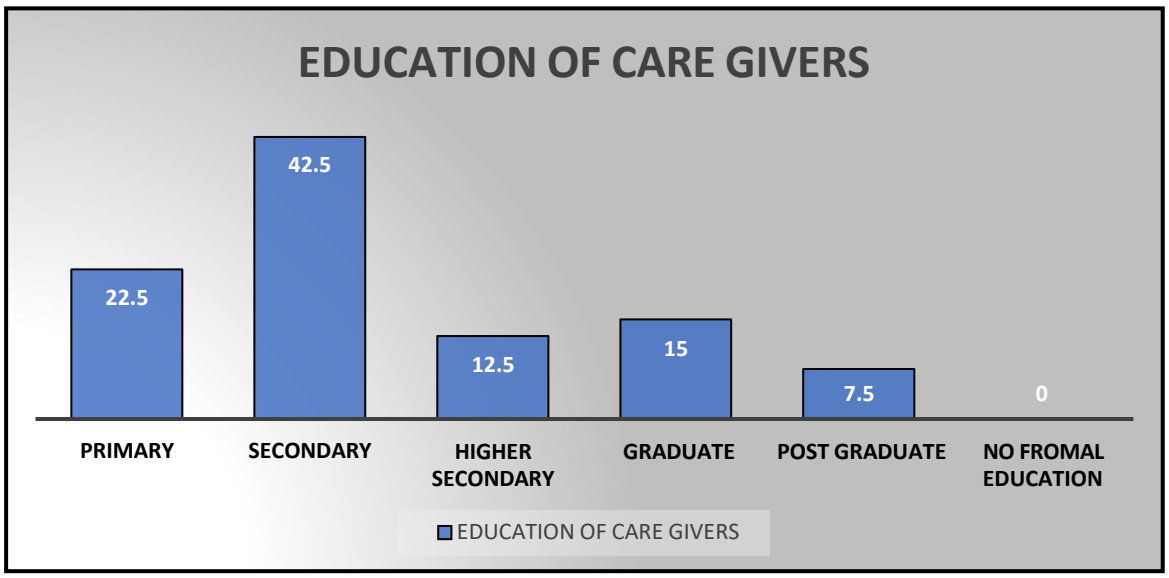

FIGURE. 9

DISTRIBUTION OF EDUCATION OF CARE GIVERS

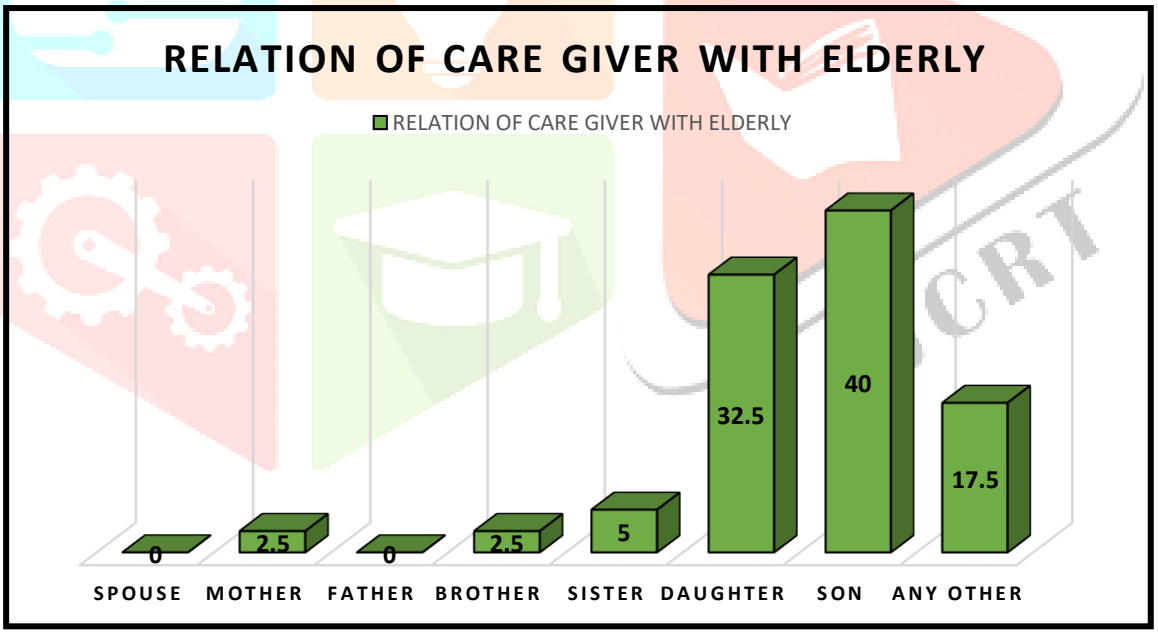

FIGURE. 10

DISTRIBUTION OF RELATION OF CARE GIVERS WITH ELDERLY

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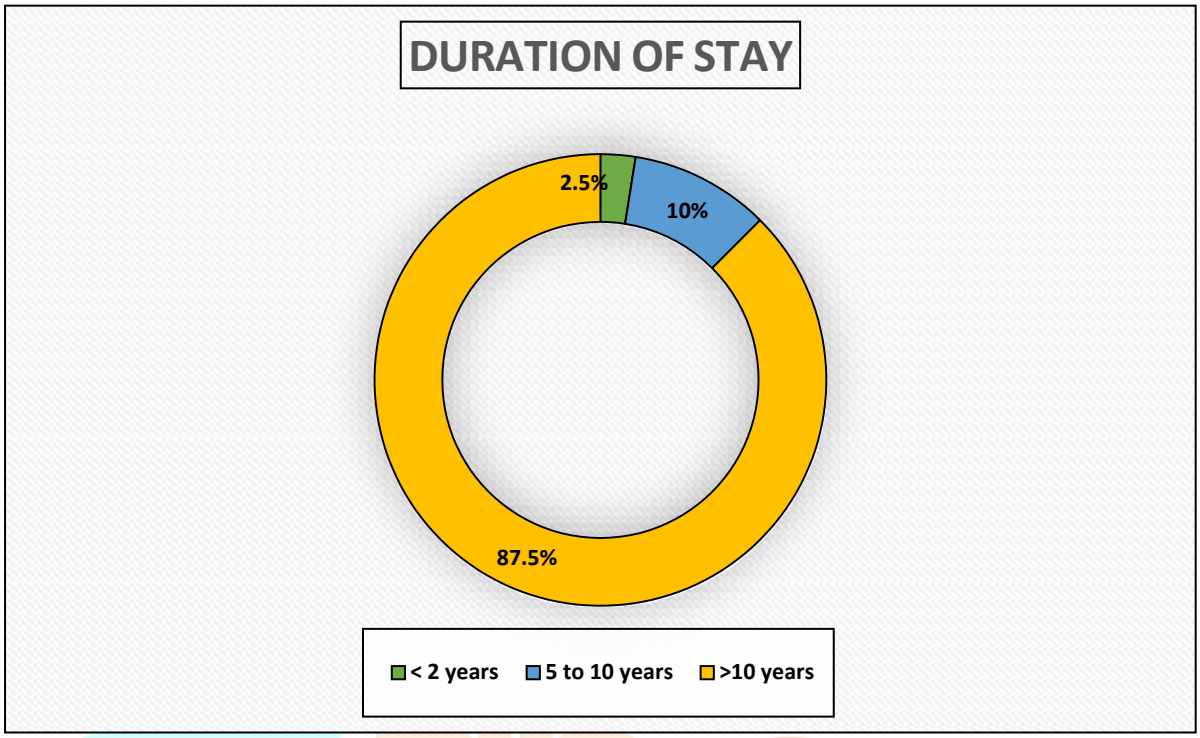

FIGURE. 11

DISTRIBUTION OF CARE GIVERS LENGTH OF STAY WITH ELDERLY

SECTION – II

Section II comprises of three parts.

Part A- This part deals with the knowledge of sample regarding prevention and managementof amnesia in relation to different areas such as:

a) Knowledge regarding meaning of amnesia.
b) Knowledge regarding types of amnesia.
c) Knowledge regarding causes of amnesia.
d) Knowledge regarding symptoms of amnesia.
e) Knowledge regarding diagnostic measures of amnesia.
f) Knowledge regarding treatment of amnesia.
g) Knowledge regarding home care of client with amnesia.
h) Knowledge regarding prevention and management amnesia.

Part B- Deals with the mean percentile of knowledge score of overall samples regarding prevention and management of amnesia.

Part C- This section deals with the comparison of pre and post-test knowledge score with regards to prevention and management of amnesia.

SECTION II (PART-A)

TABLE NO. III

DISTRIBUTION OFCAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON CONCEPT OF AMNESIA.

N=40

Sr. No.	Item	Pre-test		Post-test	
		f	%	f	%
1.	1.What is the meaning of amnesia? ----				
	a. Temporary memory loss	23	57.5	11	27.5
	b. Permanent memory loss	12	30	5	12.5
	c. Both A and B	**3**	**7.5**	**22**	**55**
	d. None of the above	2	5	2	5

From the above table it is evident that, during the pre-test only 7.5% people were aware about the meaning of amnesia. In post-test about 55% sample became aware about the meaning of amnesia. Thus, the knowledge about the meaning of amnesia increased from poor in pre-test to average in post-test.

TABLE NO. IV

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON TYPES OF AMNESIA.

N=40

Sr. no.	Item	Pre-Test		Post- Test	
		f	%	f	%
2.	If old memories are lost it is called as - - -				
	a. Anterograde amnesia	15	37.5	7	17.5
	b. Retrograde amnesia	**14**	**35**	**32**	**80**
	c. Dissociative amnesia	7	17.5	1	2.5
	d. None of the above	4	10	0	0
3.	Another name for Psychogenic amnesia----				
	a. Anterograde amnesia	7	17.5	3	7.5
	b. Retrograde amnesia	15	37.5	2	5
	c. Dissociative amnesia	**17**	**42.5**	**34**	**85**
	d. None of the above	1	2.5	1	2.5

In the pre-test only 35% caregivers defined retrograde amnesia as a loss of old memory. However, the percentage significantly increased in the post-test to 80%.

During pre-test 42.5 % sample had correctly responded that other name for psychogenic amnesia is dissociative amnesia, while in post-test 85% sample had given the correct response. Thus, the knowledge regarding types of amnesia increased from satisfactory in pre-test to excellent after the planned teaching.

TABLE NO. V

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGE ON CAUSES OF AMNESIA

N=40

Sr. no	Item	Pre-Test		Post-test	
		f	%	f	%
4.	The chronic use of alcohol causes memory loss because of------- deficiency**.**				
	a. Vitamin –B1	14	35	37	92.5
	b. Vitamin-K	**13**	**32.5**	**1**	**2.5**
	c. Vitamin- C	12	30	1	2.5
	d. Vitamin- E	1	2.5	1	2.5
5.	The following are common reasons for poor memory among elderly EXCEPT ---				
	a. Sleep problem/disturbance	9	22.5	17	42.5
	b. Stress	5	12.5	2	5
	c. Anxiety	10	25	0	0
	d. Heavy food intake	**16**	**40**	**21**	**52.5**
6.	Acute or sudden amnesia is caused due to the lack of adequate oxygen in certain parts of				
	a. Heart	3	7.5	0	0
	b. Brain	**28**	**70**	**33**	**82.5**
	c. Lungs	3	7.5	2	5
	d. Kidney	6	15	5	12.5
7.	History of triggering factors include all EXCEPT-------				
	a. Head injury in the recent past	5	12.5	4	10
	b. An emotionally traumatic event in the recent past	8	20	3	7.5
	c. History of illicit drug or alcohol abuse.	5	12.5	9	22.5
	d. Watching movies	**22**	**55**	**24**	**60**

During the pre-test only 35% sample were aware that Vitamin B1 deficiency causes memory loss in alcoholics, whereas, in the post-test 92.5% sample had given the correct answers which can be graded as excellent.

It was known to only 40% sample in pre-test that heavy intake of food is not the reason of poor memory. However, the post-test findings showed that knowledge improved from poor to average as percentage went up to 52.5%.

During pre-test 70% sample were aware that inadequate supply of oxygen to brain may cause sudden amnesia. In post-test 82.5% sample answered this correctly.

Pre-test result showed that 55% sample identified that watching movie was not the triggering factor for amnesia. In post-test only 60% sample responded correctly. The post-test knowledge in two areas were found to be average and good. This could be due to the misinterpretation of the questions by the sample.

TABLE NO. VI

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON SYMPTOMS OF AMNESIA

N-40

Sr. no.	Items	Pre-test		Post-test	
		f	%	f	%
8.	In elderly who have anterograde amnesia will usually forget- EXCEPT				
	What he/she ate for lunch	**17**	**42.5**	**21**	**52.5**
	Date of birth of his/her son.	1	2.5	1	2.5
	His childhood memory	11	27.5	13	32.5
	His/her own mobile number.	11	27.5	5	12.5
9.	Which response from elderly will signify the retrograde memory loss?				
	Name birth place	7	17.5	1	2.5
	Name of primary school teacher.	9	22.5	2	5
	Childhood games	4	10	2	5
	All the above	**20**	**50**	**35**	**87.5**
10.	The elderly with amnesia who make up stories to fill the gaps in their memory, it is called as being ----				
	Confabulation	**24**	**60**	**32**	**80**
	Angry	11	27.5	0	0
	Upset	3	7.5	1	2.5
	Jealous	2	5	7	17.5

It is evident that in pre-test 42.5% sample had identified correctly the situation which is not an example of anterograde amnesia, where as in post-test only 52.5% sample selected the correct response. Thus, knowledge showed average improvement, which could be due to the misinterpretation of the question.

It is observed that half of the sample were aware of retrograde amnesia during the pre-test and a significant improvement to 87.5% was seen in post-test.

Confabulation is making stories to fill the gap in their memory, was known to 60% of sample at the pre-test. The number increased to 80% in post-test which can be graded as excellent.

TABLE NO. VII

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON DIAGNOSTIC MEASURES OF AMNESIA

N-40

Sr. No.	Item	Pre-test		Post-test	
		f	%	f	%
06.	The diagnostic method used to detect amnesia are all, EXCEPT				
	Detailed physical and mental examination.	8	20	11	27.5
	CT scan and MRI.	6	15	5	12.5
	History collection	6	15	4	10
	Ultra-Sonography	**20**	**50**	**20**	**50**

During pre-test 50% sample were aware that ultra-Sonography is not used to detect amnesia. There was no change in the percentage after the planned teaching. Thus, the knowledge in this area remained average.

TABLE NO. VIII

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGE ABOUT TREATMENT OF AMNESIA

N=40

Sr. No.	Item	Pre-test		Post-test	
		f	%	f	%
17.	What is the benefit of physical activities in the patient with amnesia? It will reduce the risk of --------				
	Memory loss	**7**	**17.5**	**11**	**27.5**
	Heart disease	17	42.5	24	60
	Decrease weight	9	22.5	2	5
	None of the above	7	17.5	3	7.5

Physical activities in the patient with amnesia is known to reduce the risk of memory loss was correctly answered by only 17.5% in pre-test and 27.5% in the post test. On the contrary, maximum sample selected 'heart disease'. This shows that the sample did not comprehend the question correctly.

TABLE NO. IX

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON HOME CARE OF AMNESIA

N=40

Sr. No.	Items	Pre-test		Post-test	
		f	%	f	%
13.	What would be the best measure to remind elderly to brush his/her teeth daily?				
	Tell them every day	13	32.5	2	5
	Keep the alarm in their phone regarding brushing	8	20	15	37.5
	Write a note and stick it in the washroom.	3	7.5	12	30
	Keep brush and tooth paste at bedside.	**16**	**40**	**11**	**27.5**
14.	'To remind patients to take medications every day at different time', all measures would be appropriate EXCEPT.				
	a. Medication organisers.	4	10	7	17.5
	b. Give all medication at a single time.	**16**	**40**	**22**	**55**
	c. Keep the medication near patient	6	15	2	5
	d. Caregiver should always give medication to the elderly.	14	35	9	22.5

(cont…..)

TABLE NO. IX (cont….)

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON HOME CARE OF AMNESIA

N=40

Sr. No.	Items	Pre-test		Post-test	
		f	%	f	%
19.	Following are the advantages of attending social gathering for an elderly with amnesia, EXCEPT.				
	Helps to recall name of peopleand situations	5	12.5	6	15
	Provide opportunity for gossips.	**8**	**20**	**24**	**60**
	Help to recollect informationand increase knowledge.	8	20	3	7.5
	Help to reduce stress, anxiety and depression.	19	47.5	7	17.5

The above table reveals that in pre-test 40% sample had correct response as keeping brush and tooth paste at bedside was the best measure to remind elderly to brush his/her teeth, where as in post-test the number decreased to 27.5%. This could be as the other distractors were not very effective.

It can be observed that in the pre-test 40% sample had identified that, giving all medication at a single time is not the correct measure to remind patients to take medications every day at different times. Whereas, in the post-test 55% sample had given correct response, which can be graded as average.

In the pre-test 20% had knowledge of advantages of social gathering for an elderly.
The score increased to 60% in post-test, which can be graded as good.

TABLE NO. X(A)

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON PREVENTION AND MANAGEMENT OF AMNESIA

N=40

Sr. No.	Items	Pre-test		Post-test	
		f	%	f	%
12.	An elderly with memory loss has to carry an identity card, with all of the following information listed EXCEPT-				
	Name of patient	4	10	1	2.5
	Address	3	7.5	1	2.5
	Blood group	**24**	**6**	**32**	**80**
	Caregivers contact number	9	22.5	6	15
15.	To keep the elderly oriented to time and date, what is the most useful idea?				
	Tell them every day about date and time	12	30	1	2.5
	Encourage to read the news-paper daily	7	17.5	2	5
	c. Clocks with large numbers and calendars with large print.	**14**	**35**	**32**	**80**
	d. Tell the elderly to ask the family members every day about time and place	7	17.5	5	12.5
16.	All of the following are preventive aspects of amnesia with EXCEPT---				
	a. Avoid excessive alcohol consumption.	5	12.5	0	0
	b. Avoid smoking	7	17.5	4	10
	c. Avoid use of illicit drugs	14	35	8	20
	d. Avoid consuming healthy diet.	**14**	**35**	**28**	**70**

It can be stated that in pre-test only 6% sample had correct response as blood group is not that much important on identity card, where as in post-test 80% sample had answered this correctly which can be graded as excellent.

Clocks with large numbers and calendars with large print are most useful for the elderly to orient to time and date was known to 35% in pre-test, where as in post-test 80% sample had given correct response which can be graded as excellent.

In the pre-test, 35% of the sample knew that avoiding alcohol, smoking and use of illicit drugs help to prevent amnesia. This number increased to 70% in the post-test.

TABLE NO. X(B)

DISTRIBUTION OF CAREGIVERS WITH REGARDS TO THEIR KNOWLEDGEON PREVENTION AND MANAGEMENT OF AMNESIA

N-40

Sr. No.	Items	Pre-test		Post-test	
		f	%	f	%
18	Which are the activities that help to stimulates brain cells and lower risk of memory loss?				
	Learning a new skill	8	20	6	15
	Learning a new instrument	2	5	1	2.5
	Doing crossword or puzzles	12	30	5	12.5
	All of the above	**18**	**45**	**28**	**70**
20.	How will you help the elderly to do activities of daily living?				
	a. With the help of directional arrows	1	2.5	2	5
	b. With the help of pictures pasted on walls	4	10	0	0
	c. Maintain familiar settings in the house.	18	45	7	17.5
	d. All of the above.	**17**	**42.5**	**31**	**77.5**

In the pre-test 45 % sample identified all the activities to stimulate brain cell and lower the risk of memory loss. However, in post-test 70% sample had responded correctly, which can be graded as good.

Measures to help amnestic elderly to carry out activities of daily living were answered by 42.5% in the pre-test. After the teaching 77.5% sample were able to give the correct option. Thus, knowledge improved from average to good.

SECTION II (PART -B)

TABLE NO. XI

AREA WISE DISTRIBUTION OF MEAN AND MEAN PERCENTAGE OF KNOWLEDGE ABOUT PREVENTION AND MANAGEMENT OF AMNESIA

N=40

Sr. No.	Area of Knowledge	Total scoreof section	Pre-Test		Post-Test	
			Mean	Mean %	Mean	Mean%
1.	Knowledge regarding meaning of amnesia	1	0.075	7.5	0.55	55
2.	Knowledge regarding types of amnesia	2	0.775	38.75	1.65	82.5
3.	Knowledge regarding causes of amnesia	4	2	50	2.875	57.5
4.	Knowledge regarding symptoms of amnesia.	3	1.525	50.83	2.2	73.33
5.	Knowledge regarding diagnostic measures of amnesia.	1	0.5	50	0.5	50
6.	Knowledge regarding treatment of amnesia.	1	0.175	17.5	0.275	27.5
7.	Knowledge regarding home care of client with amnesia	3	1	33.33	1.425	47.5
8.	Knowledge regarding prevention and management amnesia	5	2.175	43.5	3.775	75.5

INTERPRETATION: -

The above table reveals the following:

With regards to knowledge about meaning of amnesia, it was found that the mean percentage during the pre-test was 7.5% that increased to 55% in the post-test. Similarly, knowledge regarding types of amnesia significantly improved from satisfactory (38.75%) to excellent (82.5%). There was an increase of only 7.5% in the mean percentage of knowledge regarding causes before and after the planned teaching. Knowledge regarding symptoms of amnesia increased from 50.83 to 73.33%, and knowledge regarding prevention and management of amnesia significantly increased from 43.5% to 75.5% after the teaching was implemented.

However, no change was found in the pre and post-test mean knowledge percentage ofthe sample with regards to diagnostic measures of amnesia.

The mean knowledge percentage improved from poor (33.33%) to average (47.5%) in relation to the home care of clients with amnesia.

Thus, it can be inferred that after the planned teaching, the caregivers had better knowledge regarding amnesia and its prevention and management.

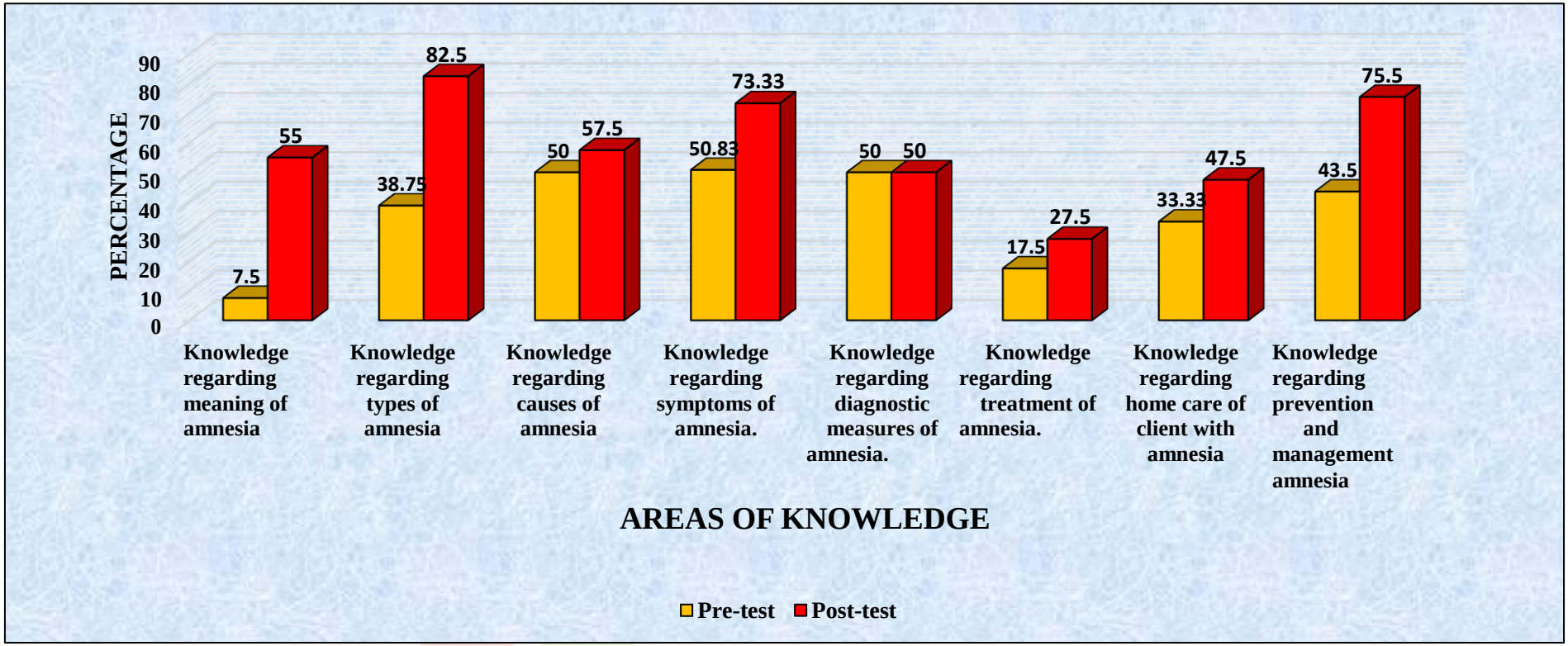

FIGURE. 12

AREAWISE DISTRIBUTION OF MEAN AND MEAN PERCENTAGE OF KNOWLEDGE ABOUT PREVENTION AND MANAGEMENT OF AMNESIA

SECTION II (PART C)

This section deals with the comparison of pre and post-test knowledge score with regards to prevention and management of amnesia.

The formula used for correlated large group was,

$\sigma M_1 = SD/\sqrt{N1}$

$\overline{\sigma M_2} = SD/\sqrt{N2}$

$SE_D = \sqrt{(\sigma M_1)^2 + (\sigma M_2)^2 - 2 \times r \times \sigma M_1 \times \sigma M_2}$

$t = \frac{M_1 - M_2}{SED}$

Where M1 and M2 =Means of each setSE_D

= Standard error of deviation.

σM_1 = Standard deviation of mean of pre-test σM_2

= Standard deviation of mean of post-testN =

sample size

Before calculating the t value

H_0 = there is no significant difference between the mean knowledge score of samples beforeand after the planned teaching.

H_1 = There will be significant difference between the mean knowledge scores of samples beforeand after the planned teaching.

TABLE NO. XII

COMPARISON OF PRE-TEST AND POST-TEST KNOWLEDGE SCORE

N=40

Sr. no.	Knowledge of care giver	M	N	SD	r	SED	t value		Significance
							Calculated	Tabulated	
1	Pre-test	8.22	40	3.23	0.23	0.59	8.45	**At 0.05-** 2.02 **At 0.01** – 2.71	Significant at 0.05 level
2	Post test	13.2	40	2.82					

df= 38

The above table deals with the comparison of the means of pre-test and post-test knowledge scores of caregivers regarding prevention and management of amnesia among elderly.

INTERPRETATION-

The calculated 't' value of 8.45 is greater than the table value of 2.02 at 0.05 level of significance for degree of freedom 38. Thus the null hypothesis (H_0) is rejected and research hypothesis (H_1) accepted. From this we can infer that post-test mean scores are significantly higher than pre-test mean scores. Thus, planned teaching had an effect on the knowledge of thecaregivers.

SECTION -III

This section deals with the comparison of knowledge of the care-givers with selected demographic variables.

The demographic variable selected for comparison are:

- Age of the caregivers
- Gender of the caregivers
- Relation of caregivers with elderly

To determine the relationship of knowledge of the caregivers with selected demographic variables 't' value was calculated using uncorrelated group formula-

$M_1 = \sum X_1/N_1 M_2 =$

$\sum X_2/N_2 x_1 = X_1 - M_1$

$x_2 = X_2 - M_2$

$SD = \sqrt{\sum(x_1)^2 + \sum(x_2)^2 / (N_1-1) + (N_2-1)}$

$SED = SD \sqrt{N_1+N_2/N_1*N_2}$

$t = \frac{M_1 - M_2}{SED}$

$df = (N_1-1) + (N_2-1)$

where,

SED= Standard error of deviationSD= Standard Deviation

M1= Mean of the pre-testM2= Mean of post-test

N1 = Total no of sample of pre-test

N2=Total no of sample of Post-test x_1 and x_2 = Deviation from means.

TABLE NO. XIII

RELATIONSHIP OF THE KNOWLEDGE SCORES OF CAREGIVERS WITH REGARDS TO AGE

Sr. no.	Variable	N	M	SD	SDD	SED	't' value		Significance
							Calculated	Tabulated	
1.	30-40 years	**15**	**13.4**	2.5014	2.7473	1.1215	0.35663	At 0.05 level 2.0687	No Significant difference at 0.05 level
	41-50 years	**10**	**13**	3.0912				At 0.01 level 2.8073	
2.	>50 years	**13**	**13.15**	3.3626	3.2491	1.3666	0.11257	At 0.05 level 2.0796	No Significant difference at 0.05 level
	41-50 years	**10**	**13**	3.0912				At 0.01 Level 2.8314	
3.	30-40 years	**15**	**13.4**	2.5014	2.9305	1.1104	0.22166	At 0.05 level 2.0555	No Significant difference at 0.05 level
	>50 years	**13**	**13.15**	3.3626				At 0.01 Level 2.7787	

INTERPRETATION-

From above table it was noted that the post-test mean knowledge score of the caregivers aged between 30-40 years was 13.4, and that of between 41-50 years was 13. The difference was statistically analysed using 't' test. The calculated value of t was 0.3563, which was less than the tabulated value 2.0687 at 0.05 level of significance for degree of freedom 23. Thus, it can be concluded that there is no significant difference between post-test knowledge scores of caregivers aged between 30-40 years and 41-50 years.

Similarly, it was noted that the post-test mean knowledge score of the caregivers more than 50 years was 13.15 and that of age between 41-50 years of age was 13. The difference was statistically analysed using 't' test. The calculated value of t was 0.11257, which was less than tabulated value 2.0796 at 0.05 level of significance for degree of freedom 21. Thus, it can be concluded that there is no significant difference between post-test knowledge scores of care givers aged more than 50 years and those between 41-50 years.

The post-test mean of knowledge scores of the caregivers aged between 30-40 years was 13.4 and of those above 50 years of age was 13.15. The difference was statistically analysed using 't' test. The calculated value of t test was 0.2216, which was less than the tabulated value 2.0555 at 0.05 level of significance for degree of freedom 26. Thus, it can be concluded that there is no significant difference between post-test knowledge scores of caregivers aged 30-40 years and >50 years.

Thus, it can be concluded that there was no difference in the knowledge score of caregivers with regards to their age.

TABLE NO. XIV

RELATIONSHIP OF THE KNOWLEDGE SCORES OF CAREGIVERS WITH REGARDS TO THE GENDER

N=40

Sr.no.	Variables	N	M	SD	SDD	SED	't' value		Significance
							Calculated	tabulated	
1.	Male	**21**	**12.95**	**3.29**	**2.84**	**0.9001**	**0.6955**	At 0.05 level 2.0244	No Significant difference at 0.05 level
2.	Female	**19**	**13.57**	**2.24**				At 0.01 level 2.7116	

df=38

From the above table it was noted that the mean post-test knowledge score of male caregivers was 12.95 and that of females was 13.57. The difference was statistically analysed using 't' test. The calculated value of t was 0.6955, which was less than the tabulated value 2.0244 at 0.05 level of significance for degree of freedom 38. Thus, it can be concluded that there is no significant difference between post-test knowledge score of caregivers as per their gender.

TABLE NO. XV

RELATIONSHIP OF THE KNOWLEDGE SCORES OF CAREGIVERS WITH REGARDS TO THE RELATIONSHIP WITH THE ELDERLY

Sr.no.	Variables	N	M	SD	SDD	SED	't' value		nificance
							calculated	tabulated	
1.	Daughter	**13**	**12.92**	**1.84**	**2.88**	**1.077**	**0.39**	At 0.05 level 2.0518	No Significant difference at 0.05 level
2.	Son	**16**	**12.5**	**3.50**				At 0.01 level 2.7707	

df=27

From above table it was noted that the mean post-test knowledge scores of daughters were 12.92 and of sons was 12.5. The difference was statistically analysed using 't' test. The calculated value of t was 0.39, which was less than the tabulated value 2.0518 at 0.05 level of significance for degree of freedom 27. Thus, it can be concluded that there is no significant difference between post-test knowledge score of caregivers as per their relationship with the elderly.

CONCLUSION

The findings of the study revealed that there was statistically significant difference in the knowledge score of the caregivers after the planned teaching on prevention and management of amnesia among the elderly. The planned teaching was thus found to be effective in the improvement of knowledge of the caregivers.

REFERNCES

9. Garret E.H. Statistics in Psychology and education, 6th edition, Bombay, Vikas andSimon Ltd.
10. Polit D.F. and Hungler B.P. Nursing Research: Principles and Methods.4th Edition.Philadelphia
11. Quotemaster. https://www.quotemaster.org
12. Sharma S. K, Nursing Research and Statistics, 2nd edition, ELSEVIER.
13. Welling M et al, (2006), Statistical Techniques, 17th edition, Mumbai, MananPrakash.

CHAPTER V

SUMMARY, FINDINGS, DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

This chapter deals with a brief summary of the study, significant findings, conclusion and recommendation of the study. These findings will contribute to the existing body of knowledge and may promote future research in the same field.

SUMMARY

The findings of the study revealed that there was statistically significant difference in the knowledge score of caregivers in prevention and management of amnesia among the elderly before and after the planned teaching. The planned teaching was effective in the improvement of knowledge of the caregivers.

NEED OF THE STUDY

Cognitive health is an important component of performing everyday activities. Cognitive health means ability to think, learn and remember. Amnesia affects the cognitive health of the elderly. Caregiver burden is often experienced by caregivers for cognitively impaired family member, which is multifaceted involving physical, psychological, social and emotional problems. The caregiver faces number of problems while dealing with the elderly having amnesia. There is no specific treatment for amnesia, but techniques for enhancing memory and psychological support can help the elderly people with amnesia and their families to cope with such situation. Thus, there is a need to educate the caregivers to manage and prevent amnesia and improve the quality of life of the elderly.

STATEMENT OF PROBLEM

A study to assess the effect of planned teaching on knowledge of caregivers regarding the prevention and management of amnesia among elderly in selected rural area of Sindhudurg District.

OBJECTIVES

- To assess the knowledge of caregivers regarding prevention and management of amnesia among the elderly before and after the planned teaching.
- To find out the comparison between knowledge of the caregivers and selected demographic variables.

RESEARCH APPROACH

A descriptive exploratory approach as used for this study.

RESEARCH DESIGN

One group pre-test and post-test design.

SETTINGS OF THE STUDY

The community-based study was conducted in the Tulsuli village of Sindhudurg district, Taluka Kudal. The list of elderly population aged 70 years and above was retrieved from the Gram Panchayat of the selected village.

In order to accommodate the subjects at one place, the investigator had selected the Assembly Hall of Lingeshwar Vidyalaya and Junior College, Tulsuli. A prior permission was sought from the principal of the school. The hall had a total capacity of 100, thus enabling to follow the norms of social distancing.

SAMPLE AND SAMPLE SIZE

In this study the sample refers to the caregivers of the elderly from selected rural area of Sindhudurg and the total sample size decided for the study was forty caregivers fulfilling the inclusion criteria.

SAMPLING CRITERIA

Inclusion criteria:

The sample were selected according to the following criteria:

- Caregivers able to understand, read and write Marathi or English.
- Caregivers willing to participate in the study
- Caregivers providing care to the elderly aged 70 years and above.

Exclusion criteria:

Caregivers having hearing and visual impairment.

TOOL AND TECHNIQUE

Based on the objectives of the study, the following tools were designed:

1. Structured questionnaire to collect the demographic data and assess knowledge of caregivers.
2. Planned teaching on prevention and management of amnesia among the elderly.

Technique

The technique used in this study to collect the data was self-reporting.

VALIDITY

The content validity of the tool developed for this study was done by giving it to twelve experts, four from the Department of Psychiatry and nine experts from the Nursing Department. Changes were incorporated in the tool as per their suggestions.

After receiving the opinion from experts, certain modifications were made in the initial tool that consisted of 25 items. As per the inputs given, few questions were reframed, statements were changed into questions and few were deleted. Thus, the final tool which was prepared consisted of 20 multiple questions in the structured format.

VALIDITY OF PLANNED TEACHING

The validity of planned teaching was obtained by verifying it from various experts from the field of nursing, psychiatry, and clinical psychologists. Few suggestions like organization of content matter, expressing it in simple form and adding few points wereincorporated.

RELIABILITY OF TOOL

The reliability of the semi structured questionnaire was established by administering it to 30 college students who reside with their grandparents. The reliability was established by using Cronbach's Alpha formula.

PILOT STUDY

The pilot study was carried out at Kudal, Sindhudurg district on four adult caregivers who stayed with their elderly on 20th January 2022. Initially the investigator introduced herself and then explained the purpose of the study to the caregivers. After obtaining their consent, a pre-test was introduced, followed by planned teaching on prevention and management of amnesia. Post-test was conducted after 7 days on the same group

DATA GATHERING PROCESS

The investigator visited the elderly and their caregivers at their residence and after introduction of self, got oriented to their problems. The investigator explained about her study and asked for their willingness and convenient date and time. For the data gathering the investigator arranged one assembly hall. The investigator visited to the gram panchayat and school and met the Sarpanch and school principal in advance and obtained the necessary permissions from the concerned authorities. The investigator gathered all the caregivers for the pre-test followed by planned teaching. After 7 days the investigator called all the caregivers again for the post-test. Thus, the investigator collected the data in planned systemic manner.

MAIN FINDINGS OF THE STUDY

Demographic data of the elderly:

Age:

More than half i.e., 55% elderly were aged between 70-75 years and 25% elderlywere aged between 76-80 years. Only 20% were 80 years and above.

Gender:

As reported by caregiver, out of all the elderly, 65 % were females and only 35 %males.

Education:

Most of the elderly had primary education that is 67.5 %, 12.5% elderly had secondary education and same percentage did not have any formal education. Only 5% elderly were higher secondary and above.

Type of family:

It is evident from the above table that almost 80% the of elderly lived with their families in joint or extended system. Whereas, 20% belong to the nuclear family norm.

Demographic data of Caregivers:

Age:

37.5 % caregivers were aged between 30 to 40 years, 32.5% caregivers were more than 50 years, 25 % care-givers were aged between 41 to 50 % and only 5 % caregivers were aged less than 30 years of age.

Gender:

Out of all the caregivers 52% were males and 48% were females.

Education:

With regards to the education of the caregivers, 42.5% had completed secondary education, 22.5% caregivers had completed primary education. Only 15% of the caregivers were educated up to graduation, 12.5% caregivers completed higher secondary education, and 7.5% caregivers were post graduates.

Relation with the elderly:

Out of all the sample, majority of the caregivers were the children i.e., 40% sons and 32.5% daughters. Remaining 17.5% caregivers included granddaughters, grandsons, daughters-in-law, 7.5% were siblings of the elderly and 2.5% were mothers.

Duration of stay with the elderly:

Majority i.e., 87.5% caregivers have been staying with their elderly for more than 10 years. 10% caregivers have been staying with their elderly for 5 to 10 years and 2.5% caregivers for less than 2 years.

Effect of planned teaching regarding prevention and management of amnesia among elderly on pre and post-test knowledge scores of the samples.

With regards to knowledge about meaning of amnesia, it was found that the mean percentage during the pre-test was 7.5% which increased to 55% in the post-test. Similarly, knowledge regarding types of amnesia significantly improved from satisfactory (38.75%) in the pre-test to excellent (82.5%) in the post-test. There was an increase of only 7.5% in the mean percentage of knowledge regarding causes before and after the planned teaching. Knowledge regarding symptoms of amnesia increased from 50.83 to 73.33%, and knowledge regarding prevention and management of amnesia significantly increased from 43.5% to 75.5% after the teaching was implemented.

However, no change was found in the pre and post-test mean knowledge percentage of the sample with regards to diagnostic measures of amnesia. The mean knowledge percentage improved from poor (33.33%) to average (47.5%) in relation to home care of clients with amnesia.

Thus, it can be inferred that after planned teaching the caregivers had better knowledge regarding amnesia and its prevention and management.

Comparison of pre-test and post-test knowledge score

The calculated t value of 8.45 is greater than the table value of 2.02 at 0.05 level of significance for degree of freedom 38. Thus, the null hypothesis (H0) is rejected and

research hypothesis (H1) accepted. From this we can infer that post-test mean scores are significantly higher than pre-test mean scores. Thus, the planned teaching had an effect on the knowledge of the caregivers.

Relationship of the knowledge scores of caregivers with regards to age

It was noted that the post-test mean knowledge score of caregivers aged between 30-40 years was 13.4, and that of aged between 41-50 years was 13. The difference was statistically analysed using 't' test. The calculated value of t was 0.3563, which was less than the tabulated value 2.0687 at 0.05 level of significance for degree of freedom
23. Thus, it can be concluded that there is no significant difference between post-test knowledge scores of caregivers aged between 30-40 years and 41-50 years.

Similarly, it was noted that the post-test mean knowledge scores of the caregivers more than 50 years was 13.15, and of aged between 41-50 years was 13. The difference was statistically analysed using 't' test. The calculated value of t was 0.11257, which was less than tabulated value 2.0796 at 0.05 level of significance for degree of freedom
21. Thus, it can be concluded that there is no significant difference between post-test knowledge scores of caregivers aged more than 50 years and those between 41-50 years.

The post-test mean of knowledge scores of caregivers aged between 30-40 years was 13.4 and of those above 50 years of age was 13.15. The difference was statistically analysed using 't' test. The calculated value of t test was 0.2216, which was less than the tabulated value 2.0555 at 0.05 level of significance for degree of freedom 26. Thus, it can be concluded that there is no significant difference between post-test knowledgescores of caregivers aged 30-40 years and >50 years.
Thus, it can be concluded that there was no difference in the knowledge scores of caregivers with regards to their age.

Relationship of the knowledge scores of caregivers with regards to the gender

It was noted that the mean post-test knowledge scores of male caregivers was 12.95 and that of females was 13.57. The difference was statistically analysed using 't' test. The calculated value of t was 0.6955, which was less than the tabulated value 2.0244 at
0.05 level of significance for degree of freedom 38. Thus, it can be concluded that there is no significant difference between the post-test knowledge scores of caregivers as pertheir gender.

Relationship of the knowledge scores of caregivers with regards to their relationships with the elderly

It was noted that the mean post-test knowledge score of daughters was 12.92, and of sons was 12.5. The difference was statistically analysed using 't' test. The calculated value of t was 0.39, which was less than the tabulated value 2.0518 at 0.05 level of significance for degree of freedom 27. Thus, it can be concluded that there is no significant difference between post-test knowledge scores of caregivers as per their relationship with the elderly.

LIMITATIONS

1. The study if conducted on small group, would have been more effective.
2. Although the tool was validated, few questions were misinterpreted by the sample due to the difficulty level and confound distractors.

DISCUSSION

The main objective of the study was to assess the effect of the planned teaching on the knowledge of caregivers of prevention and management of amnesia among the elderly. The knowledge was assessed in different areas such as meaning of amnesia, types of amnesia, causes of amnesia, symptoms of amnesia, diagnostic measures, treatment, home care of amnesia etc. The findings of the study were found to be statistically significant, however better result were expected. Almost all the objectives of the study were achieved. The knowledge of the caregivers was found to be poor in areas of causes and diagnosis of amnesia. This was supported by a study done by Perla Werne in 2001, on correlation of family caregivers' knowledge about Alzheimer's disease. Two hundred and twenty informal caregivers of an elderly person suffering from Alzheimer's disease were recruited from four large memory clinics across the country, and interviewed by trained research assistants. Overall, low levels of knowledge were found, especially in items related to the prevalence, causes and symptoms of the disease.

CONCLUSION

The result of the study clearly showed that the planned teaching regarding prevention and management of amnesia had a positive effect on knowledge of caregivers. There was significant difference noted in knowledge of samples.

IMPLICATION OF THE STUDY

Nursing Education

- Student nurses can refer to the planned teaching and gain knowledge on prevention and management of amnesia.
- Student nurses can conduct health education programme in geriatric OPDs, communities, colleges regarding prevention and management of amnesia among the elderly and disseminate this knowledge to the caregivers.

Nursing Administration

- In nursing service education program could be planned for nurses, emphasizing on the importance of prevention and management of amnesia among the elderly.
- Pamphlet and brochures on this topic can be developed and given for reference in the geriatric OPD's and other areas where geriatric patient was admitted.

Nursing Research

- The tool and technique can be used for future references.
- The findings will add to the body of knowledge regarding care of amnesia.
- The review of literature can provide information for further study.

Nursing Services

- The planned teaching can sensitize the nurses working at the bed side while caring for the elderly.
- Nurses working in the clinical area can disseminate the information regarding prevention and management of amnesia to the caregivers of the elderly.

SUGGESTIONS FOR THE IMPROVEMENT OF THE STUDY

- Study could have been conducted on smaller groups or individual level for better effectivity.
- A large sample could have helped generalisation of the findings.

RECOMMENDATIONS

On the basis of the study, following recommendations have been made for furtherstudy:

1. A similar study can be conducted to improve the knowledge and attitude of the college students who reside with their grandparents.
2. This study can be undertaken on large sample, which may bring more significant and interesting findings.
3. A similar study can be conducted on caregivers in an old age home which will help to improve the quality of the elderly care.
4. An information booklet can be developed and its effectiveness assessed in relation to care of elderly with amnesia.

PERSONAL EXPERIENCE

Initially the sample hesitated and did not show interest to participate in this study due to lack of knowledge regarding amnesia. The investigator had to spend time with them and to develop rapport and make them realize the importance of the topic. Thus, the sample could express themselves, and share the problems faced by them while dealing with the elderly and actively participated in the study.

The study provided an opportunity to the investigator to get oriented to the research process. It was a rich learning experience. The investigator gains immense satisfaction as she was able to create awareness about the elderly care among the rural community. The data collection process did not pose many obstacles as the community was familiarto the investigator.

REFERENCES:

1. Basvanthappa B.T. (2006). Nursing Research. 1st Edition, New Delhi.
2. Burn N. and Grove SK. (2001) The practice of nursing research critique and utilization,4th Edition, Philadelphia
3. Dr. Lalitha K. (2009.) Mental Health and Psychiatric Nursing, 1st Edition. Bangalore.
4. http:/www.nursinganswers.net
5. Gonsalves Benita. A study to assess the effect of planned teaching on the knowledge and attitude of Juvenile delinquents regarding prevention of substance abuse in selected remand home in Mumbai. M.Sc.(N) Unpublished dissertation, S.N.D.T. Women's University: Mumbai.
6. Polit O.F. and Hungler B.P. Nursing Research: Principles and Methods.4th Edition. Philadelphia.
7. Townsend C. and Mary A. (2012) Psychiatric Mental Health Nursing. 7th edition. NewDelhi.

BIBLIOGRAPHY

BOOKS

14. Basvanthappa B.T. (2006). Nursing Research. 1st Edition, New Delhi.
15. Burn N. and Grove SK. (2001) The Practice of Nursing Research Critique andUtilization, 4th Edition, Philadelphia.
16. Deepak. (2019). Text book of Mental Health Nursing. delhi: p v publication.
17. Denise F. Polit and Cheryl Tatano Beck. Nursing Research : Principles and Methods.First edition. Lippincott Williams and winkkins.
18. Dr. Lalitha K. (2009.) Mental Health and Psychiatric Nursing, 1st Edition. Bangalore.
19. Garret E.H. Statistics in Psychology and education, 6th edition, Bombay, Vikas andSimon Ltd.
20. Niraj Ahuja, A textbook of psychiatry,7th edition, Jaypee brothers publications, Newdelhi.
21. Pearsall J (2002).The concise oxford dictionary. 10th edition. Oxford university Press.
22. Polit D.F. and Hungler B.P. Nursing Research: Principles and Methods.4th Edition. Philadelphia.
23. Potter and patrica and Perry G Anne.(2005) Fundamental Of Nursing-Concepts Processand Practice. Third Edition. London.
24. Raj, D. E. (2017). Derbs Mental Health Nursing. Banglore: Emmess MedicalPublishers.
25. R Shreevani, A Guide to Mental Health And Psychiatric Nursing, second edition,Jaypee Brothers Publication , New Delhi
26. Sharma S. K, Nursing Research and Statistics, 2nd edition, ELSEVIER
27. Townsend C. and Mary A. (2012) Psychiatric mental health Nursing. 7th edition. NewDelhi.
28. Welling M et al, (2006), Statistical Techniques, 17th edition, Mumbai, MananPrakash.

JOURNALS

27. Ajay, S., Kasthuri, A., Kiran, P., & Malhotra, R. (2017). Association of impairments of older persons with caregiver burden among family caregivers: Findings from rural South India. Archives of gerontology and geriatrics, 68, 143-148.

28. Anand, K. S., Dhikav, V., Sachdeva, A., & Mishra, P. (2016). Perceived caregiver stress in Alzheimer's disease and mild cognitive impairment: A case control study. *Annals of Indian Academy of Neurology*, 19(1), 58.

29. Allouchery, G., Moustafa, F., Roubin, J., Pereira, B., Schmidt, J., Raconnat, J., ... & Bouvier, D. (2018). Clinical validation of S100B in the management of a mild traumatic brain injury: issues from an interventional cohort of 1449 adult patients. *Clinical Chemistry and Laboratory Medicine* (CCLM), 56(11), 1897-1904.

30. Ballesteros, S., Rieker, J. A., Mayas, J., Prieto, A., Toril, P., Jiménez, M. P., & Reales, J. M. (2020). Effects of multidomain versus single-domain training on executive control and memory in older adults: study protocol for a randomized controlled trial. Trials, 21(1), 1-15.

31. Boitet, R., Gaillard, N., Bendiab, E., Corti, L., Roos, C., Reynes, J., ... & Ducros, A. (2020). Concomitant reversible cerebral vasoconstriction syndrome and transient global amnesia. *Journal of Neurology*, 267(2), 390-394.

32. Buschke, H., Mowrey, W. B., Ramratan, W. S., Zimmerman, M. E., Loewenstein, D. A., Katz, M. J., & Lipton, R. B. (2017). Memory binding test distinguishes amnestic mild cognitive impairment and dementia from cognitively normal elderly. *Archives of Clinical Neuropsychology*, 32(1), 29-39.

33. Chételat, G., Ossenkoppele, R., Villemagne, V. L., Perrotin, A., Landeau, B., Mézenge, F., & Rabinovici, G. D. (2016). Atrophy, hypometabolism and clinical trajectories in patients with amyloid-negative Alzheimer's disease. Brain, 139(9), 2528-2539.

34. Deselms, Jessica L. in Minnesota State University, Mankato, United States in (2012). Memory Priming in Elderly Individuals Diagnosed with Dementia.

35. Jensen, C. D., Kr. igård, T., & Beier, C. P. (2020). Transient epileptic amnesia diagnosed using long-term electroencephalography. Epileptic Disorders, 22(2), 225-228.

36. Khanna, A. B., & Metgud, C. S. (2020). Prevalence of cognitive impairment in elderly population residing in an urban area of Belagavi. *Journal of Family Medicine and Primary Care*, 9(6), 2699.

37. Law, L. L., Mok, V. C., & Yau, M. M. (2019). Effects of functional tasks exercise on cognitive functions of older adults with mild cognitive impairment: a randomized controlled pilot trial. Alzheimer's Research & Therapy, 11(1), 1-10.

38. Makino, T., Umegaki, H., Ando, M., Cheng, X. W., Ishida, K., Akima, H., ... & Kuzuya, M. (2021). Effects of Aerobic, Resistance, or Combined Exercise Training Among Older Adults with Subjective Memory Complaints: A Randomized Controlled Trial. Journal of Alzheimer's Disease, 82(2), 701-717**.**

39. Misra, S., Oswal, R., & Patel, M. (2020). Family burden in caregivers of elderly with cognitive impairment residing in rural and tribal population of a district in Western India–A baseline study. Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine, 45(4), 445.

40. Peltz, C. B., Corrada, M. M., Berlau, D. J., & Kawas, C. H. (2011). Incidence of dementia in oldest-old with amnestic MCI and other cognitive impairments. Neurology,77(21), 1906-1912.

41. Polit O.F. and Hungler B.P. (1991), "Nursing Research: Principles and Methods", 4th Edition, Lippincott Publication, Philadelphia.

42. Ray, C. (2016). *Effects of stress, sex differences, and cognitive reserve on cognitive decline in healthy elderly subjects*. Loma Linda University.

43. Sinha, P., Desai, N. G., Prakash, O., Kushwaha, S., & Tripathi, C. B. (2017). Caregiver burden in Alzheimer-type dementia and psychosis: A comparative study from India. Asian journal of psychiatry, 26, 86-91.

44. Srisuwan, P., Nakawiro, D., Chansirikarnjana, S., Kuha, O., Chaikongthong, P., and Suwannagoot, T. (2020). Effects of a Group-Based 8-Week Multicomponent Cognitive Training on Cognition, Mood and Activities of Daily Living among Healthy Older Adults: A One-Year Follow-Up of a Randomized Controlled Trial. *The journal of prevention of Alzheimer's disease,* 7(2), 112-121.

45. Suzuki, T., Shimada, H., Makizako, H., Yoshida, D., Tsutsumimoto, K., Anan, Y., ... & Park, H. (2012). Effects of multicomponent exercise on cognitive function in older adults with amnestic mild cognitive impairment: a randomized controlled trial. BMC neurology, 12(1), 1-9.

46. Tomadesso, C., Perrotin, A., Mutlu, J., Mézenge, F., Landeau, B., Egret, S and Chételat, G. (2015). Brain structural, functional, and cognitive correlates of recent versus remote autobiographical memories in amnestic Mild Cognitive Impairment. *NeuroImage: Clinical,* 8, 473-482.

47. Tsai, M. Y., Tsai, M. H., Yang, S. C., Tseng, Y. L., & Chuang, Y. C. (2009). Transient global amnesia-like episode due to mistaken intake of zolpidem: drug safety concern in the elderly. *Journal of Patient Safety*, 5(1), 32-34.

48. Uemura, K., Shimada, H., Makizako, H., Doi, T., Yoshida, D., Tsutsumimoto, K. and Suzuki, T. (2013). Cognitive function affects trainability for physical performance in exercise intervention among older adults with mild cognitive impairment. Clinical interventions in aging, 8, 97.

49. Venkatraman, G. K., & Bauerschmidt, A. (2011). Two cases of delayed-onset transient global amnesia after saline-contrast transthoracic echocardiography. The Neurologist, 17(6), 338-339

50. Vicini-Chilovi, B. Riva, M., Conti, M., Zanetti, M., Caratozzolo, S., Mombelli, G. & Padovani, A. (2010). Does age at observation time affect the clinical presentation of mild cognitive impairment? Dementia and geriatric cognitive disorders, 30(3), 212-218.

51. Zhou, X. L., Wang, L. N., Wang, J., Zhou, L., & Shen, X. H. (2020). Effects of exercise interventions for specific cognitive domains in old adults with mild cognitive impairment: A meta-analysis and subgroup analysis of randomized controlled trials. Medicine, 99(31).

ARTICLES

1. Alzeheimers association. (2021). Retrieved from www.alz.org.
2. Jain, a. (2018). Memories mestrys. the New Indian Express.
3. Langer, K. G. (2019). Early History of Amnesia. A History of Neuropsychology .

INTERNET SOURCES

1. http:/www.nursinganswers.net
2. https://www.news-medical.net
3. Quotemaster. https://www.quotemaster.org

UNPUBLISHED DISSERTATION

52. Gonsalves Benita. (2016). A study to assess the effect of planned teaching on the knowledge and attitude of Juvenile delinquents regarding prevention of substance abuse in selected remand home in Mumbai. M.Sc.(N) Unpublished dissertation, S.N.D.T. Women's University: Mumbai.

53. Sangita Shaha. (2019). A study to assess the effect of planned teaching on the knowledge regarding vitamin deficiency disorder and its management among mothers of under five children in selected community of Mumbai. M.Sc.(N) Unpublished dissertation, S.N.D.T. Women's University: Mumbai.

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APPENDIX

APPENDIX-A

Leelabai Thackersey College Of Nursing
S. N. D. T. Women's University

Ref.No.N/F-155/2021-2022/

Date: 16th September 2021

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the, Research Title:

A STUDY TO ASSESS THE EFFECT OF PLANNED TEACHING ON KNOWLEDGE OF CAREGIVERS REGARDING PREVENTION AND MANAGEMENT OF AMNESIA AMONG ELDERLY IN SELECTED RURAL AREA OF SINDHUDURG DISTRICT.

Submitted by the MSc Nursing student Ms. Riya Ramchandra Khanolkar before the Ethical Committee on 16th September 2021 has been approved by the following members of the Ethical Committee.

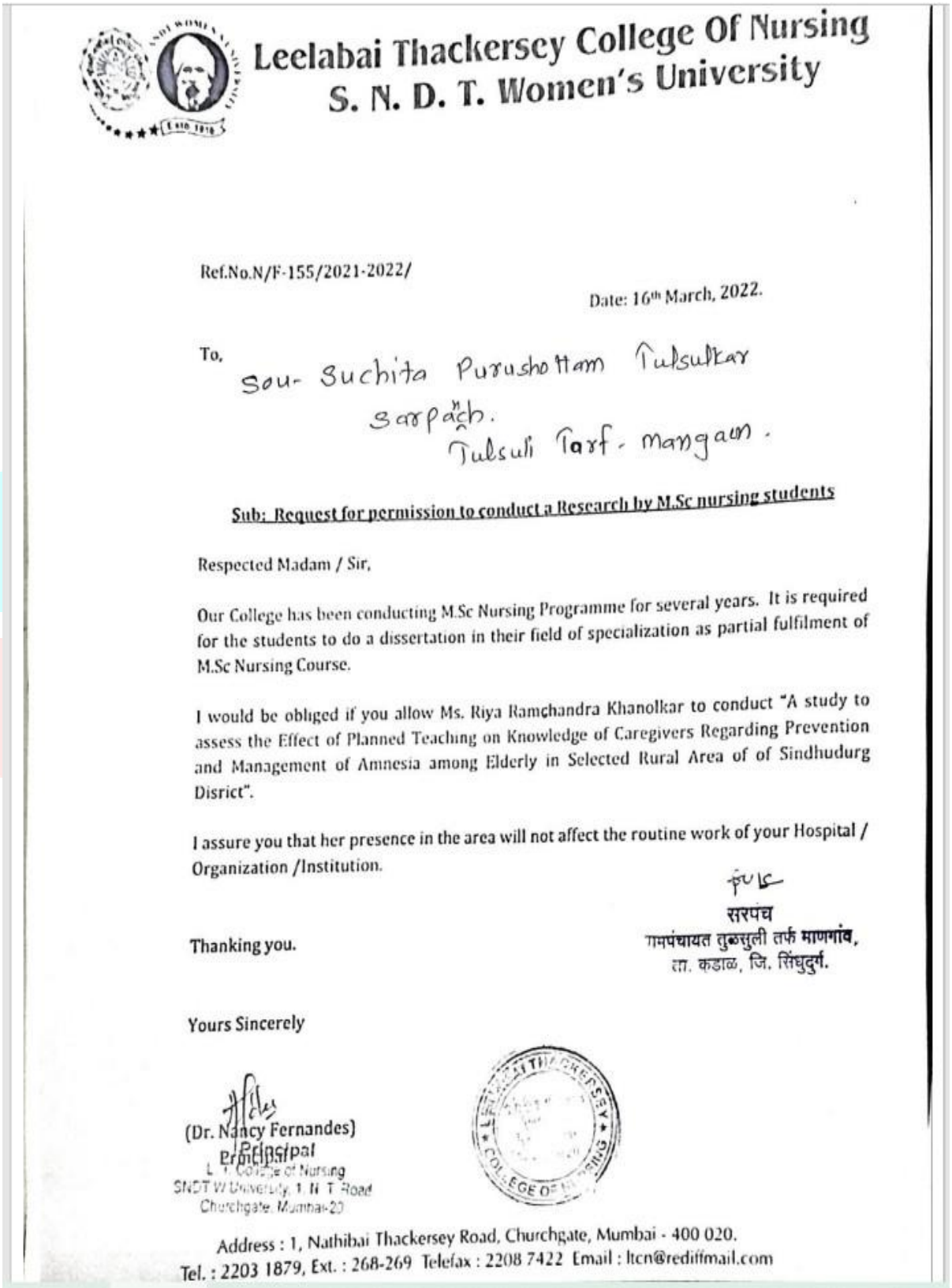
Sr. No	Name of the Ethical Committee Member	Signature
1	Dr. Shubhangi Parkar: Psychiatry Dept. K. E. M. Hospital	
2	Dr. Anuradha Sovani: HOD. Dept. of Psychology	
3	Dr. Pradnya Wakpainjan: HOD. Dept. of Education	
4	Dr. Aakanksha Waghe: Assistant Professor. Dept. of Nursing	
5	Dr. Shobha Gaikwad: Assistant Professor. Dept. of Nursing	

Dr. Nancy Fernandes
Principal
L. T. College of Nursing
SNDT W University, 1, N. T. Road,
Churchgate, Mumbai-20.

LEELABAI THACKERSEY COLLEGE OF NURSING
S.N.D.T. Women's University
1, N.T. Road, Churchgate-20.

Address : 1, Nathibai Thackersey Road, Churchgate, Mumbai - 400 020.
Tel. : 2203 1879, Ext. : 268-269 Telefax : 2208 7422 Email : ltcn@rediffmail.com

APPENDIX-B



Leelabai Thackersey College Of Nursing
S. N. D. T. Women's University

Ref.No.N/F-155/2021-2022/

Date: 16th March, 2022.

To,
Sou- Suchita Purushottam Tulsulkar
Sarpanch.
Tulsuli Tarf. Mangaon.

Sub: Request for permission to conduct a Research by M.Sc nursing students

Respected Madam / Sir,

Our College has been conducting M.Sc Nursing Programme for several years. It is required for the students to do a dissertation in their field of specialization as partial fulfilment of M.Sc Nursing Course.

I would be obliged if you allow Ms. Riya Ramchandra Khanolkar to conduct "A study to assess the Effect of Planned Teaching on Knowledge of Caregivers Regarding Prevention and Management of Amnesia among Elderly in Selected Rural Area of of Sindhudurg Disrict".

I assure you that her presence in the area will not affect the routine work of your Hospital / Organization /Institution.

सरपंच
ग्रामपंचायत तुळसुली तर्फ माणगांव,
ता. कडाळ, जि. सिंधुदुर्ग.

Thanking you.

Yours Sincerely

(Dr. Nancy Fernandes)
Principal
L. T. College of Nursing
SNDT Women's University, 1, N. T. Road
Churchgate, Mumbai-20

Address : 1, Nathibai Thackersey Road, Churchgate, Mumbai - 400 020.
Tel. : 2203 1879, Ext. : 268-269 Telefax : 2208 7422 Email : ltcn@rediffmail.com

APPENDIX-C1

TO WHOM SO EVER IT MAY CONCERN

This is to certify that I have translated and verified the research tool of Ms Riya Ramchandra Khanolkar, SyMsc Nursing Student of L T College of Nursing, SNDT Women's University churchgate.

I hereby approved her data collection tool in Marathi language which she can use in for her further studies.

Thanking you.

Your truly

Mr. Ramchandra R. Khanolkar

M.A. Marathi B.Ed.

Retired Principal of LVT Junior College Tulsuli.

APPENDIX-C2

TO WHOM SO EVER IT MAY CONCERN

This is to certify that I have translated and verified the research tool of Ms Riya Ramchandra Khanolkar, SyMsc Nursing Student of L T College of Nursing, SNDT Women's University churchgate.

I hereby approved her data collection tool in English language which she can use in for her further studies

Thanking you.

Your truly,

Mrs. Leena Ajagaonkar.

M.A. English B.Ed.

Assistant lecturer in LVT and Junior College Tulsuli

APPENDIX-D

BLUE PRINT

Sr. no.	Objectives/ Content	Knowledge	Comprehension	Application	Analysis	Evaluation	Total
1	Knowledge regarding meaning	Q. 1 (1mk)					01
2.	Knowledge regarding types of amnesia	Q. 2 (1mk) Q. 3 (1mk					02
3.	Knowledge regarding causes of amnesia	Q. 4 (1mk) Q. 5 (1mk) Q. 7 (1mk) Q. 11 (1mk)					04
4.	Knowledge regarding symptoms of amnesia.	Q.10 (1mk)	Q.8 (1mk) Q.9 (1mk)				03
5.	Knowledge regarding diagnostic measures of amnesia.	Q. 6 (1mk)					01
6.	Knowledge regarding treatment of amnesia.	Q. 17 (1mk)					01
7.	Knowledge regarding home care				Q.13 (1mk) Q.14 (1mk)	Q.19 (1mk)	03
8.	Knowledge regarding prevention and management	Q. 12 (1mk)	Q.20 (1mk)	Q.15 (1mk) Q.16 (1mk) Q.18 (1mk)			05
	TOTAL	11	03	03	02	01	20
	PERCENTAGE						

APPENDIX-E1

TOOL FOR DATA COLLECTION SECTION 1: - DEMOGRAPHIC DATA

PART -A DEMOGRAPHIC DATA OF ELDERLY-

1. Age of the elderly -

a.70-75 years

b.76-80 years

c.81-90 years d.> 90 year.

2. Gender of the elderly -

a.Male b.Female

c.Transgender

3. Education of the elderly -

a.Primary b.Secondary

c.Higher secondary

d.Graduate

e.Post- graduate

f.No formal education

4. Type of family –

a.Nuclear

b. Joint

c.Extended

PART -B DEMOGRAPHIC DATA OF CAREGIVER

1. Code of caregiver -

2. Age of the caregiver-

a. < 30 years

b.30-40 years

c.41-50 yearsd.>

50 year.

3. Gender of the caregiver-

a.Male b.Female

c.Transgender

4. Education of the caregiver-

a.Primary b.Secondary

c.Higher secondary

d.Graduate

e.Post- graduate

f.No formal education

5. Relation with elderly -

a.Spouse

b.Mother

c.Father

d.Brother

e.Sister

f.Daughter

g.Son

h.Any other-.....

6.Duration of stay with the elderly-

a.<2 years

b.2 to 5 years

c.5 to 10 years

d.>10 year

SECTION: - 2

Q. Choose the correct option of following questions.

- Attempt all the questions
- Every question has only one correct answer
- Tick (√) on correct option.

1. What is the meaning of amnesia ----

a. Temporary memory loss
b. Permanent memory loss
c. Both A and B
d. None of the above

2. If old memories are lost it is called as ----

a. Anterograde amnesia
b. Retrograde amnesia
c. Dissociative amnesia
d. None of the above

3. Another name for Psychogenic amnesia----

a. Anterograde amnesia
b. Retrograde amnesia
c. Dissociative amnesia
d. None of the above

4. The chronic use of alcohol causes memory loss because of ---------- deficiency.

a. Vitamin –B1
b. Vitamin-K
c. Vitamin- C
d. Vitamin- E

5. The following are common reasons for poor memory among elderly EXCEPT ---

a. Sleep problem/disturbance
b. Stress
c. Anxiety
d. Heavy food intake

6. What are the diagnostic method used to detect amnesia? EXCEPT

e. Detailed physical and mental examination.
f. CT scan and MRI.
g. History collection
h. Ultra Sonography

7. Acute or sudden amnesia is caused due to lack of adequate oxygen incertain parts of the--.

a. Heart
b. Brain
c. Lungs
d. Kidney

8. In elderly who has anterograde amnesia will usually forget----------. EXCEPT

e. What he/she ate for lunch
f. Date of birth of his/her son.
g. His childhood memory
h. His/her own mobile number.

9. Which response from elderly will signify the retrograde memory loss?

e. Name birth place
f. Name of primary school teacher.
g. Childhood games
h. All the above

10. The elderly with amnesia who make up stories to fill the gaps in theirmemory, it is called as being ----

e. Confabulation
f. Angry
g. Upset
h. Jealous

11. History of triggering factors include all EXCEPT-------

a. Head injury in the recent past
b. An emotionally traumatic event in the recent past
c. History of illicit drug or alcohol abuse.
d. Watching movies.

12. An elderly with memory loss has to carry an identity card, with all of the following information listed EXCEPT-----

e. Name of patient

f. Address
g. Blood group
h. Caregivers contact number.

13. What would be the best measure to remind elderly to brush his/her teethdaily, EXCEPT.

e. Tell them every day
f. Keep the alarm in their phone regarding brushing
g. Write a note and stick it in the washroom.
h. Keep brush and tooth paste at bedside.

14. 'To remind patients to take medications every day at different time', allmeasure would be appropriate EXCEPT.

e. Medication organisers.
f. Give all medication at a single time.
g. Keep the medication near patient
h. Caregiver should always give medication to the elderly.

15. To keep the elderly oriented to time and date, what is the most usefulidea?

a. Tell them every day about date and time
b. Encourage to read the news-paper daily
c. Clocks with large numbers and calendars with large print.
d. Tell the elderly to asked family members every day about time and place

16. All of the following are preventive aspects of amnesia with EXCEPT---

a. Avoid excessive alcohol consumption.
b. Avoid smoking
c. Avoid use of illicit drugs.
d. Avoid consuming healthy diet.

17. What is the benefit of physical activities in the patient with amnesia? Itwill reduced the risk of ----------

e. Memory loss
f. Heart disease
g. Decrease weight
h. None of the above

18. Which are the activities that help to stimulates brain cells and lower riskof memory loss?

e. Learning a new skill
f. Learning a new instrument
g. Doing crossword or puzzles
h. All of the above

19. Following are the advantages of attending social gathering for an elderly with amnesia, EXCEPT.

e. Helps to recall name of people and situations
f. Provide opportunity for gossips.
g. Help to recollect information and increase knowledge.
h. Help to reduce stress, anxiety and depression.

20. How will you help the elderly to do activities of daily living?

a. With the help of directional arrows
b. With the help of pictures pasted on wall
c. Maintain familiar settings in the house.
d. All of the above.

APPENDIX-E2

डेटा संकलनासाठी साधन विभाग १:- डेमोग्राविक डेटा

भाग- अ िृद्ध लोकांचा लोकसंख्याशास्त्रीय डेटा-

1. िृद्धांचे िय -

a. 70-75 वर्षे
b. 76-80 वर्षे
c. 81-90 वर्षे
d. > 90 वर्षे.

2. िृद्धांचे वलंग -

a. पुरुष
b. स्त्री
c. तृतीय पंथी

3. िृद्धांचे वशक्षण -

a. प्राथमिक
b. िाध्यमिक
c. उच्च िाध्यमिक
d. पदवीधर
e. पदव्युत्तर
f. औपचाररक मिक्षण नाही

4. कु टुंबाचा प्रकार -

a. मवभक्त
b. संयुक्त
c. मवस्तारित

काळजी घेणाऱ्याचा भाग-ब डेमोग्रावि क डेटा

1. काळजीिाहूचा क्रमांक -

2. काळजी घेणाऱ्याचे िय-

a. <30 वर्षे
b. 30-40 वर्षे
c. 41-50 वर्षे
d. > 50 वर्षे.

3. काळजी घेणाऱ्याचे वलंग-

a. पुरुष
b. स्त्री
c. तृतीय पंथी

4. काळजी घेणाऱ्याचे वशक्षण-

a. प्राथमिक
b. िाध्यमिक
c. उच्च िाध्यमिक
d. पदवीधर
e. पदव्युत्तर
f. औपचाररक मिक्षण नाही

5.ृिद्धांशी संबंध -

a. जोडीदार
b. आई
c. वडील
d. भाऊ
e. बहीण
f. कन्या
g. ुलगा
h. इतर कोणतेही नाते-.....

6. ृिद्धांसोबत राहण्याचा कालाि धी-

a. <2 वर्षे
b. 2 ते 5 वर्षे

c. 5 ते 10 वर्षे
d. > 10 वर्ष

विभाग:- 2

प्र. खालील प्रश्नांपैकी योग्य पयाय वनिडा.

- सव प्रश्न सोडावा
- प्रत्येक प्रश्नाचे एक चउत्तर बरोबर आहे.
- योग्य पयायावर (√) खूण करा.

1. स्मृवतभ्रंश म्हणजे काय ----

a. तात्पुरती स्मरणिक्ती किी होणे
b. कायिस्वरूपी स्मरणिक्ती किी होणे
c. ए आमणबी दोन्ही
d. वरीलपैकी काहीही नाही

2. जुन्या आठिणी हरिल्या तर त्याला ----------म्हणतात.

a. अँटे रोग्रेड स्मृमतभ्रंि
b. रे टोग्रेड स्मृमतभ्रंि
c. मडसोमसएमटव्ह स्मृमतभ्रंि
d. वरीलपैकी काहीही नाही

3. सायकोजेवनक स्मृतीभ्रंशाचे दुसरे नाि---------- आहे.

a. अँटे रोग्रेड स्मृमतभ्रंि
b. रे टोग्रेड स्मृमतभ्रंि
c. मडसोमसएमटव्ह स्मृमतभ्रंि
d. वरीलपैकी काहीही नाही

4. अल्कोहोलच्या दीघकाळ िापराने -------- च्या कमतरतेमुळे स्मरणशक्ती कमी होते.

a. व्हटॅमिन-B1
b. व्हटॅमिन-के
c. व्हटॅमिन- सी
d. व्हटॅमिन- ई

5. खालीलपैकी एक पयाय िगळता इतर पयाय ियोिृद्ध लोकांमध्ये स्मरणशक्ती कमी होण्याची सामान्य कारणे आहेत .

a. झोपेची सिस्या/मवप्न
b. ताण
c. मचंता
d. जड अन्न सेवन

6. खालीलपैकी एक पयाय िगळता इतर पयाय स्मृवतभ्रंश शोधण्यासाठी वनदान पद्धती म्हणून िापरल्या जातात.

a. तपीलवार िारीररक आमण िानमसक तपासणी.
b. सीटी स्कॅन आमण एिआरआय.
c. भूतकाळातील वयप्क्तक िामहती
d. अल्टा सोनोग्राफी

7. ----------च्या काही भागांमध्ये पुरेशा ऑक्सिजनच्या कमतरतेमुळे तीव्र वकं िा अचानक स्मृवतभ्रंश होतो.

a. हृदय
b. िेंदू
c. फु फ्फुसे
d. िूत्रपंड

8. खालीलपैकी एक उदाहरण िगळता इतर उदाहरणे िृद्धांमध्ये अँटे रोग्रेड स्मृतीभ्रंश आहे हे दशित.

a. दुपारच्या जेवणासाठी त्याने/मतने काय खाल्ले
b. त्याच्या/मतच्या िुलाची जन्मतारीख.
c. त्याची बालपणीची आठवण
d. त्याचा/मतचा स्वत चा िोबाईल नंबर.

9. **खालीलपैकी कोणता प्रवतसाद िृद्धांमध्ये रेटोग्रेड स्मरणशक्ती कमी होणे दशिेल?**

a. जन्मस्थानचे नाव.
b. प्राथमिक िाळे तील मिक्षकाचे नाव.
c. बालपणीचे खेळ
d. वरील सव

10. स्मृतीभ्रंश असलेले वृद्ध जे आपल्या स्मरणातील पोकळी भरून काढण्यासाठी कथा रचतात, त्याला म्हणतात.

a. गोधळ
b. रागावणे
c. नाराजi
d. चिंतर

11. भूतकाळातील घटनांना चालना देण्यासाठी आवश्यक घटकांपैकी यातील एक पर्याय वगळता इतर सर्व पर्याय योग्य आहेत.

a. अमलकडच्या काळात डोक्याला दुखापत
b. नमजकच्या भूतकाळातील एक भावमनक वेदनादायक घटना
c. बेकायदेशीर औषध सेवन वा अल्कोहोल गैरवतनाचा इमतहास.
d. मचत्रपट बघणे.

12. स्मरणशक्ती कमी असलेल्या वृद्ध व्यक्तीला ओळखपत्र सोबत ठेवणे आवश्यक लागते, त्यात एक पर्याय वगळता खालील सर्व महत्वाची ओळखपत्रांवर सूचीबद्ध केलेली असते.

a. रुग्णाचे नाव
b. पत्ता
c. रक्त गट
d. कायजीवाहू संपक क्रमांक.

13. वयोवृद्धांना दररोज दात घासण्याची आठिण करून देण्यासाठी सर्वोत्तम उपाय कोणता असेल?

a. त्यांना रोज दात घासायला सांगणे.
b. दात घासण्याबाबत त्यांच्या फोनवरध्ये अलार्म ठेवणे
c. एक मकी मलम हणे आमण ती वॉशरूमच्या वरध्ये मक्कटवणे
d. बेडजवळ ब्रश आमण टूथ पेस्ट ठेवणे

14. **'ृद्धांना दररोज ेगि ेगळ्या ेळी औषधे घेण्याची आठिण करून देण्यासाठी', एक पयाय िगळता इतर सि पयाय योग्य आहेत.**

a. औषध आयोजक
b. सव औषधे एकाच वेळी वृद्धांना द्या.
c. औषध वृद्धांजवळ ठेवा
d. काळजीवाहू व्यक्तीने नेहिी वृद्धांना औषधे द्यावीत.

15. **ृद्धांना ेळ आवणतारखे र केंवित ठे ण्यासाठी, सात उपयुक्त कल्पना कोणती आहे?**

a. त्यांना दररोज तारीख आमण वेळ सांगा
b. दररोज वृत्तपत्र वाचण्यास प्रोत्सामहत करा
c. ोठ्या संख्येसह घड्याळे आमण ोठ्या प्रंटसह कॅ लेंडर ठेवा.
d. वृद्धांना सांगा मक कु टुंबातील सदस्यांना दररोज वेळ आमण मठकाण मवचारा.

16. **खालीलपैकी एक पयाय िगळता इतर स्मृतीभ्रंशाच्या प्रवतबंधात्मक बाबी आहेत.**

a. अल्कोहोलचे जास्त सेवन टाळणे
b. धुम्रपान टाळणे
c. बेकायदेीर औषधांचा वापर टाळणे
d. सकस आहार घेणे टाळणे

17. **स्मृवतभ्रंश असलेल्या रुग्णामध्ये शारीररक हालचालीचा उत्तम ायदा होतो, यामुळे----------चा धोका कमी होईल.**

a. स्मृती भ्रं
b. हृदयरोग
c. वजन किी करणे
d. वरीलपैकी काहीही नाही

18. मेंदू च्या पेशीना उत्तेवजत करण्यासाठी आवण स्मरणशक्ती कमी होण्याचा धोकाकमी करण्यासाठी खालील पैकी कोणता पयाय योग्य आहे?

a. नवीन कौिल्य मिकणे
b. नवीन वाद्य मिकणे.
c. क्रॉसवड मकं वा िशब्द कोडी सोडवणे .
d. वरील सव

19. खालीलपैकी एक पयाय िगळता इतर स्मृतीभ्रंश असलेल्या िृद्धांसाठी सामावजक मेळाव्यास उपक्सथथत राहण्याचे िायदे आहेत

a. लोकांची आमणपररक्स्थतीची नावे लक्षात ठेवण्यास िदत मिळते
b. गप्पांना संधी मिळते
c. िामहती आठवण्यास आमणज्ञान वाढमवण्यात िदत मिळते
d. तणाव, मचंता आमण नैराश्य किी करण्यास िदत मिळते

.

20. दैनंवदनजीिनातील कामे करण्यासाठी तुम्ही िृद्धांना कशी मदत कराल?

a. मदितात्मक बाणांच्या िदतीने
b. मभंतीवर मचकटवलेल्या मचत्रांच्या िदतीने
c. घराध्ये पररमचतसेमटंग्ज ठेवल्याने.
d. वरील सव.

APPENDIX-F

ANSWERSHEET

Question no.	Answers	Question no.	Answers
1	c	11	d
2	b	12	c
3	c	13	d
4	a	14	b
5	d	15	c
6	d	16	d
7	a	17	a
8	a	18	d
9	d	19	b
10	a	20	d

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APPENDIX-G

LESSON PLAN ON PREVENTION AND MANAGEMENT OF AMNESIA

SUBMITTED TO:-

MRS. DEEPA SATARDEKARL T

COLLEGE OF NURSING

SUBMITTED BY:-

MS. RIYA R. KHANOLKAR.SYMSC NURSING

ROLL NO. 07

LT COLLEGE OF NURSING

Subject:- Mental Health Nursing

Topic:- Prevention and management of AmnesiaDate

and time:- 7th February 2022 at 11 am.

Venue:-Lingeshwar Vidyalaya High school hall (Tulsuli)

Method of teaching:- Lecture cum discussion

Teaching aids:- Power point presentation(PPT), chart, pamphlet.

Knowledge assumed:- Care givers of elderly have some knowledge about age related changes among elderly.

Aim:- At the end of the session, caregivers will gain knowledge regarding prevention and management ofamnesia.

Specific Objectives:- After the lecture caregivers are able to,

- Understand the meaning of memory and amnesia.
- Enlist types of amnesia.
- Describe causes of amnesia
- Explain symptoms of amnesia.

- Determine diagnosis of amnesia.
- Implement treatment of amnesia
- Identify home care of amnesia.
- Apply measures to prevent and manage amnesia.

Introduced you-self in front of the group and explain them why we are gather over there.

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
2 min		**INTRODUCTION:-** Memory refers to the processes that are used to acquire, store, retain, and later retrieve information. There are three major processes involved in memory: encoding, storage, and retrieval. Human memory involves the ability to both preserve and recover information we have learned or experienced. As we all know, however, this is not a flawless process. Sometimes we forget or misremember things. Sometimes things are not properly encoded in memory in the first place.	Student teacher introduce the topic by showing the video.	Video
1min	Group will be able to define amnesia.	**DEFINITION :-** Amnesia is defined as a temporary or permanent state of decreased memory. Depending on the cause of damage, it may result in partial or complete memory loss. Amnesia can occur either due to damage to some areas of the brain or due to some substance abuse. It may also be present in some individuals at the time of birth.	Student teacher explain about amnesia with the help of PPT	PPT

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
25min	Group will be able to enlist types of amnesia.	**TYPES OF AMNESIA:-** There are two main types of amnesia; anterograde amnesia (inability to form new memories) and retrograde amnesia (old memories are lost). However, various other types of amnesia have also been studies. **Anterograde Amnesia-** It is a type of amnesia in which the person is unable to create new memories. He remembers everything from the past. However, he cannot keep the record of the event that occurred after the injury to the brain. **Retrograde Amnesia-** In this type of amnesia, the patient is unable to recall memories from the past. He can form memories of the recent events that will remain intact. However, the memories stored in the brain prior to brain damage are lost. Complete or partial memory loss can be seen depending on the extent of the damage. When retrograde amnesia occurs, the memories of the events in the recent past are more affected as compared to the distant past. It is due to the reason that the distant memories	Student teacher enlist the types with the helpof PPT.	PPT

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
		have been recalled so many times that their memory tracks become deeply ingrained in the brain. These memories are stored in the widespread areas of the brain. **Dissociative Amnesia-** It is a temporary type of amnesia characterized by episodic memory loss. One episode of retrograde memory loss may last from hours to days or even years. During the episodes of memory loss, patients are unable to recall their personal information. Recent as well as distant memories are lost. Dissociative amnesia is an episodic type of memory disorder in which retrograde amnesia is present while anterograde amnesia is not seen. This type of amnesia does not result from neurological damage to the brain. Rather, it is due to some psychological causes. Thus, it is called psychogenic amnesia. Psychological events such as emotional stress can trigger this episodic memory disorder.		

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
12min	Group will be able describe causes of amnesia.	**Causes of Amnesia** Common causes and risk factors of amnesia and memory loss include concomitant psychological problems, trauma or head injury and so forth. **Concomitant psychological problems** Many patients with memory loss present with other emotional problems like depression, stress and anxiety. In these patient's memory loss is due to poor concentration and not noticing things rather than actual memory impairment. Sleeping problems are also reasons for poor memory in these patients. **Trauma, head injury, epileptic seizure or stroke** These may lead to sudden memory loss or amnesia.	Student teacher describe cause with the help of PPT and asked question.	PPT

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
		In stroke, some of the blood supply to a part of the brain is cut off. This causes the brain tissues to die. If the patient forgets everything that happened before the incident it is called retrograde amnesia and if he or she forgets all that happened after the incident, it is called anterograde amnesia. This type of acute or sudden amnesia is caused due to lack of adequate oxygen in certain parts of the brain. **Other causes of amnesia include:** Thyroid problems – those with lower activities of the thyroid gland are at risk ofmemory loss Sedatives and some medications used against Parkinson's disease may causememory loss over time. Long term damage to the brain due to alcohol abuse. Dietary or other deficiency of the vitamin B1 or thiamine may lead to amnesia.		

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
		Psychogenic amnesia where the patient blocks out a part of his or her memory ofan unpleasant event in the past. This makes them unable to remember important information. Tumours of the brain may lead to amnesia Brain infections like Lyme's disease, syphilis or HIV/AIDS may lead to memoryloss After certain types of brain surgery. After cancer chemotherapy, brain radiation or bone marrow transplant After Electroconvulsive therapy especially over long term. Hormonal changes are responsible for memory loss. General physical illness may affect concentration and memory.		

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
05min	Group will be able to explain symptoms of amnesia.	**Specific symptoms of amnesia-** Loss of explicit memory or recent memory - The typical amnesic patient is unable to recall recent information like what they ate for lunch or a newly heardtelephone number etc. These are called explicit memory as they are memories for facts and events thatare capable of being consciously remembered. Patient or sufferer of loss of explicit memory can often declare the loss as this is in his or her knowledge. Loss of implicit memory – Implicit memory refers to retention of the event or material information but incapability to recall it through conscious effort. In many cases the patient does not even have the knowledge that he or she has thisinformation. Normal or near-normal ability to learn new skills in amnesia patients. Patients have good learning ability (e.g. making a circle using a compass) which impliesgood implicit memory but they do not remember ever having practised the skillwhich implies poor explicit memory.	Student teacher will explain the sign and symptoms of amnesia with the help of chart.	CHART

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
		Anterograde amnesia – this means the patient forgets all events that have happened after a particular traumatic event. This is seen in acute or sudden onsetamnesia like after a head injury, stroke or seizure. These patients do not tend to forget their childhood, events and skills prior to the accident. They however have trouble remembering day-to-day events. Retrograde amnesia refers to an inability to remember information that was acquired before the traumatic event or disease. Typically, there is very poor recallof events that occurred in the near past of the brain damage. This is called “Confabulation” in which the sufferers make up stories to fill thegaps in their memory. There are other features like loss of feeling in the fingersand toes. This type of amnesia may remain even after five years of abstinence from alcohol.		

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
10min	Group will be able determine diagnosis of amnesia	**Diagnosis of Amnesia** Assessment and diagnosis of amnesic states usually involve a detailed look at medical and mental health history of the patient. Many patients presenting with amnesia may also suffer from other conditions like stress, anxiety or depression. During clinical assessment, questions are usually asked regarding the frequency of memory lapses, types of things forgotten, repetition of same phrases or questions in the same conversation, as well as the frequency of forgetting routinetasks like brushing, bathing etc. These questionnaires may be directed to the patients or family members or carers if the memory loss is more severe. History of triggering factors is enquired. This includes history of head injury inthe recent past, an emotionally traumatic event in the recent past, recent requirement of a surgery under general anaesthesia, history of illicit drug or alcohol abuse.	Student teacher explain about diagnostic evaluation with the help of PPT, asked for any query wait for some time and then go ahead with topic.	PPT

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
		A detailed physical examination is performed next to assess for different causesof amnesia. The most important method of diagnosis includes psychometric tests or cognitivetests. In addition to a clinical evaluation of amnesia, metabolic tests and imaging may also be used to diagnose the cause of the amnesia. Blood tests may be performedto test for various circulating biochemical factors that may be indicative of pathology. A CT scan or MRI scan of the brain is often prescribed in addition to other tests. Routine blood tests assessing total blood count, liver and kidney functions areoften prescribed for the diagnosis of the cause of memory loss.		

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
5min	Group will be able to determine treatment of amnesia.	**Treatment of amnesia and memory loss-** Cognitive therapy using speech or language therapist can be of help in patients with mild to moderate memory loss. In many cases mild memory loss may persist. Treatment of underlying medical conditions leading to memory loss. This includes treating low thyroid function, liver and kidney disease. Treatment of stroke, head injury, blood clots in brain and bleeding within the brain may be used to reduce memory loss due to these causes.	Student teacher explain about management with the help of power point presentation	PPT

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
11min	Group will able to describe home care of amnesia.	**Home care for amnesia** Prevention of falls – Often the elderly suffers from memory loss. This populationis also prone to falls. Good lighting and avoidance of clutter helps prevent falls. Doors should be left open and many houses have a provision to keep dangerous materials locked up and make sure the person cannot lock themselves in a room.Rooms can be labelled to prevent patients getting lost. Patient is required to carry some form of identification with their name and address or contact number. To prevent getting scalded by hot water it is necessary to install hot water shut- down and thermostats. There should be safety taps or tap covers to prevent riskof accidents. Common concern in the kitchen is leaving the stove left on. A stove cut off may be used to cut off gas or power after a specified time. To remind patients to take medications there are medication organisers and pill reminders. The organizers have compartments for regular doses of medication. There are also electrical pill reminders that have an alarm to remind individuals to take their tablets.	Student teacher describe about home care for amnesia with the help of pamphlet.	Pamphlet

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
		All-important numbers, such as family and emergency, should be near the telephone. To keep the person oriented to time and place clocks with large numbers and calendars with large print may help reduce anxiety and frustration. Direction arrows in the house to carry out activities of daily living. Pictorial charts that help to give direction and remind to do next procedure Maintain familiarities in the settings of the house. Use mobile reminders to do certain activities. Learn a new skill. Follow a daily routine. Plan tasks, make to-do lists, and use memory tools such as calendars and notes. Stay involved in activities that can help both the mind and body. Volunteer in your community, at a school, or at your place of worship. Spend time with friends and family. Get enough sleep, generally seven to eight hours each night. Exercise and eat well.		

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
9min	Group will be able to identify preventive measures of amnesia.	**Prevention of amnesia-** Memory loss may be prevented by healthy living and reduction of risk factors forheart disease, diabetes etc. This includes lowering cholesterol and high blood pressure. This also reduces risk of stroke and Alzheimer's disease. Excessive alcohol consumption, smoking, use of illicit drugs etc. should beavoided. Regular physical activity helps maintain blood flow to the brain and reduces risk factors of memory loss. Healthy and balanced diet is important in reducing risk of memory loss. Greenleafy vegetables reduce the risk of decline of memory with age. Good social relationships and interactions can help reduce risk of memory loss. Brain activity should be maintained. This can be regular reading, writing, learning a new skill, or instrument, doing crossword or puzzles etc. stimulatesbrain cells and lower risk of memory loss.	Student teacher help to identify preventive measures with the help of power point presentation	PPT

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
2 min 1min		**CONCLUSION:-** Amnesia refers to partial or complete memory loss. Becoming forgetful is common and normal as a person ages, however, when memory loss begins to interfere with activities of daily living, it needs to be assessed by a physician to be a sign of a deeper illness. **SUMMARY: -** Experiencing a moment of forgetfulness now and then is perfectly normal and happens to every one of us now and then. However, if this memory loss starts to become a trend, then it might be a cause of concern. At the same time, experiencing progressive memory loss due to health conditions can be a severe cause of concern. If you find that your memory loss is starting to have an effect on your day to day life, or if it also accompanied by other symptoms, then you have to give more attention toward this situation.		

TIME	ONTRIBUTORY OBJECTIVES	LEARNING CONTENT	TEACHING LEARNING ACTIVITY	A.V. AIDS
2min		**BIBLIOGRAPHY:-** Elakkuvana Bhaskara Raj ,Debr's Mental Health Nursing , Published by Emmess medical publisher, Bangalore. R Shreevani, A guide to mental health and psychiatric nursing, second edition, Jaypeebrothers publication , New Delhi Niraj Ahuja, A textbook of psychiatry,7th edition, Jaypee brothers publications, Newdelhi. https://www.news-medical.net		

APPENDIX-H

पाठ योजना चालू

स्मृतीभ्रंश प्रवतबंध आ वणव्यिथथापन

सादर के ले:-

सौ. दीपा साताडेकर एलटी
कॉलेज ऑफ नमसग
सादर करणारी -
कु. ररया आर खानोलकर.
SYMSC नमसग रोल क्र. ०७
एलटी कॉलेज ऑफ नमसग

मवर्षय :- िानमसक आरोग्य नमसग

मवर्षय: - स्मृतीभ्रंिाशी प्रमतबंध आमण व्यवस्थापन

तारीख आमण वेळ :- ७ फ़ेब्रुवारी २०२२ , ११ वाजता.

स्थळ :-मलंगेश्वर मवद्यालय हायस्कूल सभागृह (तुळसुली)

मिकवण्याची पद्त :- व्याख्यान व चचा

मिकवण्याचे साधन:- पॉवर पॉइंट प्रेझेंटेिन (PPT), चाट, पमत्रका.

गृहीत ज्ञान :- वृद्ांची काळजी घेणाऱ्यांना वृद्ांिधील वयािी संबंमधत बदलांबद्दल काही िामहती असते. **उवि्ष्ट :** - सत्राच्या िेवटी, काळजीवाहकांना स्मृतीभ्रंिाशी प्रमतबंध आमण व्यवस्थापनामवर्षयी ज्ञान मिळे ल .**वि्वशष्ट उवि्ष्टे** :- व्याख्यानानंतर काळजीवाहू सक्षि होतात,

- स्मृती आमण स्मृमतभ्रंिाचा अथ सिजून घेणे
- स्मृमतभ्रंिाचे प्रकार सूचीबद् करणे
- स्मृमतभ्रंिाची कारणे सांगणे
- स्मृमतभ्रंिाची लक्षणे स्पष्ट करणे
- स्मृमतभ्रंिाचे मनदान मनमित करणे

- स्मृतभ्रंश उपचार लागू करणे
- स्मृतीभ्रंशाची घरगुती काळजी ओळखणे
- स्मृतीभ्रंश रोखण्यासाठी आमण व्यवस्थापित करण्यासाठी उपाय लागू करणे

सिूहासिोर तुिची-स्वतः ची ओळख करून मदली आमण आम्ही मतथे का जिलो आहोत हे त्यांना सिजावून सांगणे.

वेळ	ागदान उमद्दष्टे	मिक्षण साधिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
2 मि 1 मिमनट	गट स्मृमतभ्रंि िाचे परभामर्षत करण्यास सक्षि असेल.	**प्रस्तावना:-** िेिरी म्हणजे त्या प्रमक्रयांचा संदभ आहे ज्याचा वापर िामहती प्राप्त करण्यासाठी, संग्रम ह त करण्यासाठी, ठे वण्यासाठी आ मण नंतर पुनप्राप्त करण्यासाठी के ला जातो. िेिरीिध्ये तीन प्रिुख प्रमक्रयांचा सिावेि आहे: एन्कोमडंग, स्टोरेज आ मण पुनप्राप्ती. िानवी स्मरणिक्तीिध्ये आपण मिकलेली मकं वा अनुभवलेली िामहती जतन आ मण पुनप्राप्त करण्याची क्षिता सिामवष्ट असते. आपल्या सवाना िामहत आहे की, तथामप, ही एक म न्दर्ोष प्रमक्रया नाही. कधी कधी आपण गोष्टी मवसरतो मकं वा चुकतो. काहीवेळा गोष्टी प्रथि स्थानावर िेिरीिध्ये योग्यररत्या एन्कोड के ल्या जात नाहीत . **व्याख्या :-** स्मृती किी होण्याची तात्पुरती मकं वा कायिस्वरूपी स्थती म्हणून स्मृतभ्रंिाची व्याख्या के ली जाते. नुकसानीच्या कारणावर	मवद्यार्थी मिक्षक व्हव्हमडओ दाखवून मवर्षयाची ओळख करूनदेतात. मवद्यार्थी मिक्षकPPT च्या साहाय्याने स्मृतभ्रंि ाबद्दल सिजावून सांगतात	व्हव्हमडओ पीपीटी

		अवलंबून, याचिुळे आंमिक मकं वा संपूण िशेिरी किी		

वेळ	ोगदान उमद्दष्टे	मिक्षण साि्ग्री	मिकवणे मिकणे मक्रयाकलाप	AV एड्स
10 मि	गट स्मृतीभ्रंिाच्या प्रकारांची नोदं करण्यास सक्षि असेल.	होऊ िकते. िेंदूच्या काही भागांना झालेल्या नुकसानीिुळे मकं वा काही पदाथाच्या सेवनाि्ुळे स्मृमतभ्रंि होऊ िकतो. हे जन्माच्या वेळी काही व्यक्तीिध्ये दे खील असू िकते. **<u>स्मृवतभ्रंशाचे प्रकार:-</u>** स्मृमतभ्रंिाचे दोन िुख्य प्रकार आहेत; अँटेरोग्रेड अॅम्नेमिया (नवीन आठवणी तयार करण्यास असिथता) आमण रेटोग्रेड अॅम्नेमिया (जुन्या आठवणी नष्ट झाल्या आहेत). तथामप, इतर मवमवधप्रकारच्या स्मृमतभ्रंिाचाही अभ्यास करण्यात आला आहे. **अँटेरोग्रेड स्मृतीभ्रंश-** हा एक प्रकारचा स्मृतभ्रंि आहे ज्याि्ध्ये व्यक्ती नवीन आठवणी तयार करू िकत नाही. त्याला भूतकाळातील सव काही आठवते. िात्र, िेंदूला इजा झाल्यानंतर घडलेल्या घटनेची नोदं तो ठेवू िकत नाही.	मवद्यार्थी मिक्षक PPT च्या िदतीने प्रकारांची नोदं करतात.	पीपीटी

वेळ	ोगदान उमद्दष्टे	मिक्षण साेिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
		रेटोग्रेड स्मृवतभ्रंश- या प्रकारच्या स्मृमतभ्रंिात रुग्णाला भूतकाळातील आठवणी आठवत नाहीत. तो नुकत्याच घडलेल्या घटनांच्या आठवणी तयार करू िकतो ज्या अबामधत राहतील. िात्र, िेंदू ला इजा होण्यापूवी िेंदू िध्ये साठवलेल्या आठवणी नष्ट होतात. पूण मकं वा आंमिक स्मृती नुकसान हानीच्या प्रिाणात अवलंबून मदसू िकते. जेव्हा रेटोग्रेड स्मृमतभ्रंि होतो, तेव्हा दूरच्या भूतकाळाच्या तुलनेत नजीकच्या भूतकाळातील घटनांच्या आठवणी अमधक प्रभामवत होतात. दूरच्या आठवणी इतक्या वेळा आठवल्या की त्यांच्या स्मरणिक्तीचा िागोवा िेंदू िध्ये खोलवर रुजला. या आठवणी िेंदूच्या मवस्तृत भागात साठवल्या जातात. **वडसोवसएवटव्ह स्मृवतभ्रंश-** हा एक तात्पुरता प्रकारचा स्मृतीभ्रंि आहे ज्याचे वैमिष्ट्य एमपसोमडक स्मृती किी होते. रेटोग्रेड िेिरी लॉसचा एक भाग काही तासांपासून मदवसांपयत मकं वा वर्षापयत म क्कू िकतो. स्मृती किी होण्याच्या एमपसोड दरम्यान, रुग्णांना त्यांची वैयव्हक्तक िामहती आठवत नाही. हल्लीच्या तसेच दूरच्या आठवणी हरवल्या आहेत.		

वेळ	ोगदान उमद्दष्टे	मिक्षण साहिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
१५ मि	गट स्मृमतभ्रंिाच्या कारणांचे वणन करण्यास सक्षि असेल.	मडसोमसएमटव्ह अॅम्नेमिया हा एक एमपसोमडक प्रकारचा िेिरी मडसऑडर आहे ज्याि ध्ये रे टोग्रेड अॅम्नेमिया असतो तर अँटोग्रेड अॅम्नेमिया मदसत नाही. या प्रकारचा स्मृमतभ्रंि िेंदू ला झालेल्या न्यूरोलॉमजकल हानीिुळे होत नाही. उलट ते काही िानमसक कारणांिुळे होते. त्यािुळे याला सायकोजेम नक अॅम्नेमिया म्हणतात. भावम नक तणावासारख्या िानमसक घटना या एमपसोमडक िेिरी मडसऑडरला चालना दे ऊ िकतात. **<u>स्मृवतभ्रंशाची कारणे</u>** स्मृमतभ्रंि आ मण स्मरणिक्ती किी होण्याची साि ान्य कारणे आ मण जोखीि घटकांि ध्ये सहवती िानमसक सिस्या, आघात मकं वा डोक्याला दु खापत इत्यादीचं ा सिावे ि होतो. **सहिती मानवसक समस्या** स्मरणिक्ती किी असलेले अनेक रुग्ण नैराश्य, तणाव आमण मचंता यासारख्या इतर भावमनक सिस्यांसह उपव्हस्थत असतात. या रुग्णांची स्मरणिक्ती किी होणे हे एकाग्रता किी झाल्यािुळे आ मण वास्तमवक स्मरणिक्ती किी होण्याऐवजी गोष्टी लक्षात न घेतल्याने होते. या रुग्णांची स्मरणिक्ती किी होण्याचे कारण म्हणजे झोपेची सिस्या.	मवद्यार्थी मिक्षक PPT च्या िदतीने कारणाचे वणन करतात आमण प्रश्न मवचारतात.	पीपीटी

		आघात, डोक्यालला दुखापत, अपस्माराचा झटका वकं ितसरा स्ोक		

वेळ	ोगदान उमद्दष्टे	मिक्षण साेिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
		याेिुळे अचानक स्मरणिक्तेी किेी होणे मकं वा स्मृमतभ्रंिे होऊ िकतेो. स्टोकिध्ये िेंदूच्या काही भागाला होणारा रक्तपुरवठा खंमडत होतेो. याेिुळे िेंदूच्या ऊतीचं ा िृत्यू होतेो. जर रुग्ण घटनेपूवी घडलेल्या सव गोष्टेी मवसरला तर त्याला रेटोग्रेड अॅम्नेमिया म्हणतात आ मणजर तो मकं वा तेी घटनेनंतर घडलेल्या सव गोष्टेी मवसरला तर त्याला अँटोग्रेड अॅम्नेमिया म्हणतात. िेंदूच्या काही भागांिध्ये पुरेिे ा ऑक्सिजनच्या कितरतेिुळे या प्रकारचा तीव्र मकं वा अचानक स्मृमतभ्रंिे होतेो. **स्मृवतभ्रंशाच्या इतर कारणांमध्ये हे समावि आहे:** थायरॉईड सिस्या - ज्यांना थायरॉईड ग्रंथीची मक्रया किी असते त्यांना स्मरणिक्तीकिी होण्याचा धोका असतो पामकन्सन रोगामवरूद् वापरण्यात येणारेी िे ामिक आमण काही औरषधे कालांतराने स्मरणिक्तेी किेी करू िेकतात. अल्कोहोलच्या गैरवापराेिुळे िेंदूला दीघकालीन नुकसान. कॉसाकोफचे िनोमवकार दीघकालीन अल्कोहोल गैरवतन ाेिुळे होते. व्हटॅमिन बी 1 मकं वा थायमिनच्या आहारातील मकं वा इतर कितरतेिुळे स्मृमतभ्रंिे		

		होऊ िकतो.		

वेळ	ोगदान उमद्दष्टे	मिक्षण साेिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
		क्षमणक जागम त कस्मृमतभ्रंिि िेंदू च्या काही भागाि ध्ये रक्तप्रवाहाच्या सिस्यांिुळे उद्भवते, ज्याि ुळे स्मृती कि ी होण्याचे अचानक भाग होतात जे नंतर एखाद्या व्यक्तीला आठवत नाही. सायकोजेम क स्मृतीभ्रंिि जेथे रुग्ण भूतकाळातील एखाद्या अमप्रय घटनेबद्दल त्याच्या मकं वा मतच्या स्मृतीचा काही भाग ब्लॉक करतो . याि ुळे त्यांना िहत्त्वाची िामहती लक्षात ठेवता येत नाही. िेंदू तील यूि रि ुळे स्मृमतभ्रंिि होऊ िकतो लाइि रोग, म स मफलीस मकं वा HIV/AIDS सारख्या िेंदू च्या संसगाि ुळे स्मरणिक्ती की होऊ िकते मवमिष्ट प्रकारच्या िेंदू च्या ि स्तमक्रयेनंतर. कॅ न्सरनंतर के िोथेरपी, ब्रेन रे मडएिन मकं वा बोन ि ॅरो ट ान्सप्लांट मवि ेषत: दीघकालीन Electroconvulsive थेरपी नंतर. अल्झायि र रोगाि ुळे होणाऱ्या स्मृमतभ्रंिि ात स्मरणिक्ती कि ी होणे मिध्रुवीय मवकार मकं वा ह्स्कझोफ्रे म न्याच्या खराब म न्यंमत्रत प्रकरणांि ध्ये स्मरणिक्ती कि ी होणे मदसू ि कते. संप्रेरक बदल स्मृती की होणे जबाबदार आहेत. साि ान्य ि ारीररक आजाराि ुळे एकाग्रता आमण स्मरणिक्तीवर पररणाि होऊ िकतो.		

वेळ	ोगदान उमद्दष्टे	मिक्षण सामिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
12 मि	गट स्मृमतभ्रंिाची लक्षणे स्पष्ट करण्यास सक्षि असेल.	**स्मृव तभ्रंशाची वविशष्ट लक्षणे-** स्पष्ट स्मृती मकं वा अलीकडील स्मृती किी होणे - साि्य स्मरणिक्तीचा रुग्ण दु पारच्या जेवणासाठी काय खाल्ले मकं वा नवीन ऐकलेला टे मलफोन नंबर इत्यादी अलीकडील िामहती आठवू िकत नाही. त्यांना स्पष्ट स्मृती म्हणतात कारण त्या तथ्ये आमण घटनांच्या आठवणी आहेत ज्या जाणीवपूवक लक्षात ठे वण्यास सक्षि आहेत. स्पष्ट स्मरणिक्तती किी झाल्याचा रुग्ण मकं वा पीमडत व्यक्ती अनेकदा नुकसान घोमर्षत करू िकतो कारण हे त्याच्या मकं वा मतच्या िामहतीत आहे. अव्यक्त स्मृती नष्ट होणे - अव्यक्त स्मृती म्हणजे घटना मकं वा भौमतक िामहती राखून ठे वणे परंतु जाणीवपूवक प्रयत्नांिारे ते लक्षात ठे वण्याची अक्षिता. अनेक प्रकरणांिध्ये रुग्ण अगदी तो मकं वा ती ही िामहती िाहीत आहे की नाही. स्मृतीभ्रंि रुग्णांिध्ये नवीन कौिल्ये मिकण्याची साि्य मकं वा जवळपास-साि्य क्षिता. रूग्णांची मिकण्याची क्षिता चांगली असते (उदा. होकायंत्र वापरून वतळ	मवद्यार्थी मिक्षक चाटच्या सहाय्याने स्मृमतभ्रंिाची मचन्हे आ म ण लक्षणे सिजावून सांगतील.	पीपीटी

वेळ	ोगदान उमद्दष्टे	मिक्षण साेिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
		बनवणे) ज्याचा अथ चांगला अंतममह तस्मरणिक्ती दिमवतो परंतु त्यांनी कधीही अिा कौिल्याचा सराव के ल्याचे आठवत नाही ज्यामुळे स्पष्ट स्मरणिक्ती किी आहे. अॅटेरोग्रेड अॅम्नेमिया - याचा अथ रुग्ण एखाद्या मवमिष्ट आघातजन्य घटनेनंतर घडलेल्या सव घटना मवसरतो. डोक्यााला दुखापत, स्टोक मकं वा फे फरे यासारख्या तीव्र मकं वा अचानक सुरू झालेल्या स्मृमतभ्रंिात हे मदसून येते. हे रुग्ण अपघाातापूवीचे त्यांचे बालपण, प्रसंग आमण कौिल्ये मवसरत नाहीत. तथामप, त्यांना दैनंमदन घडाियोडी लक्षात ठे वण्यास त्रास होतो. रे टोग्रेड स्मृतीभ्रंि म्हणजे क्लेिकारक घटना मकं वा रोगापूवी मिळवलेली िामहती लक्षात ठे वण्यास असिथता. साियतः , िेदू ला झालेल्या नुकसानीच्या नजीकच्या भूतकाळात घडलेल्या घटनांची फारच किी आठवण असते. िध्ये Korsakoff च्या िनथक्ष्थती स्मृती किी होणे दारू दुरुपयोग झाले आहे. व्यक्तीच्या अल्पकालीन स्मृती िबद मकं वा मक्रे मकं वा लक्षात एक साधी कथा, रुग्ण falters एक स्टंग मदली तर, साियन मदसून ियात्र िकते. याला "कॉन्फॅ ब्युलेिन" म्हणतात ज्याध्ये पीमडत लोक त्यांच्या स्मरणातील पोकळी भरून काढण्यासाठी कथा तयार करतात. बोटे आमण बोटे िध्ये भावना किी होणे यासारखी इतर वैमिष्ट्ये आहेत. पाच वर्षानी अल्कोहोल सोडल्यानंतरही या प्रकारचा स्मृमतभ्रंि राहू िकतो.		

वेळ	ोगदान उमद्दष्टे	मिक्षण साधिग्री	मिकवणे मिकणे मक्रयाकलाप	AV एड्स
१० मि	गट स्मृतीभ्रंिाचे मनदान करण्यास सक्षि असेल	**<u>स्मृवतभ्रंशाचे वनदान</u>** अॅम्नेमसकअवस्थेचे िूल्यांकन आमण मनदानाधिष्ये साधिान्यतः रुग्णाच्या वैद्यकीय आमण िानमसक आरोग्याच्या इमतहासाचा तपिीलवार मवचार के ला जातो. स्मृतीभ्रंि असलेल्या अनेक रुग्णांना तणाव, मचंता मकंवा नैराश्य यासारख्या इतर परररक्स्थतीचंा त्रास होऊ िकतो. व्हक्लमनकल िूल्यांकनादरम्यान, साधिान्यतः िेिरी लॅप्सची वारंवारता, मवसरलेल्या गोष्टीचंे प्रकार, सिान संभार्षणातील सिान वाक्ये मकंवा प्रश्नांची पुनरावृत्ती, तसेच ब्रि करणे, आंघोळ करणे इत्यादी मनयमित काि मवसरण्याची वारंवारता यासंबंधी प्रश्न मवचारले जातात. या प्रश्नावली असू िकतात. स्मृती किी होणे अमधक गंभीर असल्यासरुग्णांना मकंवा कुटुंबातील सदस्यांना मकंवा कायजीवाहूंना मनदे मित के ले जाते. सुरवात घटक इमतहास मवचारले आहे. अलीकडील पूवी डोक्याला दुखापत इमतहास	मवद्यार्थी मिक्षक PPT च्या िदतीने मनदान िूल्यिा पन बद्दल स्पष्टीकरण देतात, कोणत्याही प्रश्नासाठी काहीवेळ प्रतीक्षा करण्यास सांमगतले आमण नंतर मवर्षयासह पुढे जा.	चाट

		अलीकडील काळात एक भावमन क्क अत्यंत क्लेिकारक घटना, सवसाधारण भूल		

वेळ	ोगदान उमद्दष्टे	मिक्षण साधिग्री	मिकवणे मिकणे मक्रयाकलाप	AV एड्स
		अंतगत िस्त्रमक्रया अलीकडील गरज, बेकायदे िीर औषध मकं वा अल्कोहोल गैरवतन इमतहास सिावे ि आहे. स्मृमतभ्रंिाच्या म व मध्य कारणांचे ि ूल्यांकन करण्यासाठी समवस्तर िारीररक तपासणी के ली जाते. म न्दानाच्या सवात िहत्त्वाच्या पद ्तीिध्ये सायकोि ेमटक चाचण्या मकं वा संज्ञानात्मक चाचण्यांचा सिावे ि होतो. स्मृतीभ्रंिाच्या व्क्लमनकल ि ूल्यांकनाव्यमतररक्त, चयापचय चाचण्या आमण इि ेमजंगचा वापर स्मृतीभ्रंिाच्या कारणाचे मनदान करण्यासाठी के ला जाऊ िकतो. पॅथॉलॉजीचे सूचक असू िकतील अि ा म व मध्य प्रसाररत जैवरासायमनक घटकांची चाचणी घेण्यासाठी रक्त चाचण्या के ल्या जाऊ िकतात. इतर चाचण्यांव्यमतरक्त ि ेंदू चे सीटी स्कॅ न मकं वा एिआरआय स्कॅ न अनेकदा म न्यारारतके ले जातात.		

वेळ	ोगदान उमद्दष्टे	मिक्षण साेिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
५ मि	गट स्मृमतभ्रंि उपचार म न्धाररत करण्यास सक्षि असेल.	स्मरणिक्ती किी होण्याच्या कारणाचे मनदान करण्यासाठी एकू ण रक्त संख्या, यकृ तआा मण िूत्रमपंडाच्या काायाचे िूल्याांकन करणाऱ्या म न्यमित रक्त चाचण्या अनेकदा म न्धाररतके ल्या जातात. **<u>स्मृ व तभ्रंश आवण स्मरणशक्ती कमी होणे यासि उपचार-</u>** स्पीच मकं वा लँग्वेज थेरमपस्ट वापरून संज्ञानात्मक थेरपी सौम्य ते िध्यि स्मरणिक्ती किी असलेल्या रुग्णांना िदत करू िकते. अनेक प्रकरणांिध्ये सौम्य स्मृती किी होणे मटकू न राहाणे िकता. खाली वैद्यकीय अटी स्मृतीकिी होणे अग्रगण्य उपचार. यािध्ये किी थायरॉइड फं क्शन, यकृ त आ मण मकडनी रोगावर उपचार करणे सिामवष्ट आहे. स्टोक, डोके दु खापत, िेंदू तील रक्ताच्या गु ठळ्या आ मण िेंदू िध्ये रक्तस्त्राव या कारणांिुळे होणारी स्मरणिक्ती किी करण्यासाठी उपचारांचा वापर के ला जाऊ िकतो.	मवद्यार्थी मिक्षक पॉवर पॉइंट प्रेझेंटेिन च्या िदतीने व्यवस्थापनाबद्दल सिजावून सांगतात	पीपीटी

वेळ	ोगदान उमद्दष्टे	मिक्षण साधिग्री	मिकवणे मिकणे मक्रयाकलाप	AV एड्स
15 मि	गट स्मृतीभ्रंिाच्या घरगुती काळजीचे वणन करण्यास सक्षि असेल.	**<u>स्मृतीभ्रंशासाठी घरगुती काळजी</u>** फॉल्स प्रमतबंध - स्मृती किी होणे पासून अनेकदा वृद् ग्रस्त. ही लोकसंख्याही किी होण्याचा धोका आहे. चांगली प्रकाियोजना आमण गोधं ळ टाळणे प्रमतबंमधत येते िदत करते. दारे उघडी ठे वली पामहजेत आमण अनेक घरांिध्ये धोकादायक वस्तू लॉक करूनठे वण्याची आमण ती व्यक्ती स्वत ला खोलीत लॉक करू िकत नाही याची काळजी घेण्याची तरतूद आहे. रुग्ण हरवण्यापासून रोखण्यासाठी खोल्या लेबल के ल्या जाऊ िकतात. रुग्णाने त्यांचे नाव आमण पत्ता मकं वा संपक क्रिांकासह काही ओळखपत्रे बाळगणे आवश्यक आहे. गरि पाण्याने गळती होण्यापासून रोखण्यासाठी गरि पाण्याचे िट-डाउन आमण थिस्टॅट्स स्थामपत करणे आवश्यक आहे. अपघाताचा धोका टाळण्यासाठी सुरक्षाटॅप मकं वा टॅप कव्हर असावेत. स्वयंपाकघरातील साियान्य मचंता म्हणजे स्टोव्ह सोडणे. ठरामवक वेळे नंतर गॅस मकं वा वीज कापण्यासाठी स्टोव्ह कट ऑफ वापरला जाऊ िकतो. रुग्णांना औषधे घेण्याची आठवण करून देण्यासाठी औषधी संयोजक आमण गोळ्यास्मरणपत्रे आहेत. आयोजकांकडे औषधांच्या मनयमित डोससाठी कप्पे आहेत. इलेरकल मपल स्मरणपत्रे दे खील आहेत ज्यात लोकांना त्यांच्या गोळ्या घेण्याची आठवण करून दे ण्यासाठी अलाि आहे.	मवद्यार्थी मिक्षकाने पॅम्फलेटच्या िदतीने स्मृतीभ्रंिासाठी घरगुती काळजीबद्दल वणन के ले आहे.	पमत्रका

वेळ	ोगदान उमद्दष्टे	मि क्षण सामग्री	मि कव णे मि कणे मक्रयाकलाप	AV एड्स
		सव-िहत्त्वाचे क्रिाांक, जसे की कु टुंब आमण आणीबाणी, टे मलफोन जवळ असावेत. व्यक्तीला वेळे वर कें मित ठे वण्यासाठी आमण िोठ्या संख्येसह घड्याळे आमण िोठ्या मप्रंटसह कॅ लेंडरिुळे मचंता आमण म नराि्या किी होण्यास िदत होऊ िकते. घरात मदिा बाण दररोज मजवंत उपक्रि अिलात आणणे. स मवत्र तक्ते जे मदिा दे ण्यास िदत करतात आमण पुढील प्रमक्रया करण्याची आठवण करून देतात घराच्या सेमटंगिध्ये ओळखी ठे वा. काही मक्रयाकलाप करण्यासाठी िोबाइल स्मरणपत्रे वापरा. नवीन कौिल्य मिका. रोजची मदनचया पाळा. कायाची योजना करा, काि्याच्या सूची बनवा आमण कॅ लेंडर आमण नोट्स यासारखी िेिरी साधने वापरा. िन आमण िरीर दोघांनाही िदत करू िकतील अिा मक्रयाकलापांिध्ये गुंतून रहा. तुिच्या सिुदायाि्ये, िाळे त मकं वा तुिच्या प्राथनास्थळी स्वयंसेवक. मित्र आमण कुटुंमबयांसोबत वेळ घालवा. पुरेिी झोप घ्या, साधारणपणे प्रत्येक रात्री सात ते आठ तास. व्यायाि करा आमण चांगले खा.		

वेळ	ोगदान उमद्दष्टे	मिक्षण साधिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
10 मि	गट स्मृमतभ्रंि प्रमतबंधात्मक उपाय ओळखण्यास सक्षि असेल.	**स्मृतिभ्रंश प्रतिबंध-** स्मरणिक्ती किी होणे मनरोगी राहून आमण हृदयमवकार, िधु िेह इ.चे जोखीि घटक किी करून रोखले जाऊ िकते. याध्ये कोलेस्टेरॉल आमण उच्च रक्तदाब किी करणे सिामवष्ट आहे. याुळे स्ोक आमण अल्झायिर रोगाचा धोकाही किी होतो. अमत िद्यपान, धुम्रपान, बेकायदेिीर और्षधांचा वापर इत्यादी टाळावे. मगंगको मबलोबा सारख्या काही और्षधी वनस्पती स्मरणिक्ती किी होण्यास प्रमतबंधकरतात असा कोणताही पुरावा नाही. मनयमित िारीररक हालचालीि िेदू लाि रक्त प्रवाह राखण्यास िदत करते आमणस्मरणिक्ती किी होण्याचे जोखीि घटक किी करते. स्मरणिक्ती किी होण्याचा धोका किी करण्यासाठी मनरोगी आमण संतुमलत आहार िहत्त्वाचा आहे. महरव्याि पालेभाज्याि वयानुसार स्मरणिक्ती किी होण्याचाि धोकाि किी करतात. चांगले साियामजक संबंध आमण परस्परसंवाद स्मरणिक्ती किी होण्याचा धोका किी करण्यास िदत करू िकतात.	मवद्यार्थी मिक्षक पॉवर पॉइंट प्रेझेंटेिन च्या िदतीने प्रमतबंधात्मक उपाय ओळखण्यास िदत करतात	पीपीटी

वेळ	ोगदान उमद्दष्टंे	मिक्षण साि्ग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
5 मि 2 मि		िेंदू ची मक्रया कायि ठे वली पामहजे. हे म स्मरि वाचन, लेखन, नवीन कौिल्य मकं वा वाद्य मिकणे, क्रॉसवड मकं वा कोडी इत्यादी असू िकते. िेंदू च्या पेिीनं ा चालना मिळते आमण स्मरणिक्ती किी होण्याचा धोका किी होतो. **<u>संक्षेप :-</u>** 1) स्मृमतभ्रंिाच्या प्रकारांची यादी करा. 2) तुम्ही स्मृतीभ्रंिाचे मनदान कसे कराल? 3) स्मृमतभ्रंिासाठी प्रमतबंधात्मक उपाय काय आहेत? **<u>वनष्कष:-</u>** स्मृमतभ्रंि म्हणजे आंमिक मकं वा पूण स्मरणिक्ती किी होणे होय. एखाद्या व्यक्तीच्या वयानुसार मवस्मरण होणे साि्य आमण साि्य आहे, तथामप, जेव्हा स्मरणिक्ती किी होणे दैनंमदन जीवनातील मक्रयाकलापांिध्ये व्यत्यय आणू लागते, तेव्हा ते एखाद्या सखोल आजाराचे लक्षण असल्याचे डॉिरांनी िूल्यांकन करणे आवश्यक आहे. **सारांश:-**		

वेळ	ोगदान उमद्दष्टे	मिक्षण साेिग्री	मिकव णे मिकणे मक्रयाकलाप	AV एड्स
1 मिमनट 2 मि		आत्ता आ मण नंतर मवस्मरणाचा क्षण अनुभवणे अगदी साि्यान्य आहे आ मण आपल्यापैकी प्रत्येकाला आता आ मण नंतर घडते. तथामप, जर ही स्मरणिक्ती किी होणे हा टेंड बनू लागला तर ते मचंतेचे कारण असू िकते. त्याच वेळी, आरोग्याच्या स्थतीिुळे प्रगतीिील स्मरणिक्ती किी होणे हे मचंतेचे गंभीर कारण असू िकते. तुिची स्मरणिक्ती किी झाल्याचा तुिच्या दैनंमदन जीवनावर पररणाि होऊ लागला आहे, म्कं वा इतर लक्षणांसोबत सुद्धा तुिच्या लक्षात आल्यास, तुम्हाला या पररक्स्थतीकडे अमधक लक्ष द्यावे लागेल. **<u>सदंभग्रंथ :-</u>** Elakkuvana भास्कर राज, Debr's Mental Health Nursing, Emmess Medical प्रकाि्क, बंगलोर िारा प्रकामित. आर श्रीवानी, िानमसक आरोग्य आ मण िानसोपचार नमसगसाठी िागदिक, दुसरी आवृत्ती, जेपी ब्रदस प्रकाि्न, नवी मदल्ली म नरज आहुजा, िानसोपचाराचे पाठ्यपुस्तक, ७वी आवृत्ती, जेपी ब्रदस पब्लके िन्स, नवी मदल्ली. https://www.news-medical.net		

APPENDIX-I CONSENT FORM

Dear Respondent,

I Ms. Riya Khanolkar student of second-year M. Sc Nursing L.T. college of nursing. As partial fulfilment of course, I am doing a research study on "A study to assess the effect ofplanned teaching on knowledge of caregivers regarding prevention and management of amnesia among elderly in selected rural area of Sindhudurg".

I assure you that the information provided will be used solely for the purpose of this studyand will be kept confidential.

I will be grateful if you consent to participate in my study.Thanking

you.

Yours sincerely, Ms.

Riya khanolkar

_____

Date:07 /02 /2022

I am willing to participate in the above-mentioned study.

_____

(Signature of respondents)

_____

(Name of respondents)

APPENDIX-J

संमती पत्र

मप्रय प्रमतसादक,

िी कु िारी ररया खानोलकर M. Sc नमसग मिितीय वर्षात मिकत असून, एलटी कॉलेज ऑफ नमसगची मवद्यामथनी आहे. अथातच आंमिक पूतता म्हणून, िी " मसंधुदुगातील म ग्रडक ग्रामिीण भागातील वृद्धांिधील स्मृतीभ्रंि प्रमतबंध आमण व्यवस्थापनासंबंधी कोळजीवाहकांच्या ज्ञानावर म ग्रोमजत मिक्षणाच्या पररणामिाचे िूल्यांकन " या मवर्षयावर एक संिोधन करत आहे .

िी तुम्हाला खात्री देते की प्रदान के लेली िामहती के वळ या अभ्यासाच्या उद्देिासाठी वापरली जाईल आमण ती गोपनीय ठे वली जाईल.

तुम्ही िाझ्या अभ्यासात सहभागी होण्यास संिती मदल्यास िी कृ तज्ञ होईन. आपली आभारी.

तुिची नम्र,

कु.ररया खानोलकर _

_____

तारीख: ०7/०२/२०२२

िी वर नमूद के लेल्या अभ्यासात सहभागी होण्यास इच्छु क आहे.

_____

(प्रमतसादकत्याची स्वाक्षरी)

_____

(प्रमतसादरकत्याचे नावं)

APPENDIX- K

NAME OF EXPERTS FOR THE TOOL VALIDATION

Sr. No.	Name of the expert	Designation	Sign
1	Nancy FernandesPereira	Principal L. T. College of Nursing Women University,Mumbai.	
2	Mrs. Deepa Satardekar	Assistant Professor L. T. College of Nursing Women University,Mumbai.	
3	Dr. Mrs. Akanksha Waghe	Assistant Professor L. T. College of Nursing Women University,Mumbai.	
4	Dr. Mrs. Shobha Gaikwad	Assistant Professor L. T. College of Nursing Women University,Mumbai.	
5	Ms. Leena Kootingal	Assistant Professor L. T. College of Nursing Women University,Mumbai.	
6	Dr. Mrs. Devita Nalawade	Assistant Professor L. T. College of Nursing Women University,Mumbai.	
7	Mrs. Sheetal Kothare	Assistant Professor L. T. College of Nursing Women University,Mumbai.	
8	Mrs. Kirti Jamdar	Assistant Professor L. T. College of Nursing Women University,Mumbai.	
9.	Mrs. Sebin Bijo Parackel	Faculty L. T. College of Nursing Women University,Mumbai.	
10	Mrs. Chitra Naik	Vice Principal Kokilaben Dhirubhai Ambani ge of NursingMumbai	

Sr. No.	Name of the expert	Designation	Sign
11	Dr. Sagar Karia	Assistant Professor Department of Psychiatry Lokmanya Tilak Municipal General Hospital Mumbai	
12	Dr. Parijat Roy	Assistant Professor Department of Psychiatry Lokmanya Tilak Municipal General Hospital Mumbai	
13	Mrs. Alpa M.Alure	Clinical Psychologist Department of Psychiatry Lokmanya Tilak Municipal General Hospital Mumbai	
14	Ms. Tejesvi Dave	Clinical Psychologist Department of Psychitry Lokmanya Tilak Municipal General Hospital Mumbai	

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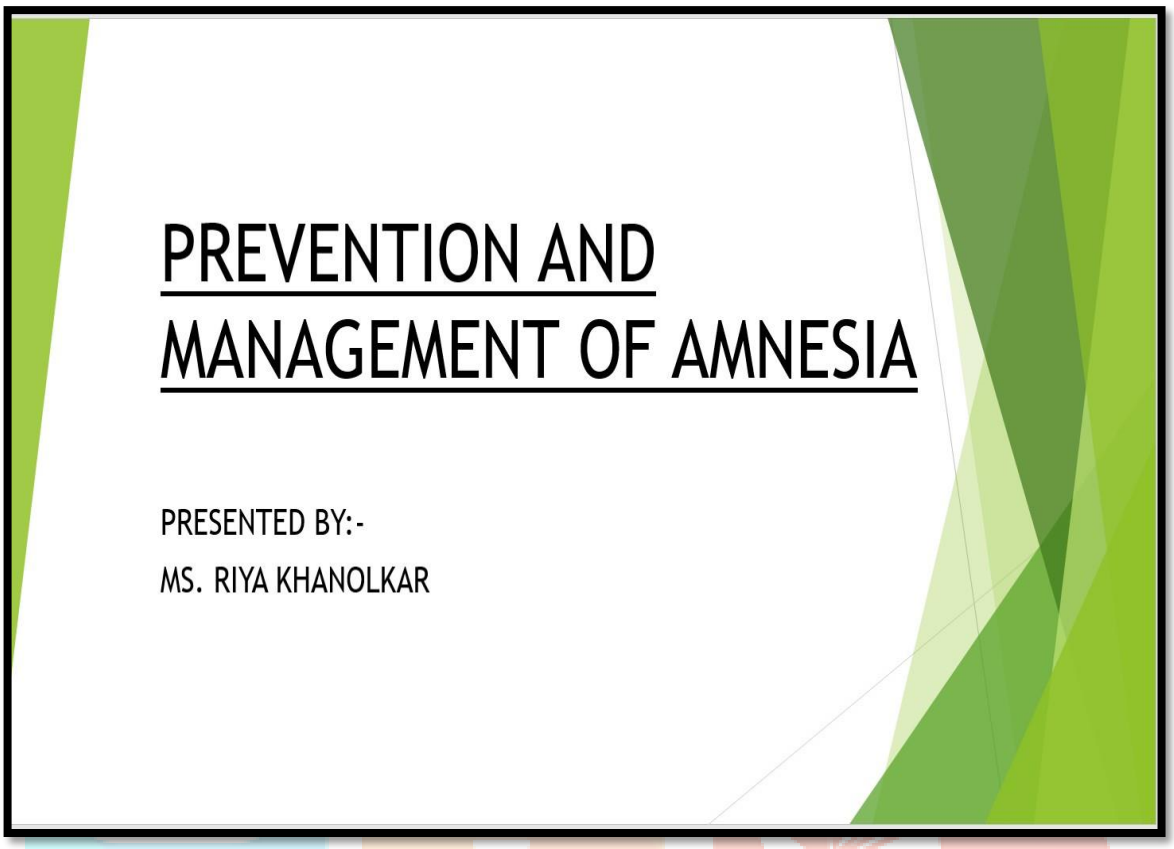

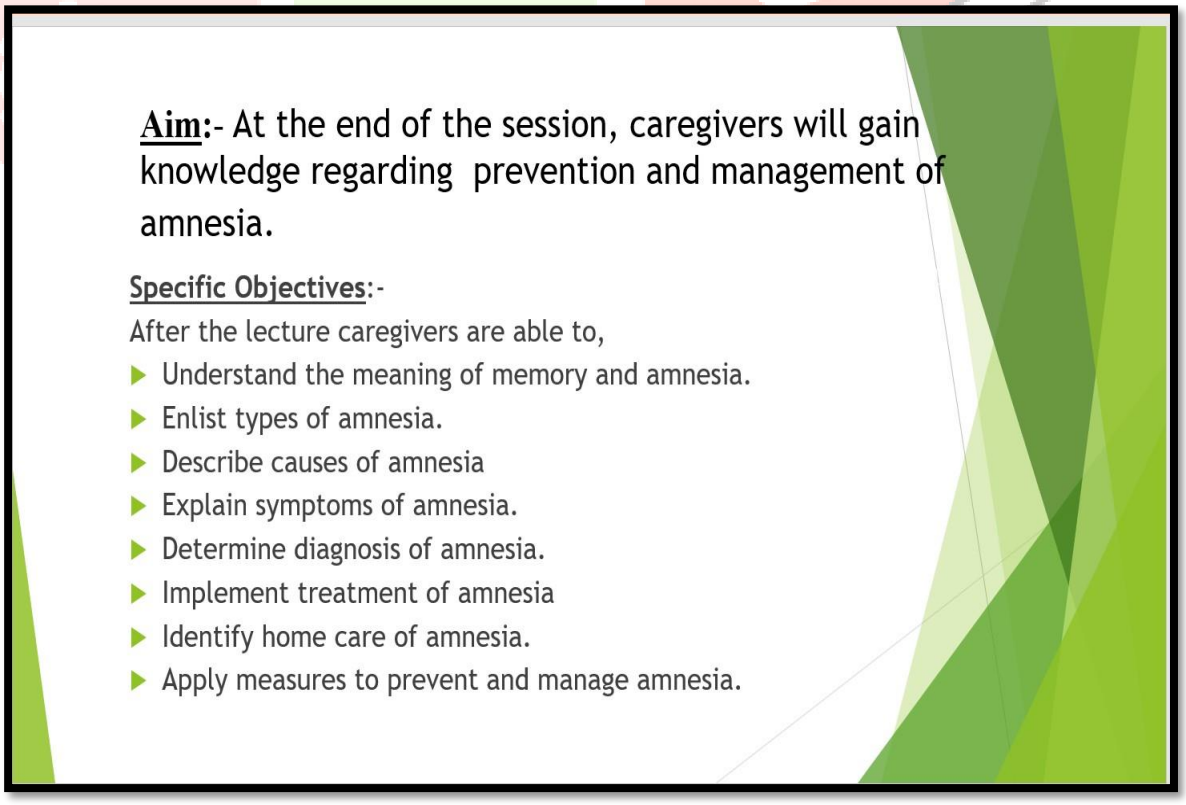

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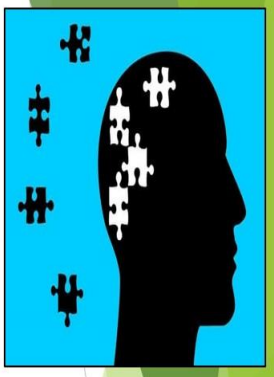
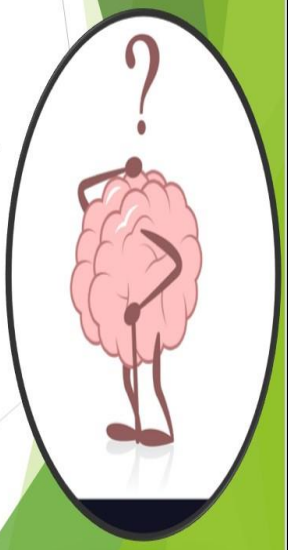
INTRODUCTION



- Memory refers to the processes that are used to acquire, store, retain, and later retrieve information.
- There are three major processes involved in memory: encoding, storage, and retrieval. Human memory involves the ability to both preserve and recover information we have learned or experienced. As we all know, however, this is not a flawless process.
- Sometimes we forget or misremember things. Sometimes things are not properly encoded in memory in the first place.

DEFINITION

- Amnesia is defined as a temporary or permanent state of decreased memory. Depending on the cause of damage, it may result in partial or complete memory loss. Amnesia can occur either due to damage to some areas of the brain or due to some substance abuse. It may also be present in some individuals at the time of birth.



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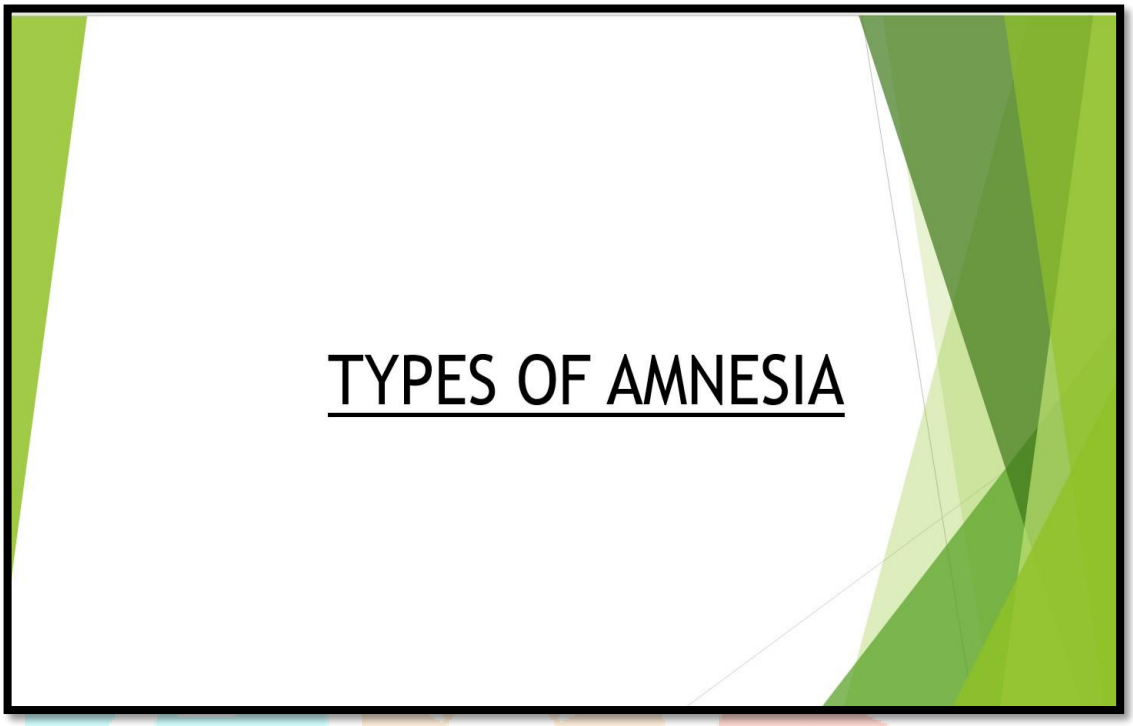

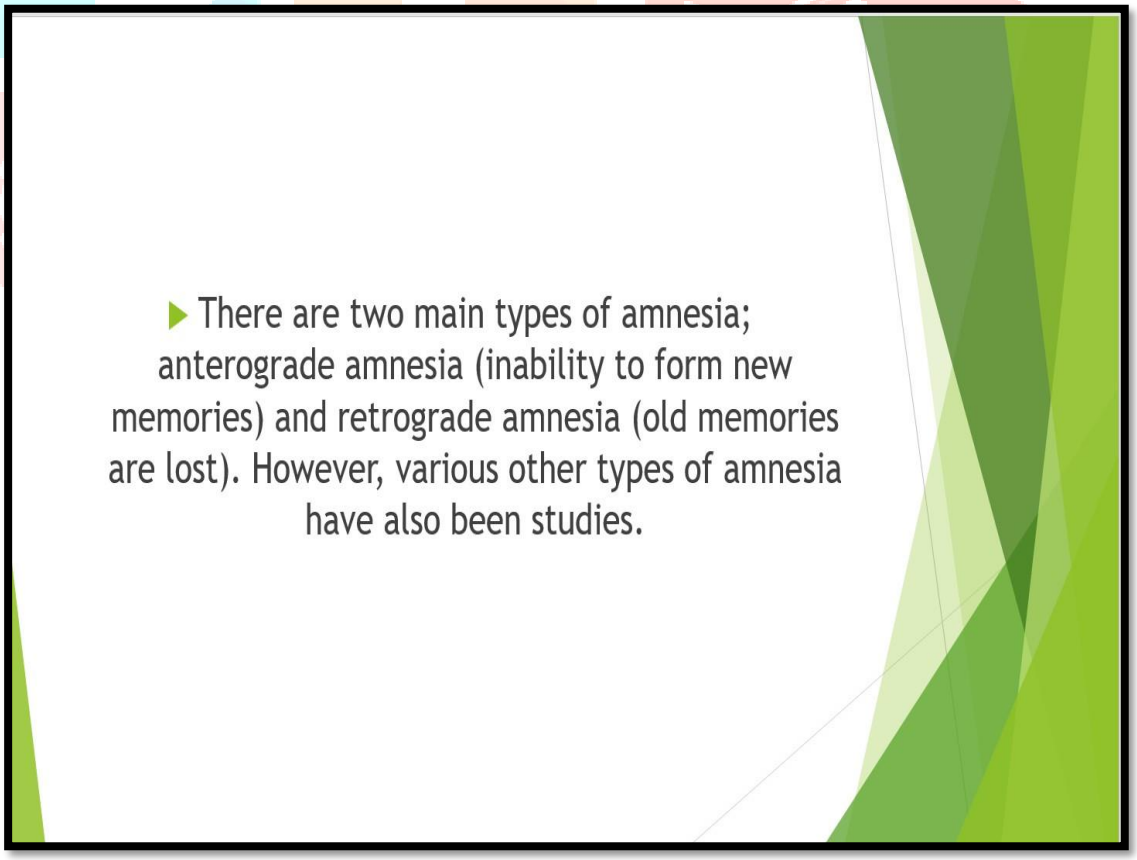

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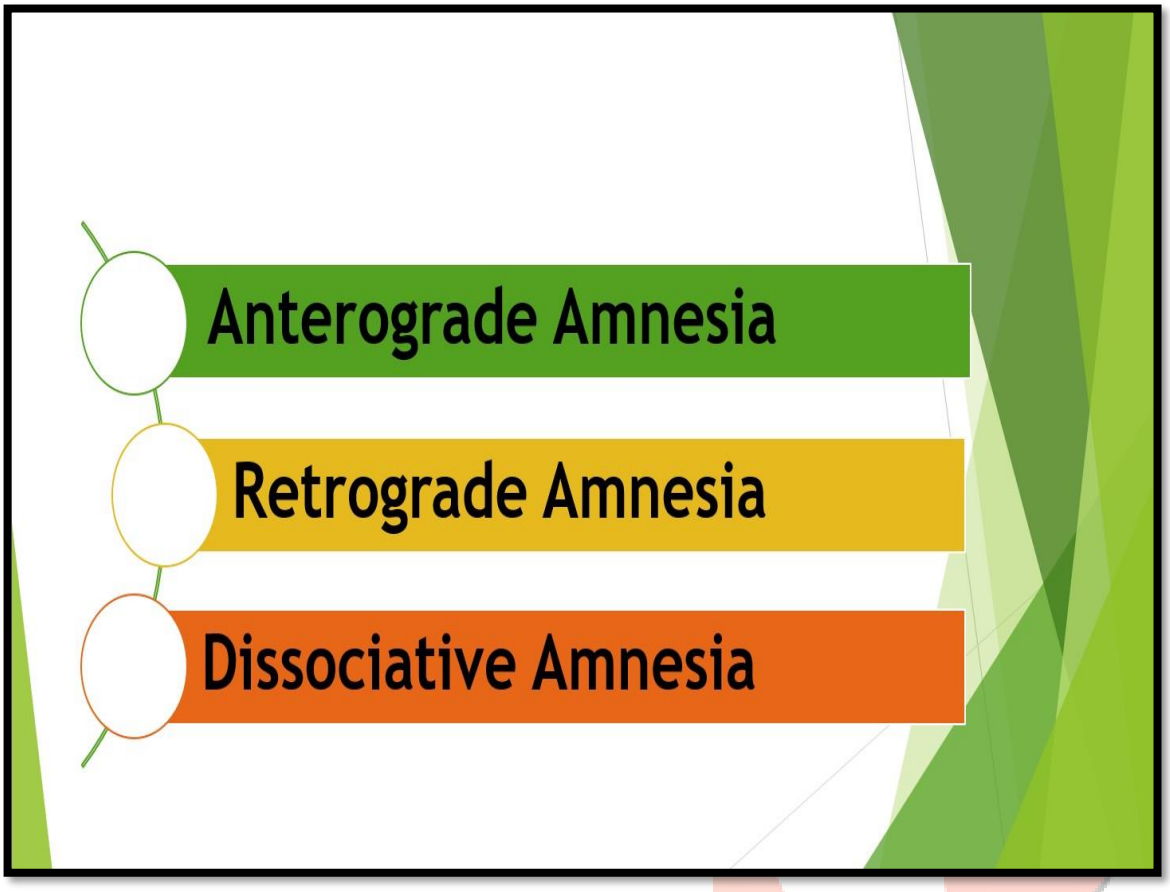

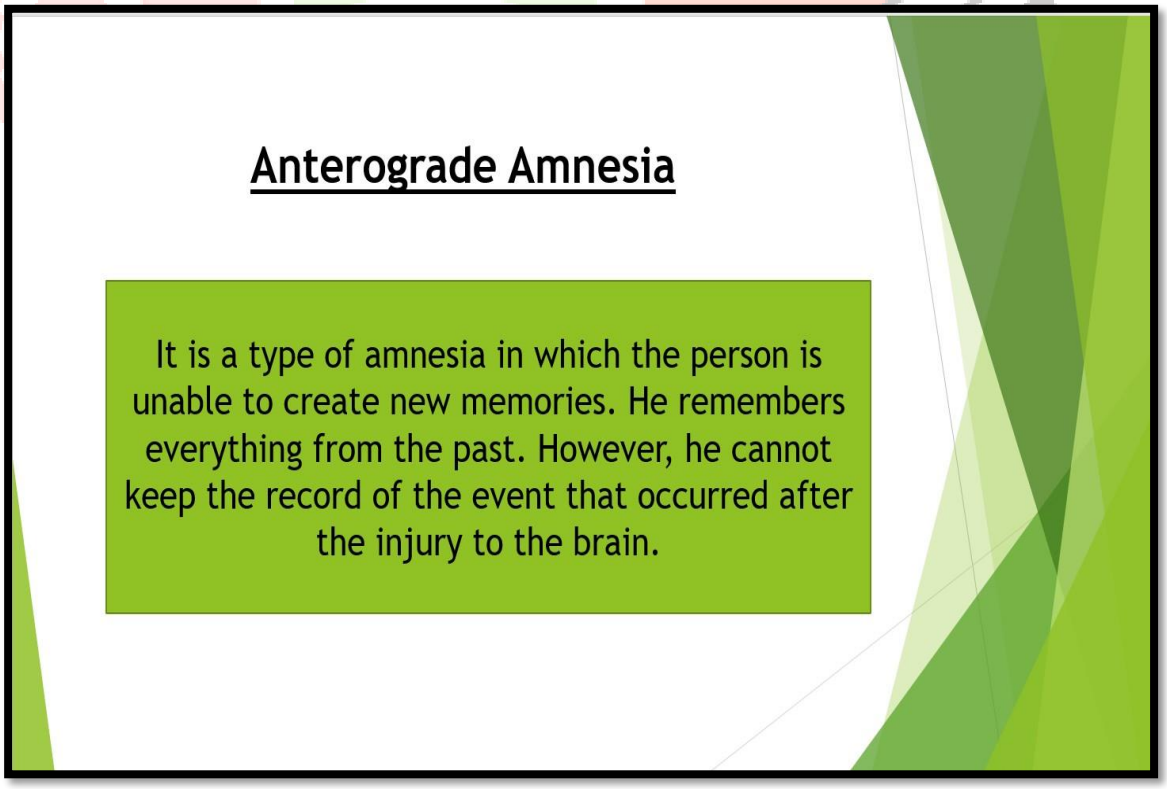

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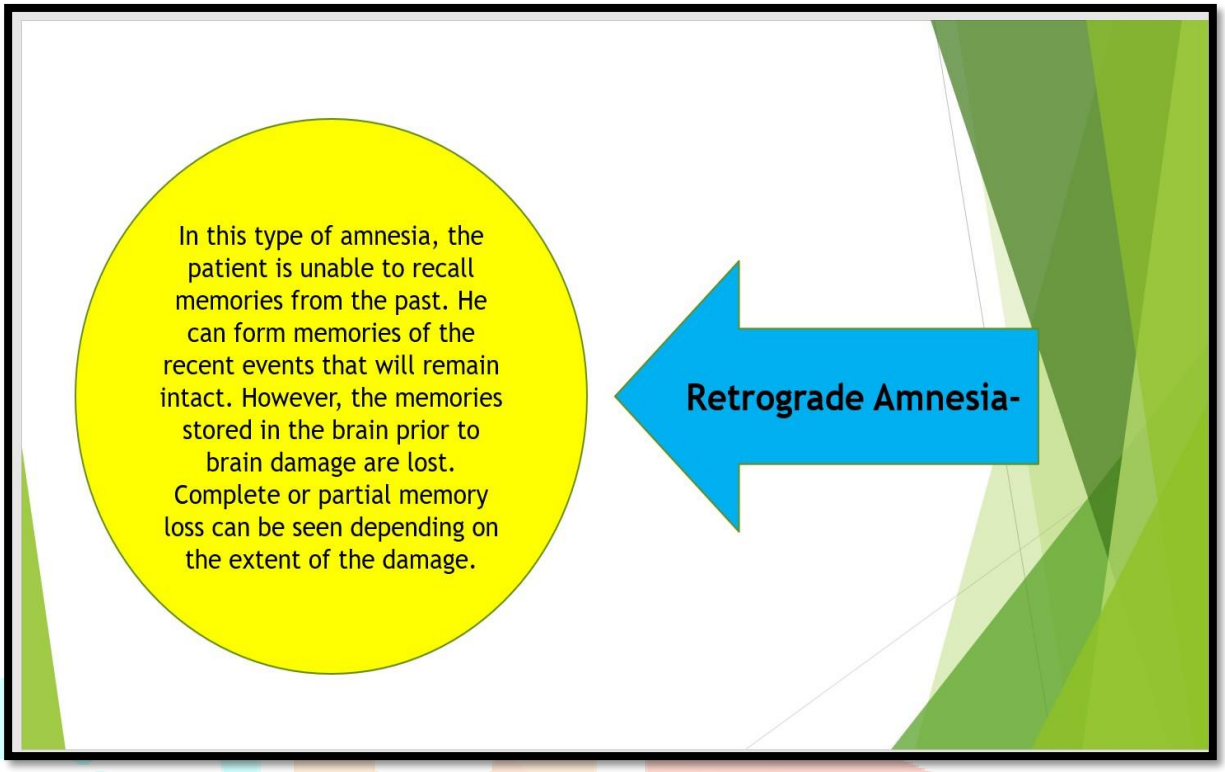

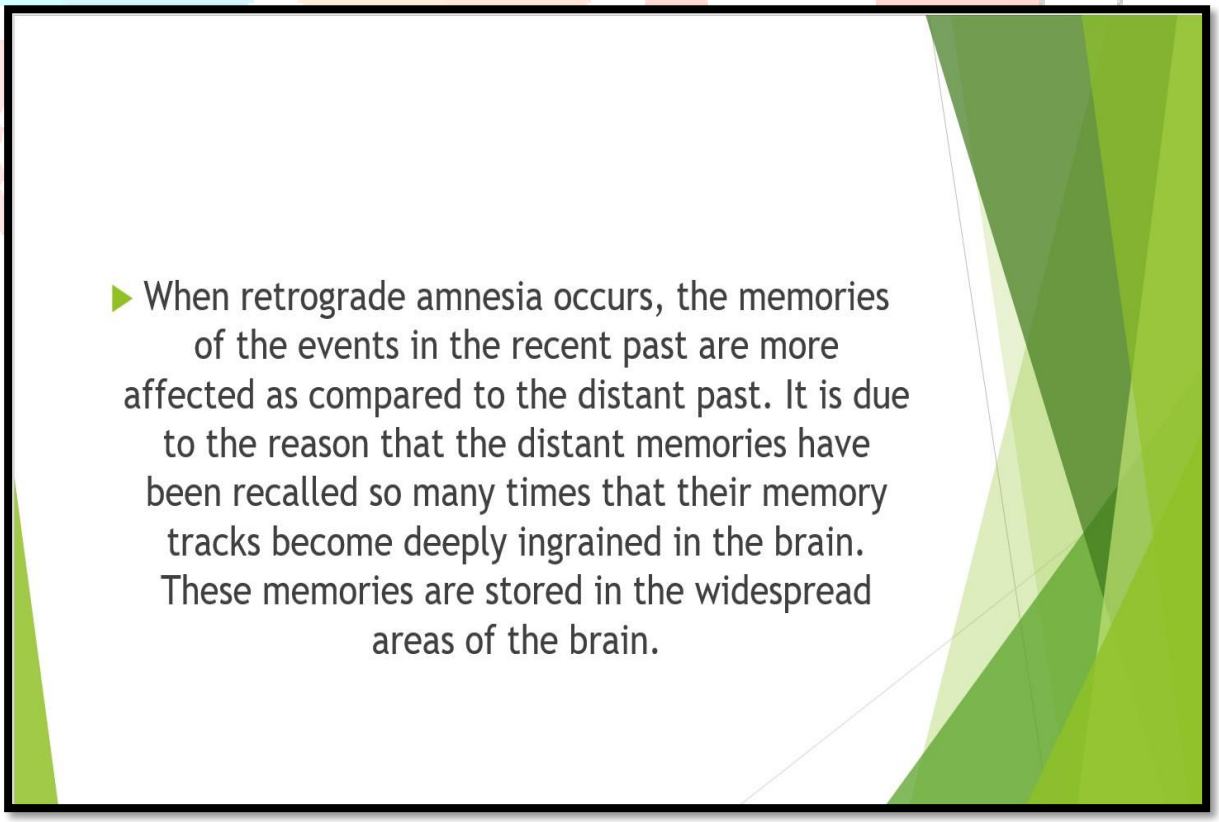

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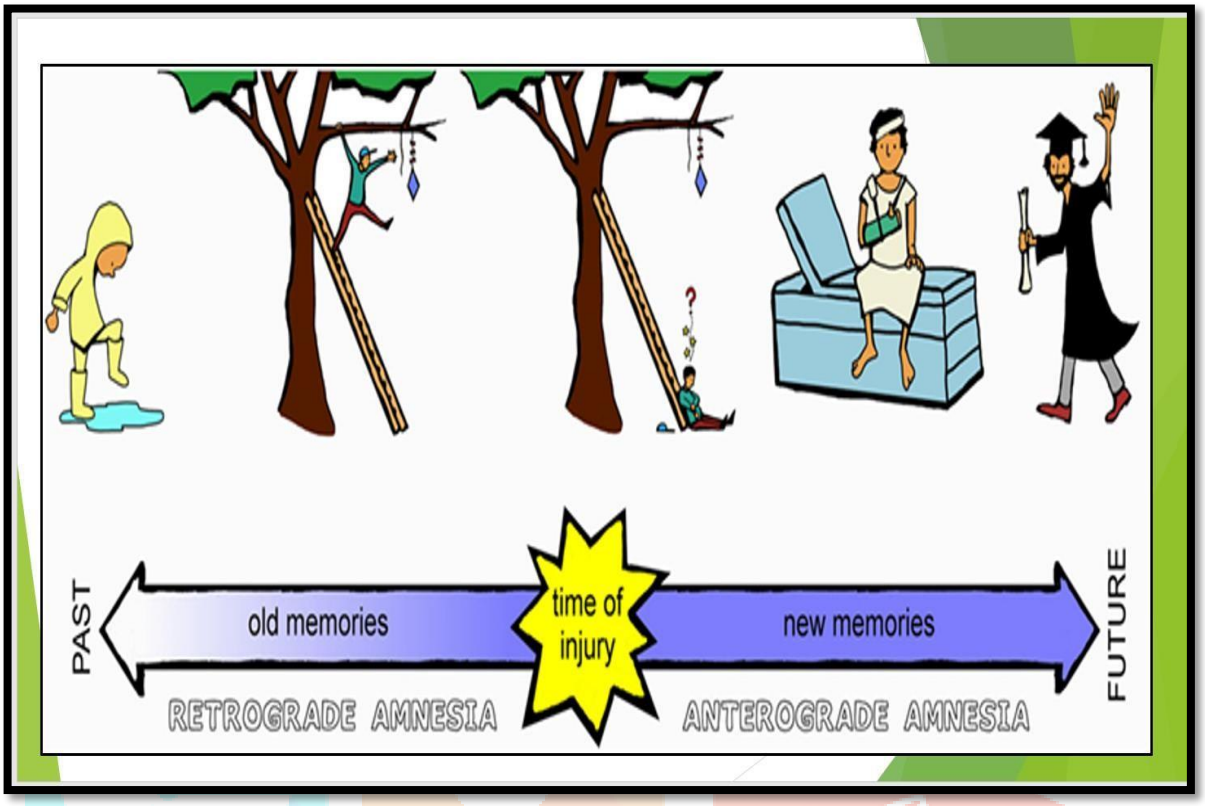

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Dissociative Amnesia

It is a temporary type of amnesia characterized by episodic memory loss. One episode of retrograde memory loss may last from hours to days or even years. During the episodes of memory loss, patients are unable to recall their personal information. Recent as well as distant memories are lost.

Dissociative amnesia is an episodic type of memory disorder in which retrograde amnesia is present while anterograde amnesia is not seen. This type of amnesia does not result from neurological damage to the brain. Rather, it is due to some psychological causes. Thus, it is called psychogenic amnesia. Psychological events such as emotional stress can trigger this episodic memory disorder.

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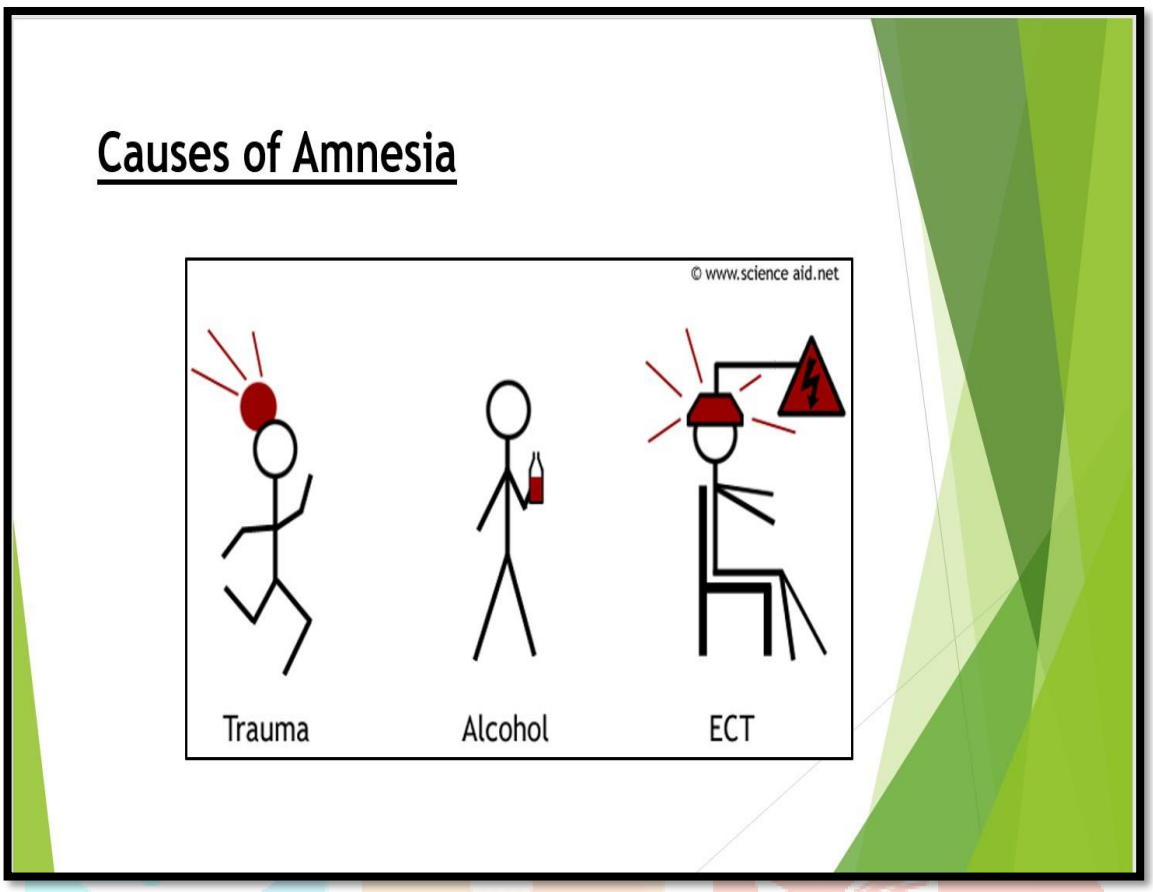

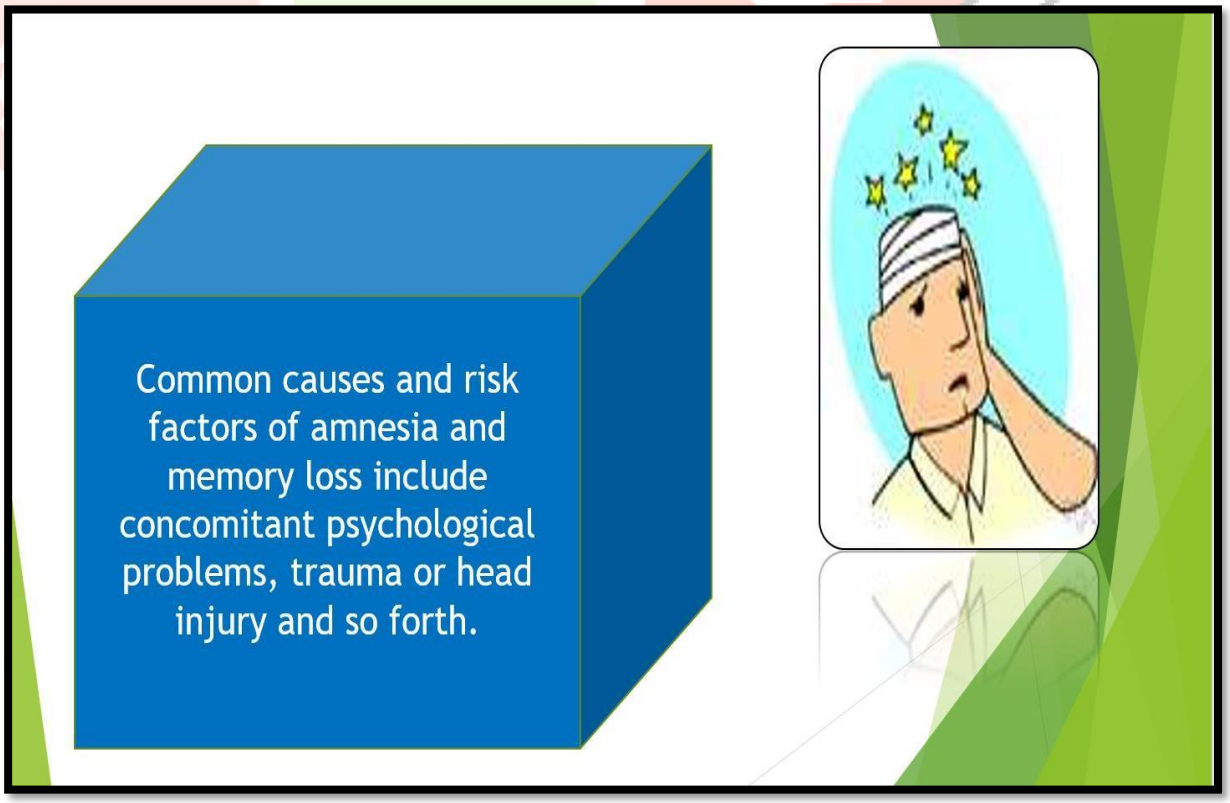

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Concomitant psychological problems

- Many patients with memory loss present with other emotional problems like depression, stress and anxiety.
- In these patient's memory loss is due to poor concentration and not noticing things rather than actual memory impairment.
- Sleeping problems are also reasons for poor memory in these patients.

Trauma, head injury, epileptic seizure or stroke

- These may lead to sudden memory loss or amnesia.
- In stroke, some of the blood supply to a part of the brain is cut off. This causes the brain tissues to die.
- If the patient forgets everything that happened before the incident it is called retrograde amnesia and if he or she forgets all that happened after the incident, it is called anterograde amnesia.
- This type of acute or sudden amnesia is caused due to lack of adequate oxygen in certain parts of the brain.

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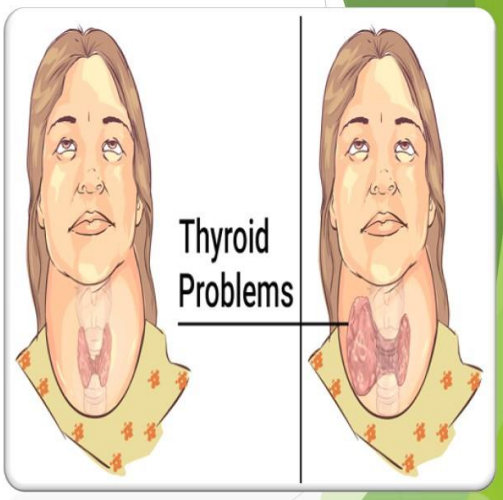
Other causes of amnesia include:

- Thyroid problems - those with lower activities of the thyroid gland are at risk of memory loss
- Sedatives and some medications used against Parkinson's disease may cause memory loss over time.
- Long term damage to the brain due to alcohol abuse.
- Dietary or other deficiency of the vitamin B1 or thiamine may lead to amnesia.
- Psychogenic amnesia where the patient blocks out a part of his or her memory of an unpleasant event in the past. This makes them unable to remember important information.

- Tumours of the brain may lead to amnesia
- Brain infections like Lyme's disease, syphilis or HIV/AIDS may lead to memory loss
- After certain types of brain surgery.
- After cancer chemotherapy, brain radiation or bone marrow transplant
- After Electroconvulsive therapy especially over long term.
- Hormonal changes are responsible for memory loss.
- General physical illness may affect concentration and memory.



Specific symptoms of amnesia-

Loss of explicit memory or recent memory - The typical amnesic patient is unable to recall recent information like what they ate for lunch or a newly heard telephone number etc.

These are called explicit memory as they are memories for facts and events that are capable of being consciously remembered. Patient or sufferer of loss of explicit memory can often declare the loss as this is in his or her knowledge

Loss of implicit memory - Implicit memory refers to retention of the event or material information but incapability to recall it through conscious effort. In many cases the patient does not even have the knowledge that he or she has this information.

Normal or near-normal ability to learn new skills in amnesia patients. Patients have good learning ability which implies good implicit memory but they do not remember ever having practised the skill which implies poor explicit memory.

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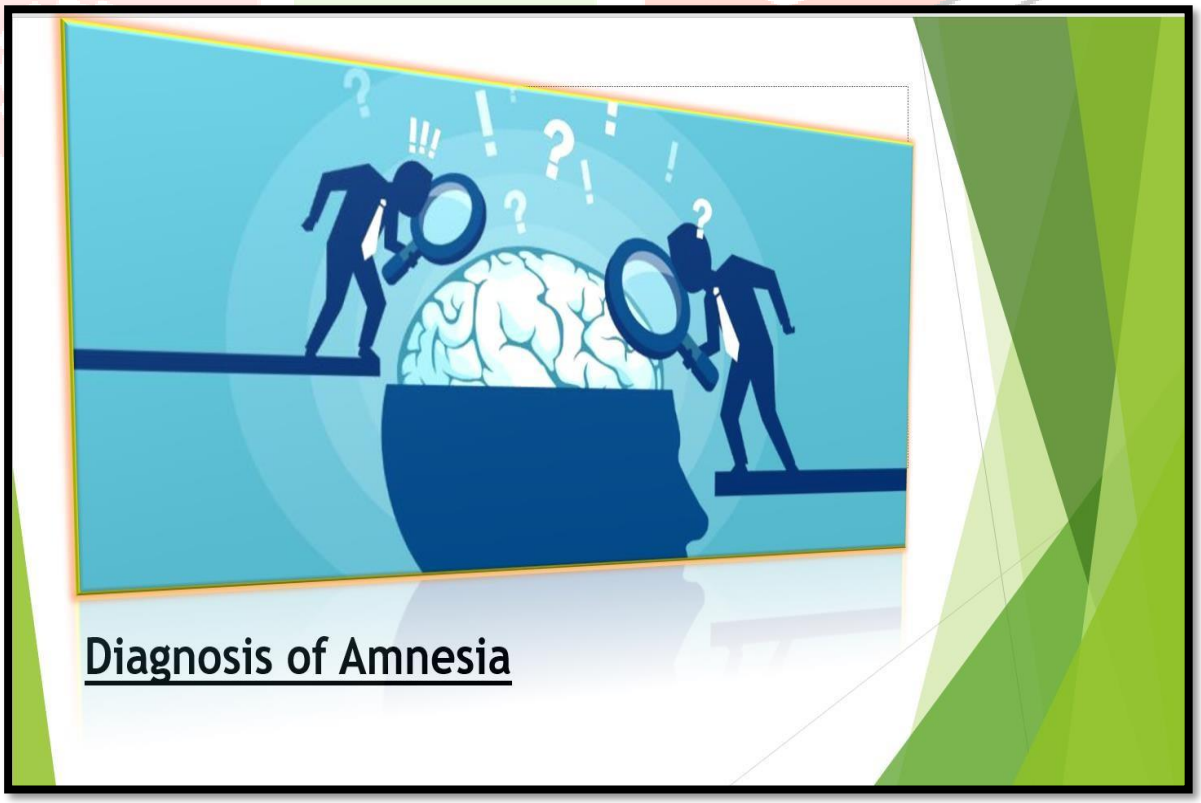
Anterograde amnesia - this means the patient forgets all events that have happened after a particular traumatic event. This is seen in acute or sudden onset amnesia like after a head injury, stroke or seizure.

These patients do not tend to forget their childhood, events and skills prior to the accident. They however have trouble remembering day-to-day events.

Retrograde amnesia refers to an inability to remember information that was acquired before the traumatic event or disease. Typically, there is very poor recall of events that occurred in the near past of the brain damage.

This is called "Confabulation" in which the sufferers make up stories to fill the gaps in their memory. There are other features like loss of feeling in the fingers and toes. This type of amnesia may remain even after five years of abstinence from alcohol.



Diagnosis of Amnesia

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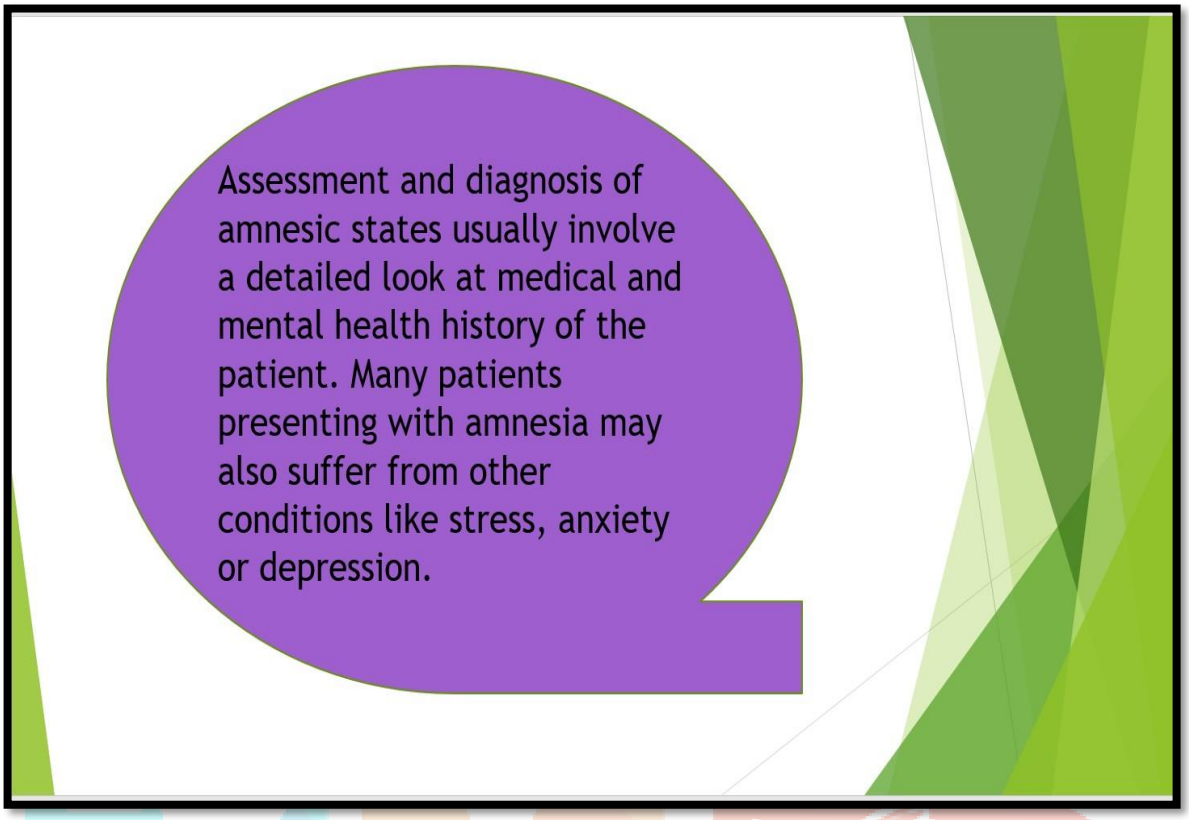

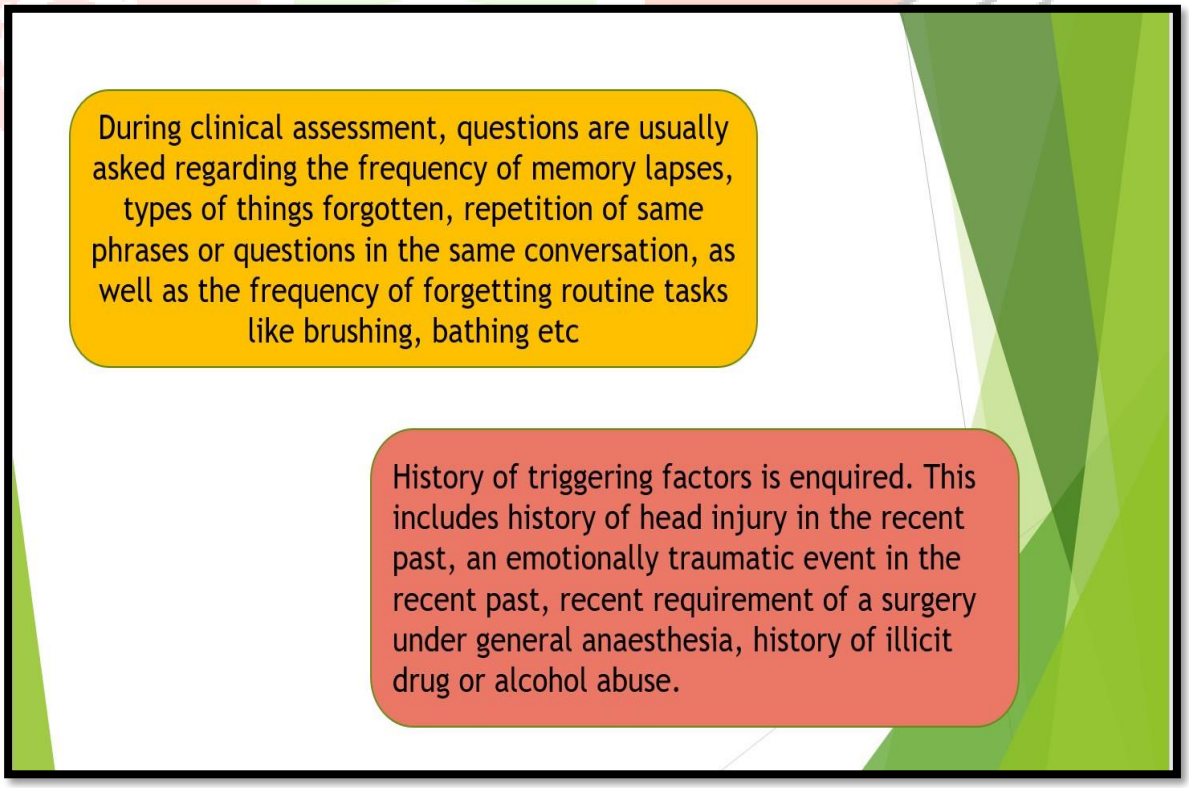

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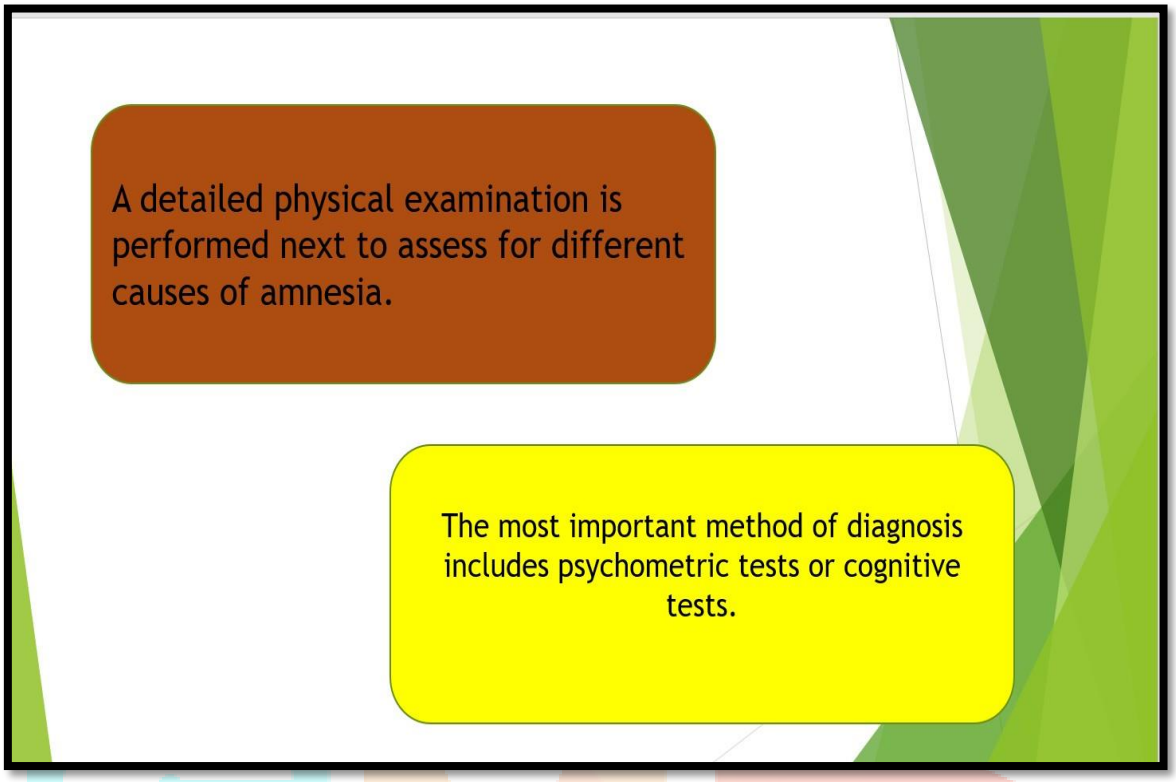

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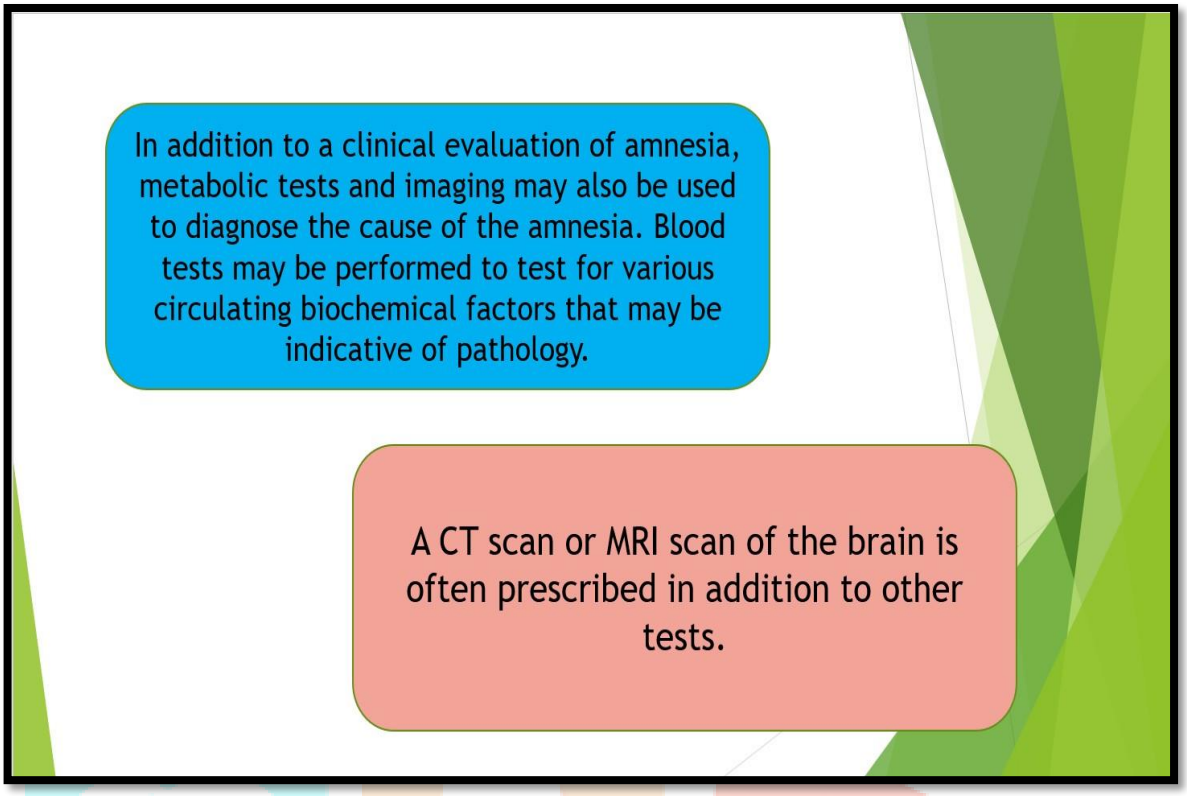

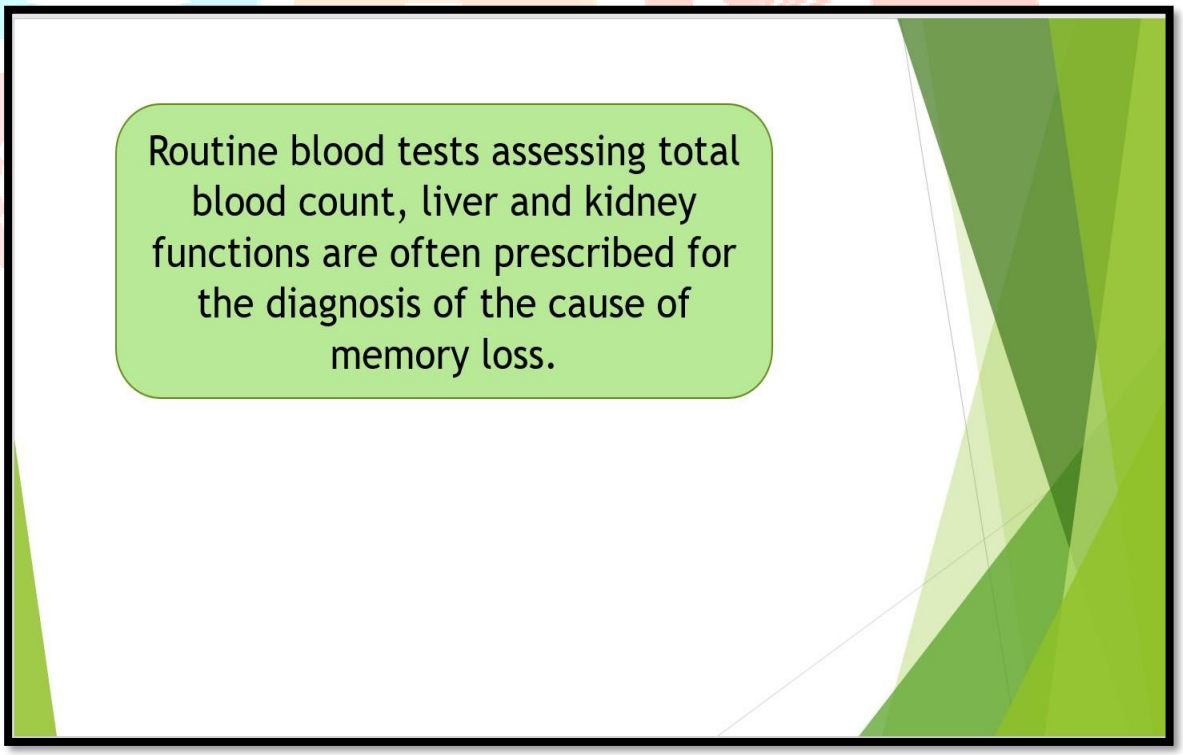

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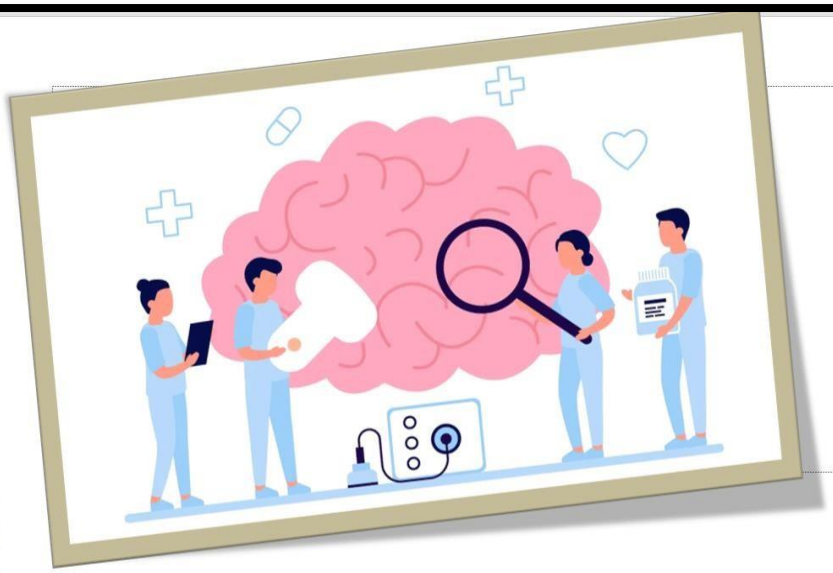

Treatment of amnesia and memory loss-

Cognitive therapy using speech or language therapist can be of help in patients with mild to moderate memory loss.

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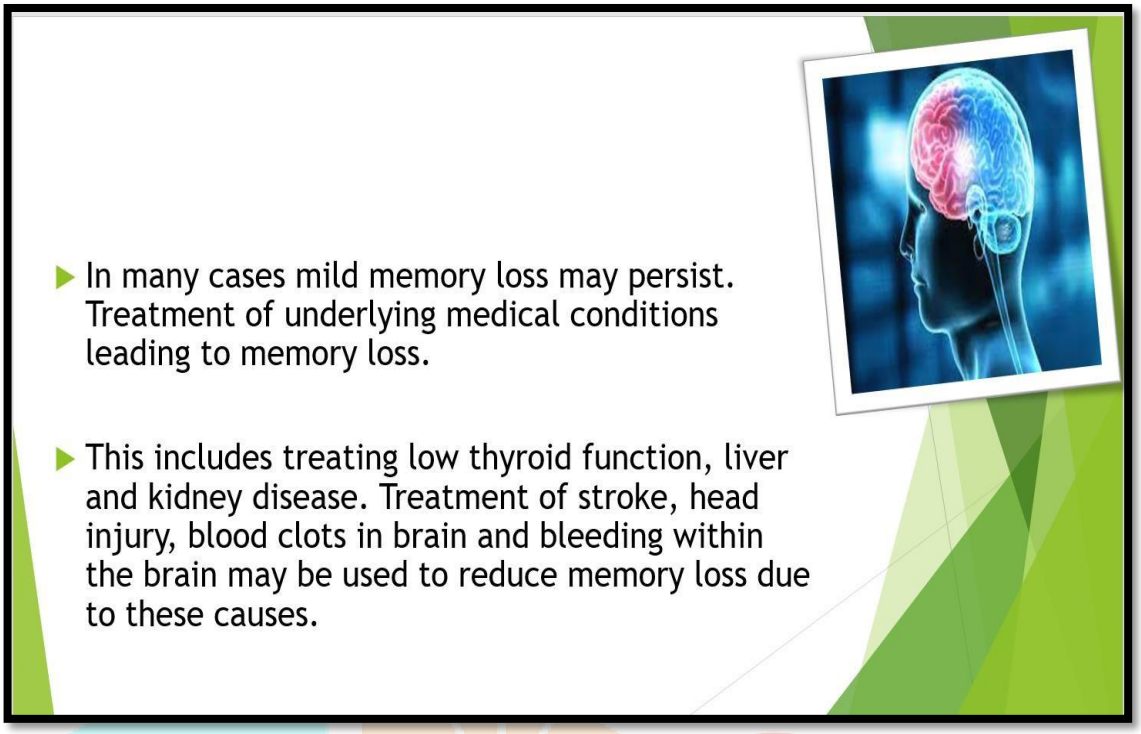

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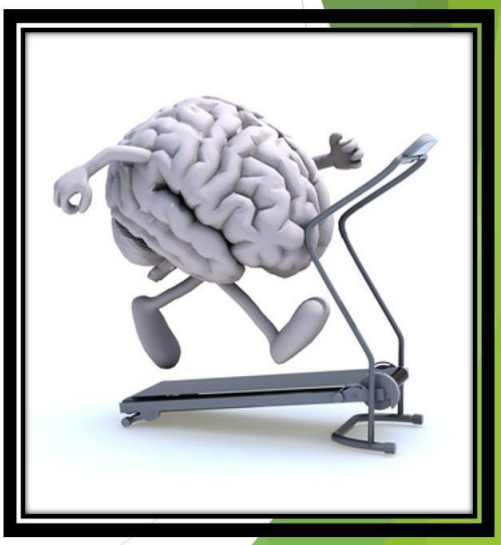
Prevention of Amnesia



Memory loss may be prevented by healthy living and reduction of risk factors for heart disease, diabetes etc. This includes lowering cholesterol and high blood pressure. This also reduces risk of stroke and Alzheimer's disease.

Excessive alcohol consumption, smoking, use of illicit drugs etc. should be avoided.

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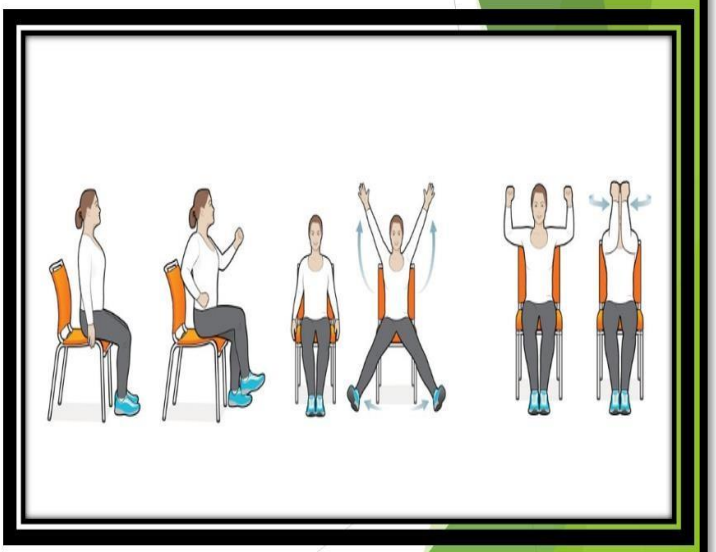
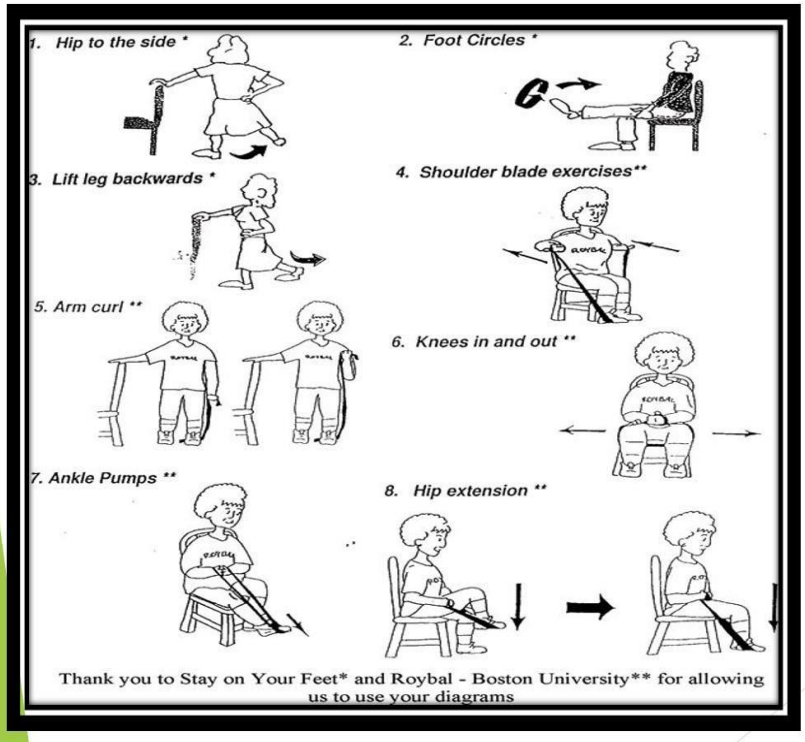
Regular physical activity helps maintain blood flow to the brain and reduces risk factors of memory loss.





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Healthy and balanced diet is important in reducing risk of memory loss. Green leafy vegetables reduce the risk of decline of memory with age.

Vitamin B1 rich food like almond, green leafy vegetable, eggs, milk products include in your diet with proper precaution.

Good social relationships and interactions can help reduce risk of memory loss.

Brain activity should be maintained. This can be regular reading, writing, learning a new skill, or instrument, doing crossword or puzzles etc. stimulates brain cells and lower risk of memory loss.

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QUESTION??????

- List the types of Amnesia?
- How do you diagnosed Amnesia?
- What are the preventive measures of amnesia?

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CONCLUSION:-

- Amnesia refers to partial or complete memory loss. Becoming forgetful is common and normal as a person ages, however, when memory loss begins to interfere with activities of daily living, it needs to be assessed by a physician to be a sign of a deeper illness.

SUMMARY: -

- Experiencing a moment of forgetfulness now and then is perfectly normal and happens to every one of us now and then. However, if this memory loss starts to become a trend, then it might be a cause of concern. At the same time, experiencing progressive memory loss due to health conditions can be a severe cause of concern. If you find that your memory loss is starting to have an effect on your day to day life, or if it also accompanied by other symptoms, then you have to give more attention toward this situation.

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स्मृतीभ्रंश प्रतिबंध आणि व्यवस्थापन

सादर करणारी :-

रिया खानोलकर

विशिष्ट उद्दिष्टे :-

- स्मृती आणि स्मृतिभ्रंशाचा अर्थ समजून घेणे
- स्मृतिभ्रंशाचे प्रकार सूचीबद्ध करणे
- स्मृतिभ्रंशाची कारणे सांगणे
- स्मृतिभ्रंशाची लक्षणे स्पष्ट करणे
- स्मृतिभ्रंशाचे निदान निश्चित करणे
- स्मृतिभ्रंश उपचार लागू करणे
- स्मृतीभ्रंशाची घरगुती काळजी ओळखणे
- स्मृतीभ्रंश रोखण्यासाठी आणि व्यवस्थापित करण्यासाठी उपाय लागू करणे

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प्रस्तावना : -

- मेमरी किंवा स्मृति म्हणजे त्या प्रक्रियांचा संदर्भ आहे ज्याचा वापर माहिती प्र करण्यासाठी, संग्रहित करण्यासाठी, ठेवण्यासाठी आणि नंतर पुनर्प्राप्त करण्यासाठी केला जातो.
- मेमरीमध्ये तीन प्रमुख प्रक्रियांचा समावेश आहे: एन्कोडिंग, स्टोरेज आणि पुनर्प्राप्ती. मानवी स्मरणशक्तीमध्ये आपण शिकलेली किंवा अनुभवलेली माहिती जतन आणि पुनर्प्राप्त करण्याची क्षमता समाविष्ट असते. काहीवेळा गोष्टी प्रथम स्थानावर मेमरीमध्ये योग्यरित्या जतन केल्या जात नाहीत त्यामुळे कधी कधी आपण गोष्टी विसरतो किंवा चुकतो.

व्याख्या : -

- स्मृती कमी होण्याची तात्पुरती किंवा कायमस्वरूपी स्थिती म्हणून स्मृतिभ्रंशाची व्याख्या केली जाते. नुकसानीच्या कारणावर अवलंबून, यामुळे आंशिक किंवा संपूर्ण मेमरी कमी होऊ शकते. मेंदूच्या काही भागांना झालेल्या नुकसानीमुळे किंवा काही पदार्थांच्या सेवनामुळे स्मृतिभ्रंश होऊ शकतो. हे जन्माच्या वेळी काही व्यक्तींमध्ये देखील असू शकते.

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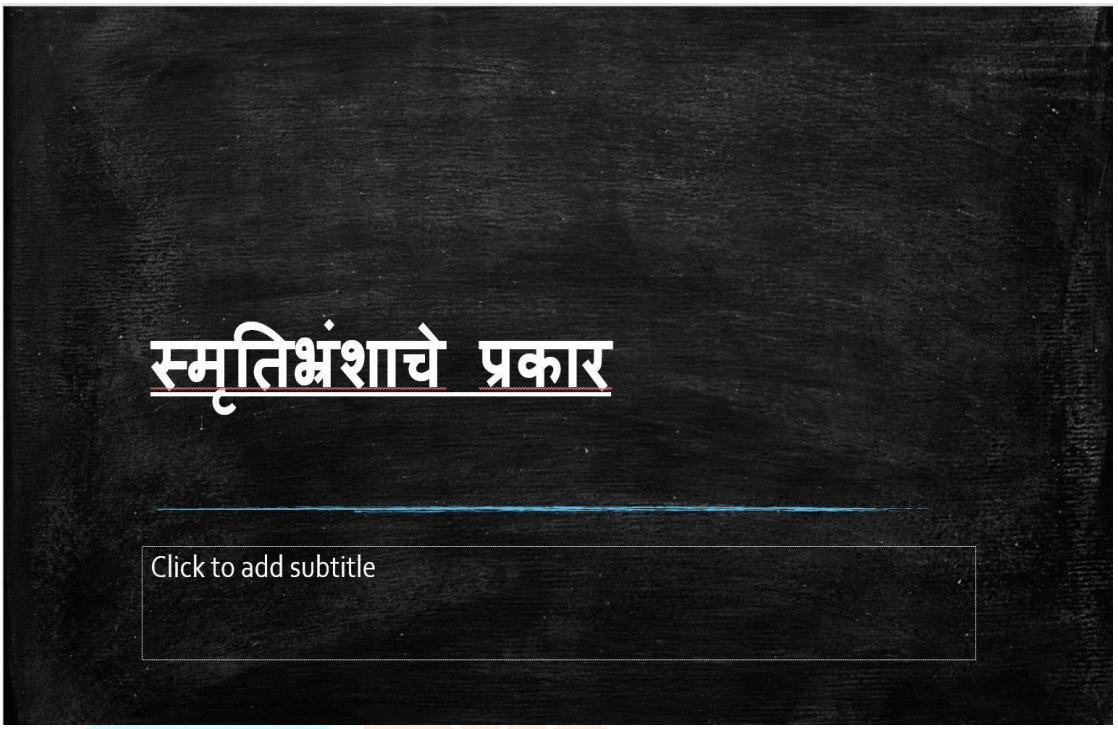

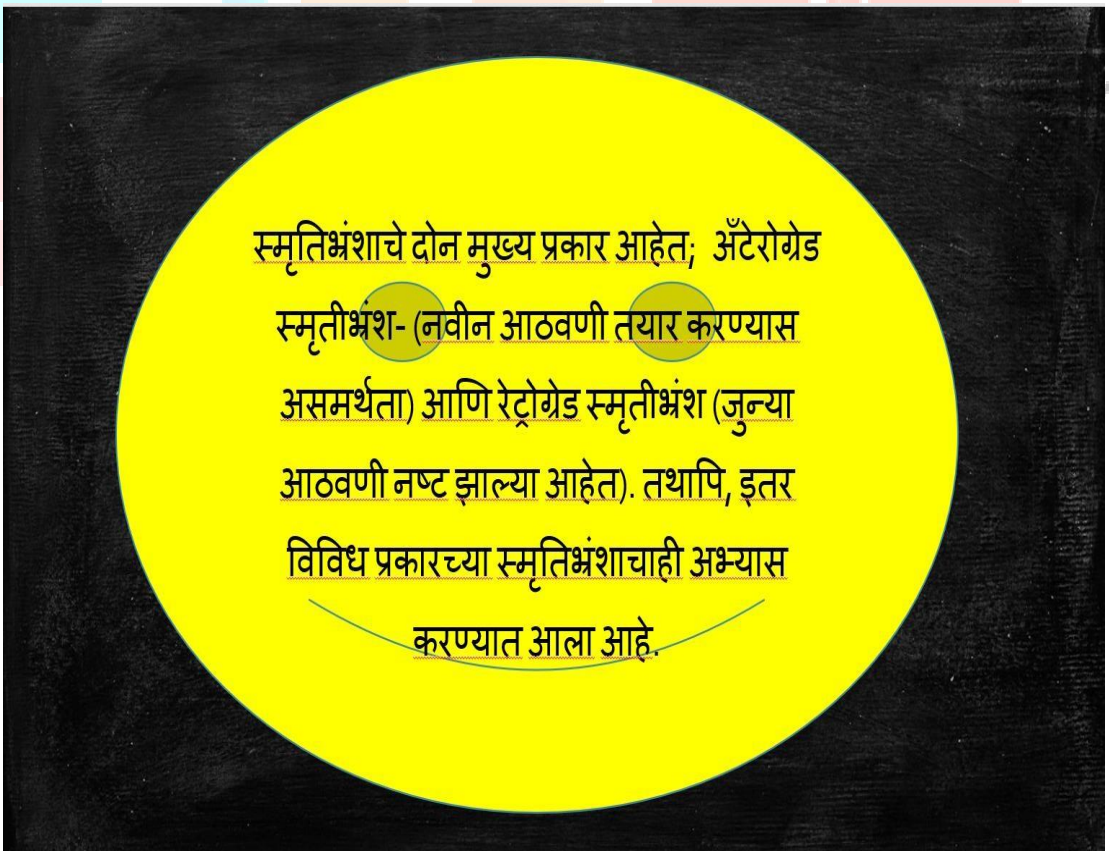

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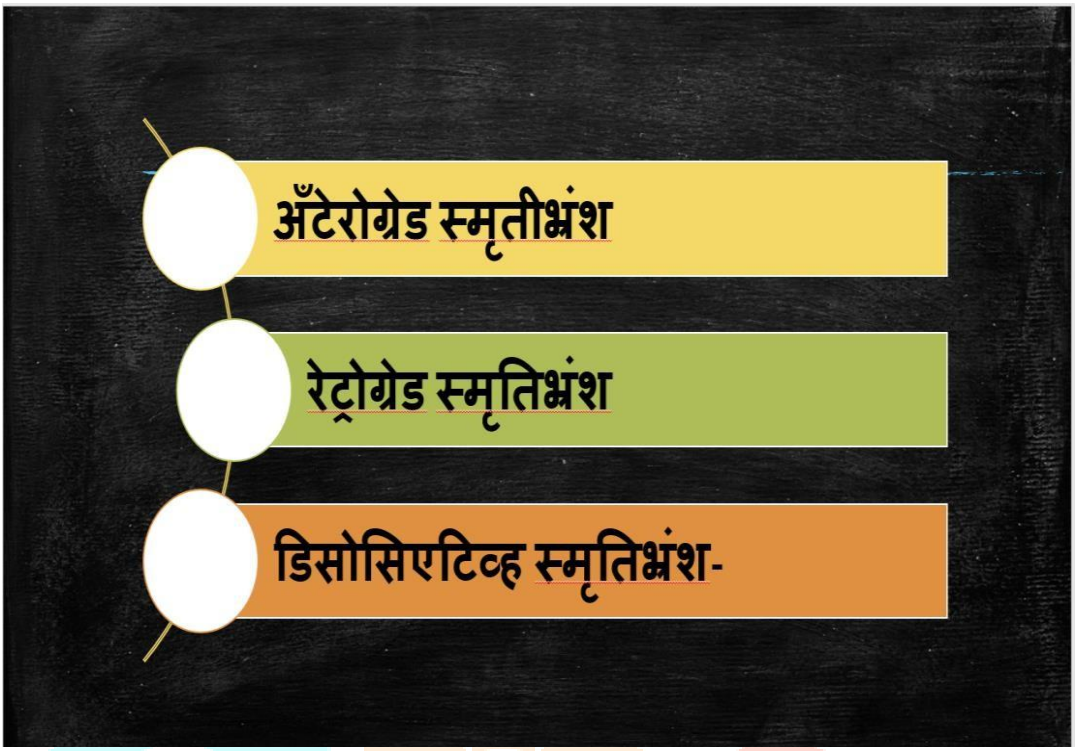

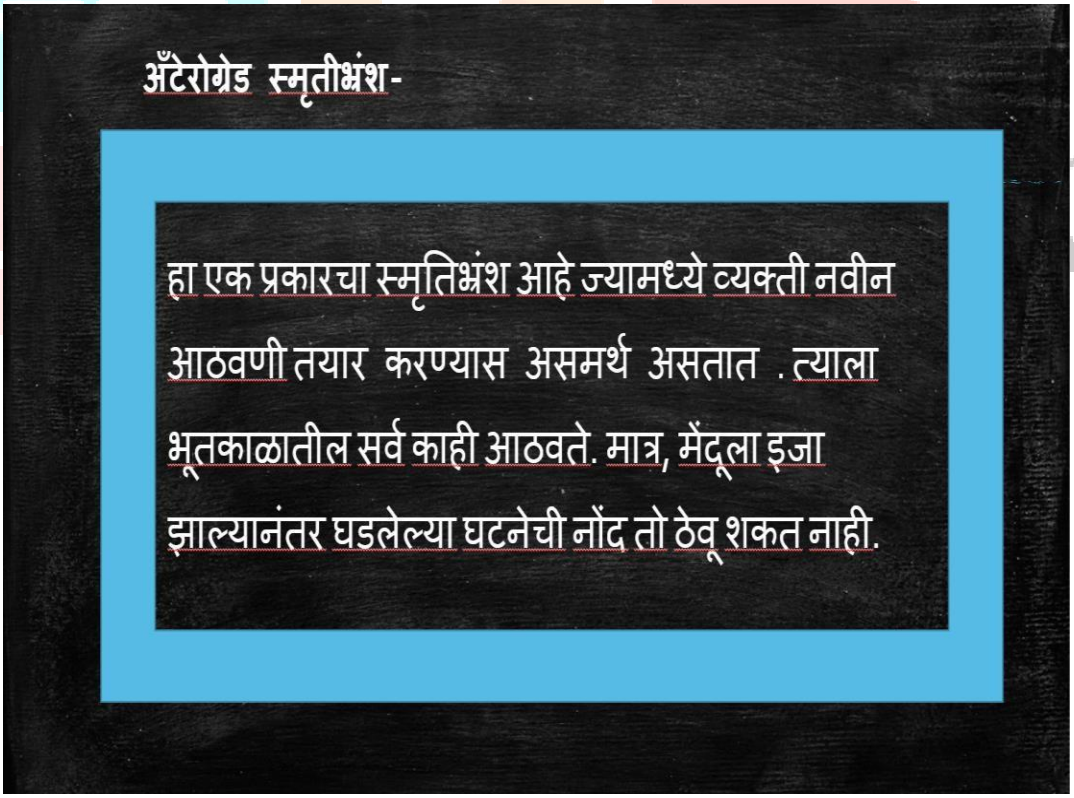

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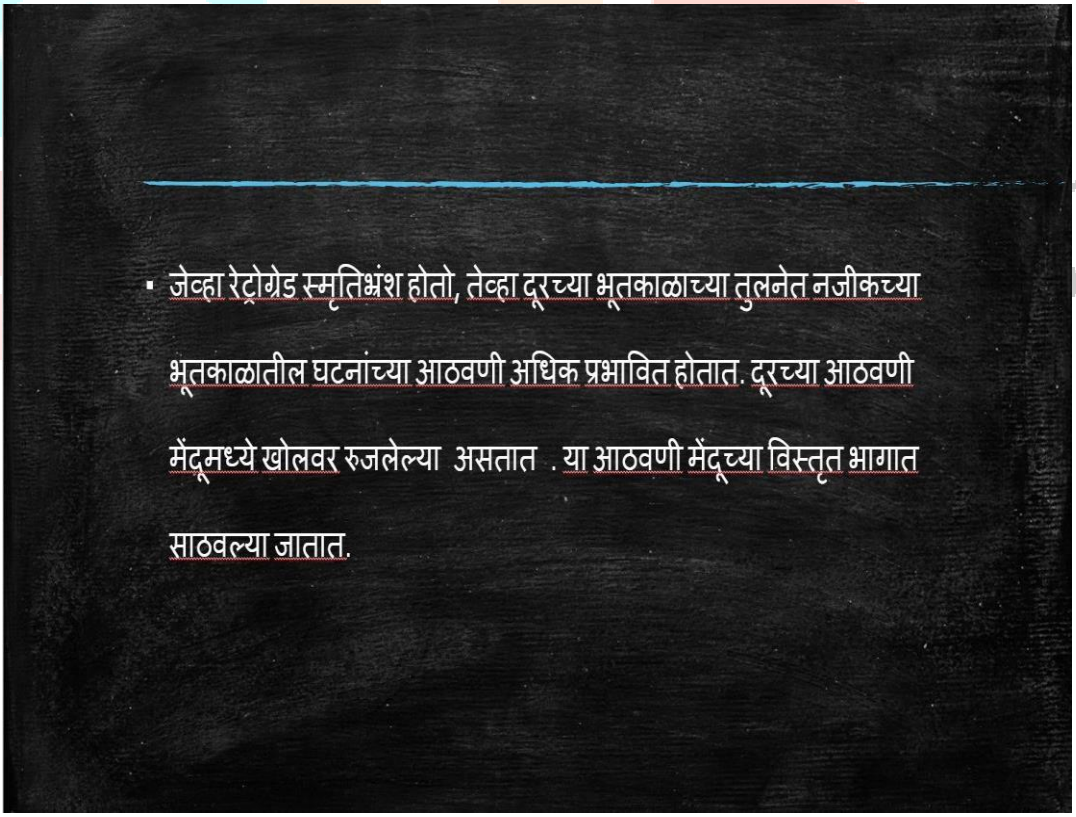
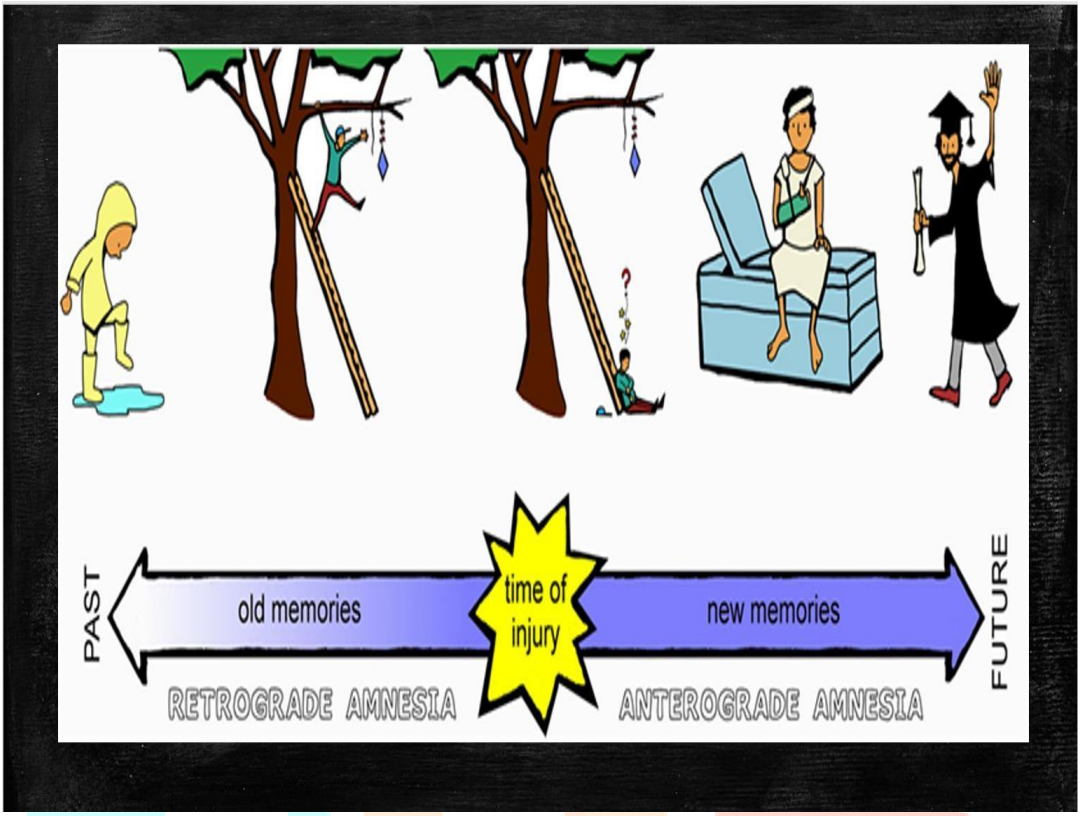
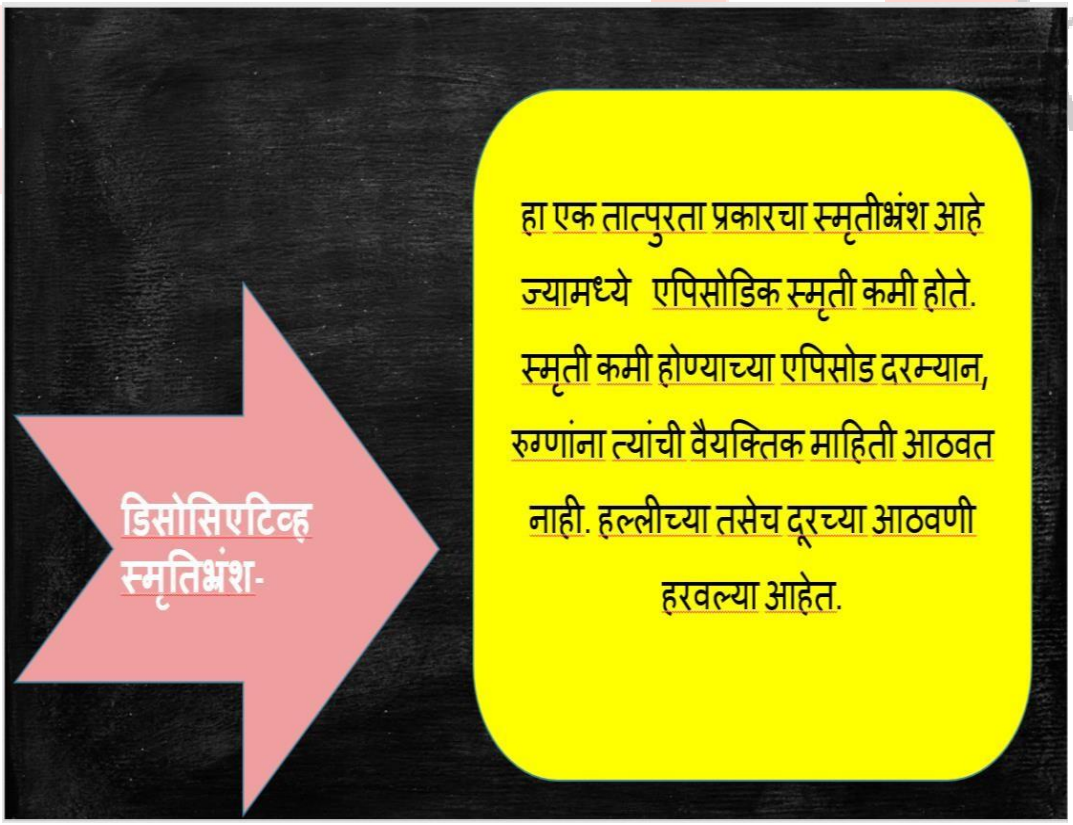
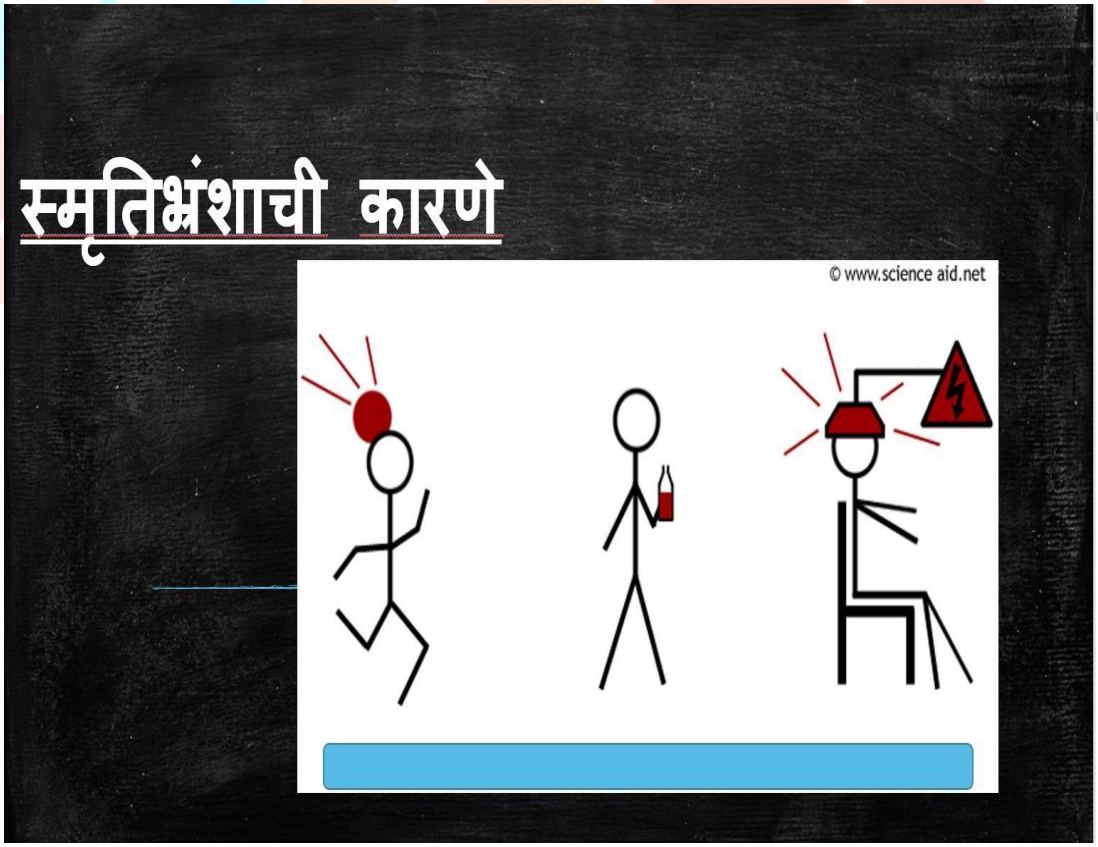



PAST
old memories
time of injury
new memories
FUTURE
RETROGRADE AMNESIA
ANTEROGRADE AMNESIA


डिसोसिएटिव्ह स्मृतिभ्रंश-
हा एक तात्पुरता प्रकारचा स्मृतीभ्रंश आहे ज्यामध्ये एपिसोडिक स्मृती कमी होते. स्मृती कमी होण्याच्या एपिसोड दरम्यान, रुग्णांना त्यांची वैयक्तिक माहिती आठवत नाही. हल्लीच्या तसेच दूरच्या आठवणी हरवल्या आहेत.


डिसोसिएटिव्ह ॲम्नेशिया हा एक एपिसोडिक प्रकारचा मेमरी विकार आहे. या प्रकारचा स्मृतिभ्रंश मेंदूला झालेल्या न्यूरोलॉजिकल हानीमुळे होत नाही. उलट ते काही मानसिक कारणांमुळे होते. त्यामुळे याला सायकोजेनिक ॲम्नेशिया म्हणतात. भावनिक तणावासारख्या मानसिक घटना या एपिसोडिक मेमरी विकारला चालना देऊ शकतात.


स्मृतिभ्रंशाची कारणे
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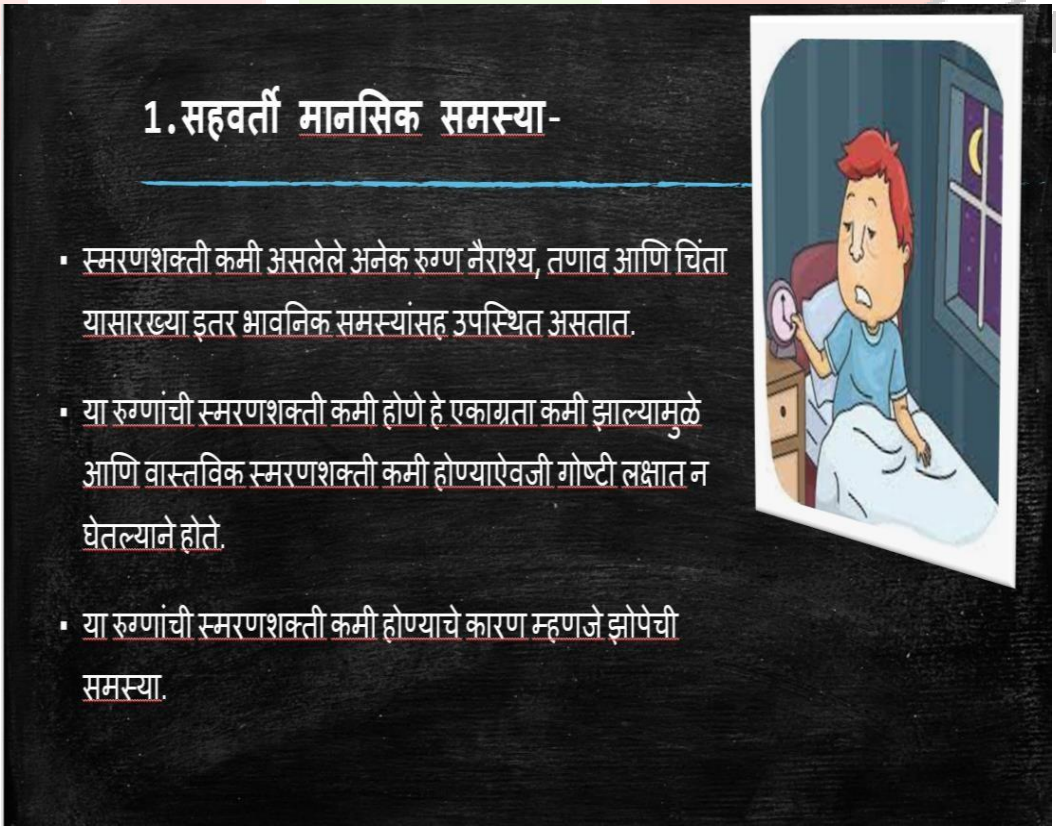
स्मृतिभ्रंश आणि स्मरणशक्ती कमी होण्याची सामान्य कारणे आणि जोखीम घटकांमध्ये सहवर्ती मानसिक समस्या, आघात किंवा डोक्याला दुखापत इत्यादींचा समावेश होतो.


1. सहवर्ती मानसिक समस्या-
• स्मरणशक्ती कमी असलेले अनेक रुग्ण नैराश्य, तणाव आणि चिंता यासारख्या इतर भावनिक समस्यांसह उपस्थित असतात.
• या रुग्णांची स्मरणशक्ती कमी होणे हे एकाग्रता कमी झाल्यामुळे आणि वास्तविक स्मरणशक्ती कमी होण्याऐवजी गोष्टी लक्षात न घेतल्याने होते.
• या रुग्णांची स्मरणशक्ती कमी होण्याचे कारण म्हणजे झोपेची समस्या.

2.आघात, डोक्याला दुखापत, अपस्माराचा झटका किंवा स्ट्रोक

- यामुळे अचानक स्मरणशक्ती कमी होणे किंवा स्मृतिभ्रंश होऊ शकतो.
- स्ट्रोकमध्ये मेंदूच्या काही भागाला होणारा रक्तपुरवठा खंडित होतो. यामुळे मेंदूच्या ऊतींचा मृत्यू होतो.
- जर रुग्ण घटनेपूर्वी घडलेल्या सर्व गोष्टी विसरला तर त्याला रेट्रोग्रेड ॲम्नेशिया म्हणतात आणि जर तो किंवा ती घटनेनंतर घडलेल्या सर्व गोष्टी विसरला तर त्याला ॲंट्रोग्रेड ॲम्नेशिया म्हणतात.
- मेंदूच्या काही भागांमध्ये पुरेशा ऑक्सिजनच्या कमतरतेमुळे या प्रकारचा तीव्र किंवा अचानक स्मृतिभ्रंश होतो.

3. स्मृतिभ्रंशाची इतर कारणे-

- थायरॉईड समस्या - ज्यांच्या थायरॉईड ग्रंथीची क्रिया कमी असते त्यांना स्मरणशक्ती कमी होण्याचा धोका असतो
- काही रोगविरूद्ध वापरण्यात येणारी औषधे कालांतराने स्मरणशक्ती कमी करू शकतात. उदा. पार्किन्सन रोग.
- मद्यपानाच्या अतिरिक्त दीर्घकालीन वापरामुळे
- व्हिटॅमिन बी 1 किंवा थायमिनच्या आहारातील किंवा इतर कमतरतेमुळे स्मृतिभ्रंश होऊ शकतो.
- सायकोजेनिक स्मृतीभ्रंश जेथे रुग्ण भूतकाळातील एखाद्या अप्रिय घटनेबद्दल त्याच्या किंवा तिच्या स्मृतीचा काही भाग ब्लॉक करतो . यामुळे त्यांना महत्त्वाची माहिती लक्षात ठेवता येत नाही.

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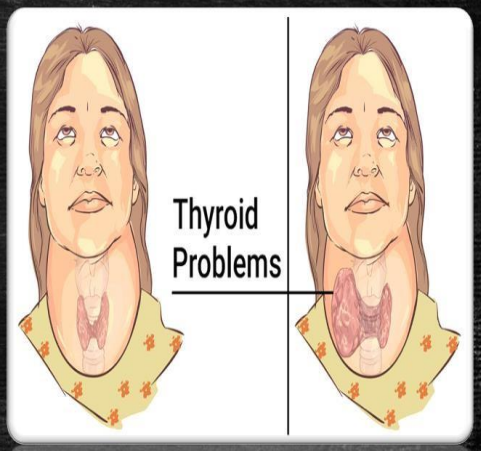
- मेंदूतील ट्यूमरमुळे स्मृतिभ्रंश होऊ शकतो
- मेंदूच्या संसर्गामुळे स्मरणशक्ती कमी होऊ शकते
- विशिष्ट प्रकारच्या मेंदूच्या शस्त्रक्रियेनंतर.
- कॅन्सरनंतर केमोथेरपी, ब्रेन रेडिएशन किंवा बोन मॅरो ट्रान्सप्लांट
- विशेषत: दीर्घकालीन Electroconvulsive थेरपी नंतर.
- संप्रेरकातील बदल हे स्मृती कमी होण्यासाठी जबाबदार असतात
- सामान्य शारीरिक आजारामुळे एकाग्रता आणि स्मरणशक्तीवर परिणाम होऊ शकतो.



स्मृतिभ्रंशाची विशिष्ट लक्षणे

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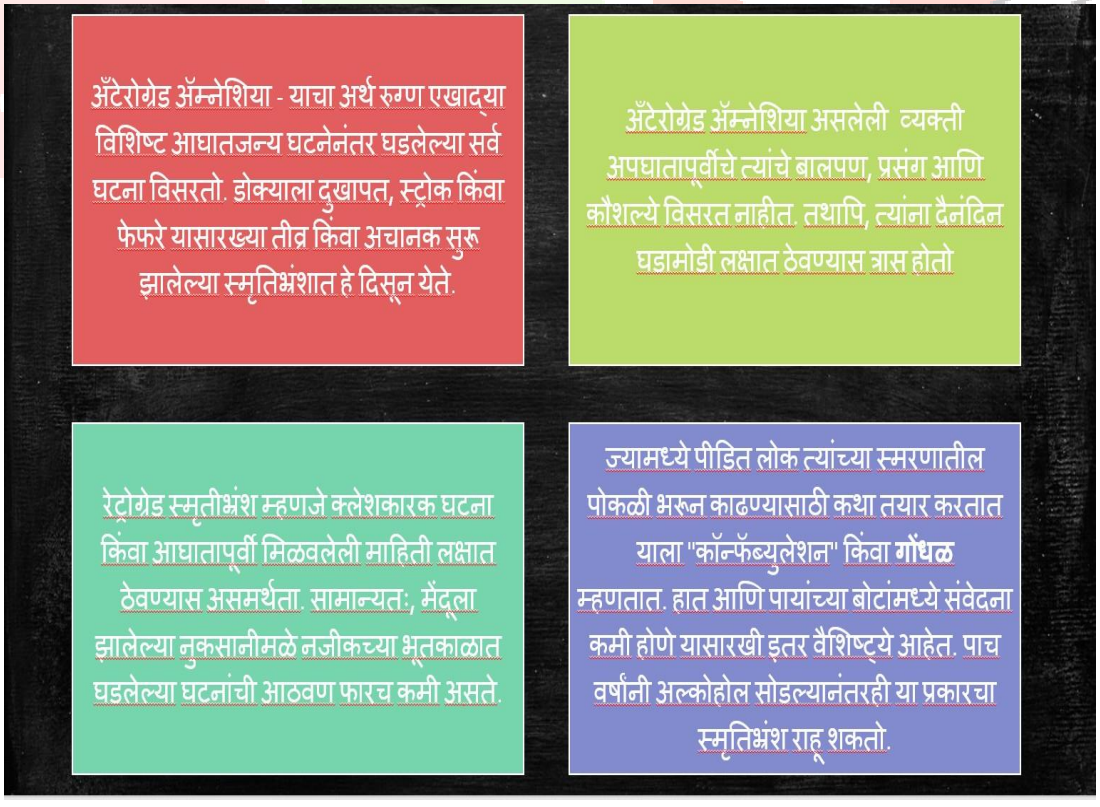

स्मृतिभ्रंश अवस्थेचे मूल्यांकन आणि निदानामध्ये सामान्यतः रुग्णाच्या वैद्यकीय आणि मानसिक आरोग्याच्या इतिहासाचा तपशीलवार विचार केला जातो. स्मृतीभ्रंश असलेल्या अनेक रुग्णांना तणाव, चिंता किंवा नैराश्य यासारख्या इतर परिस्थितींचा त्रास होऊ शकतो.

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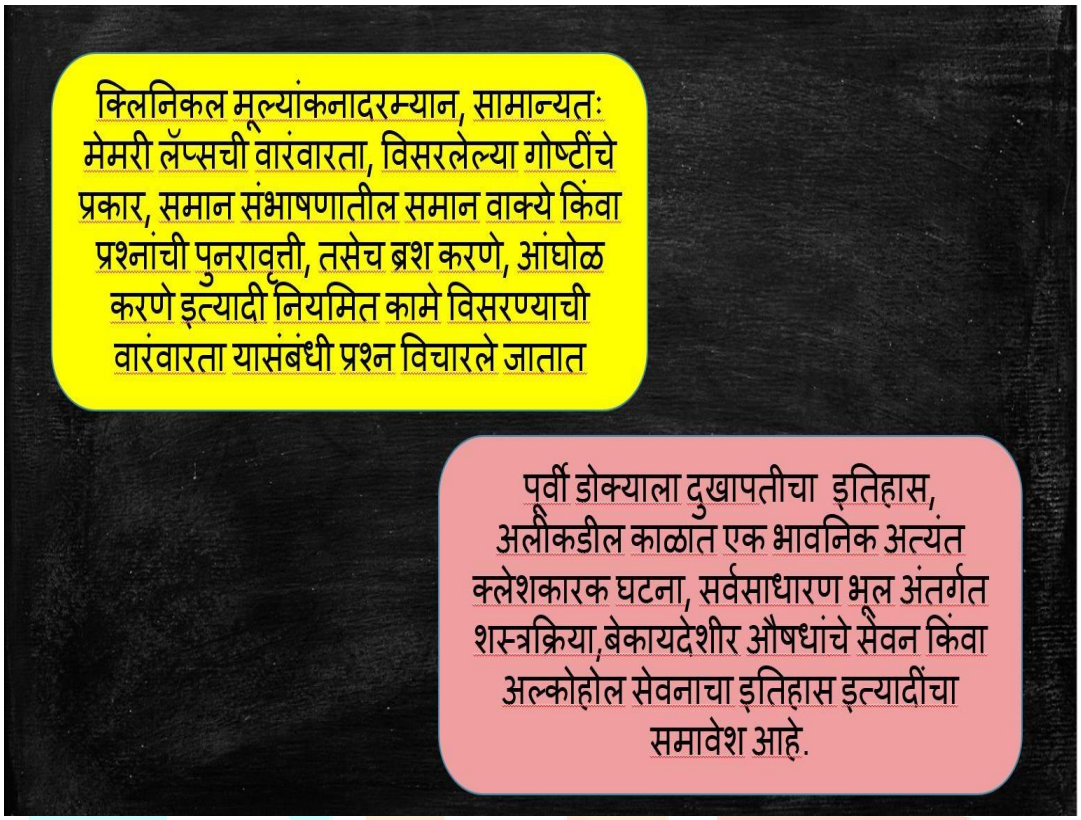

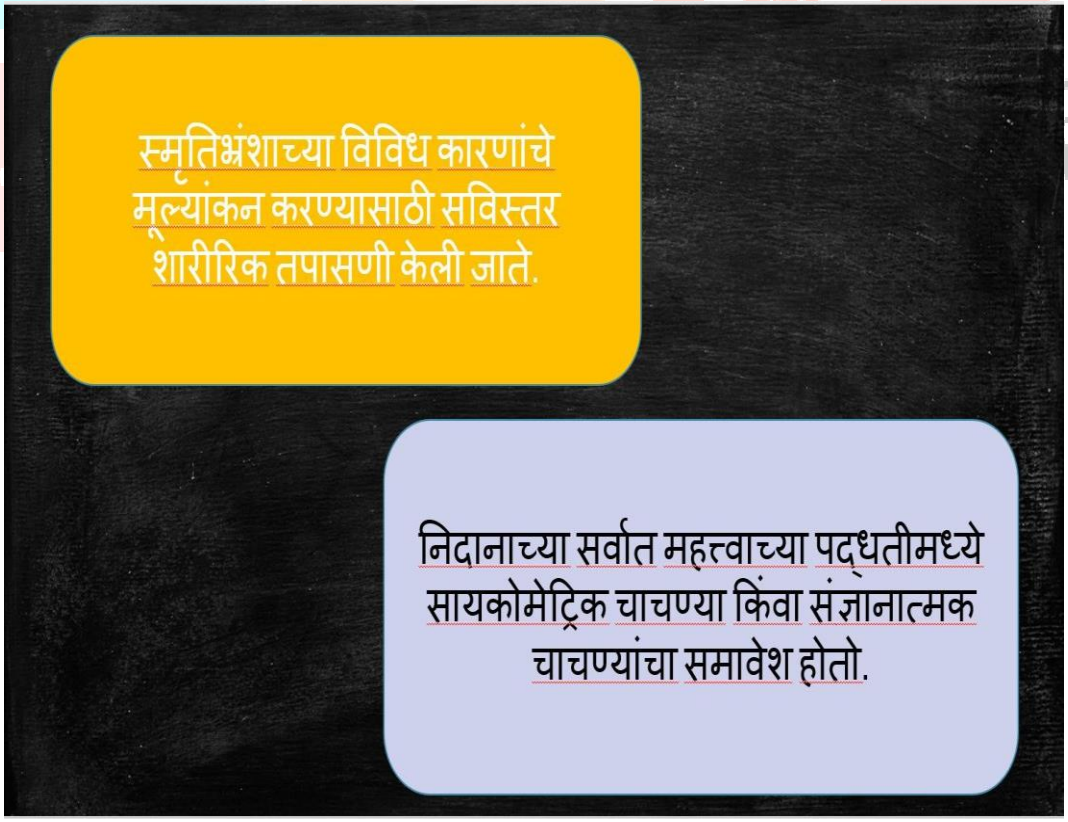

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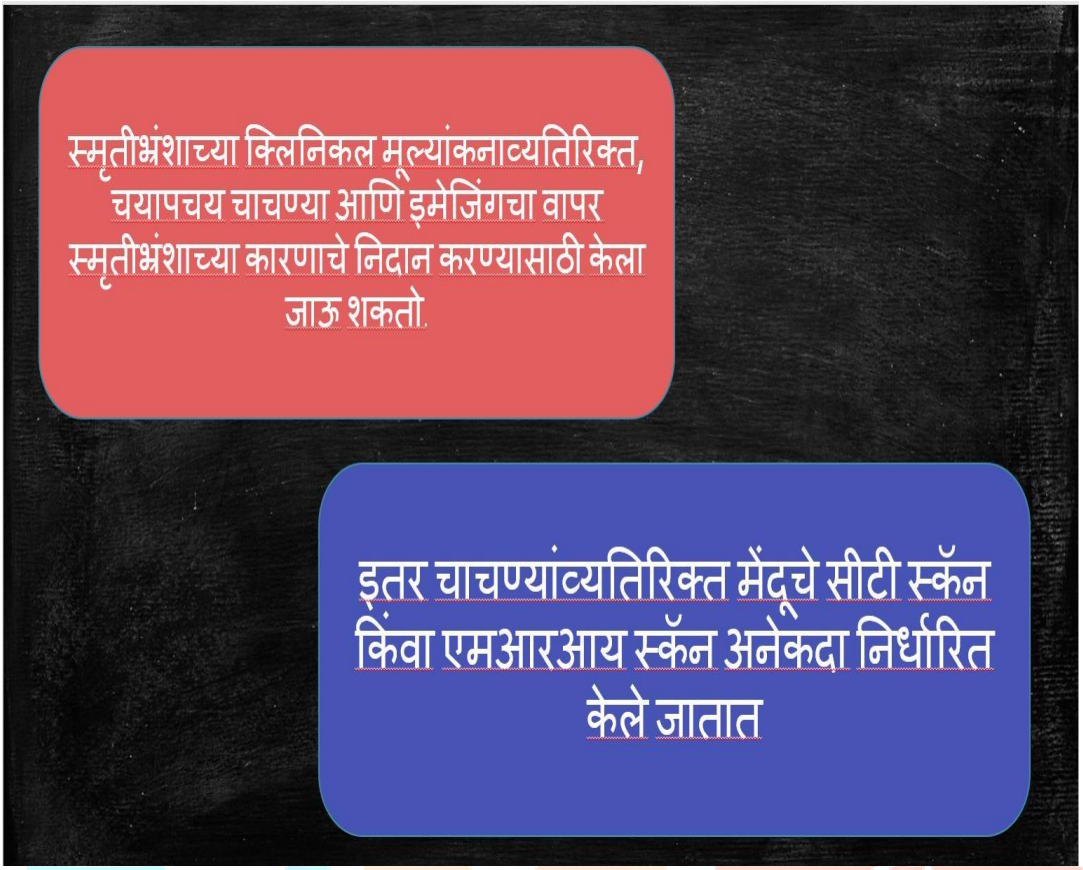

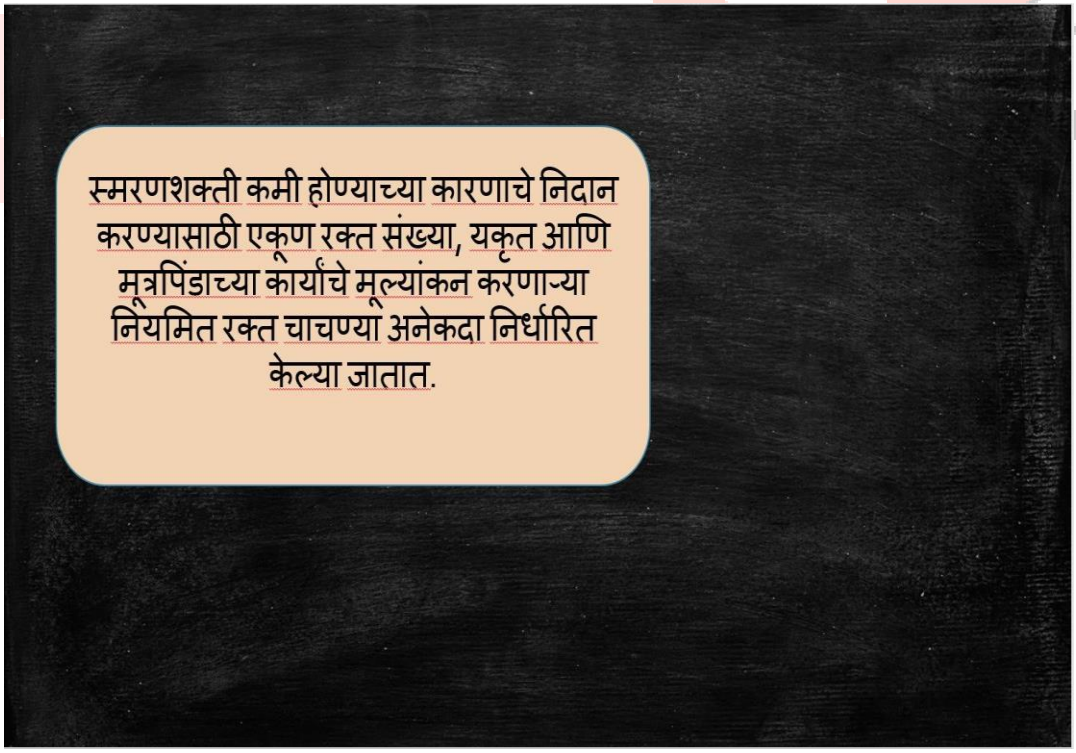

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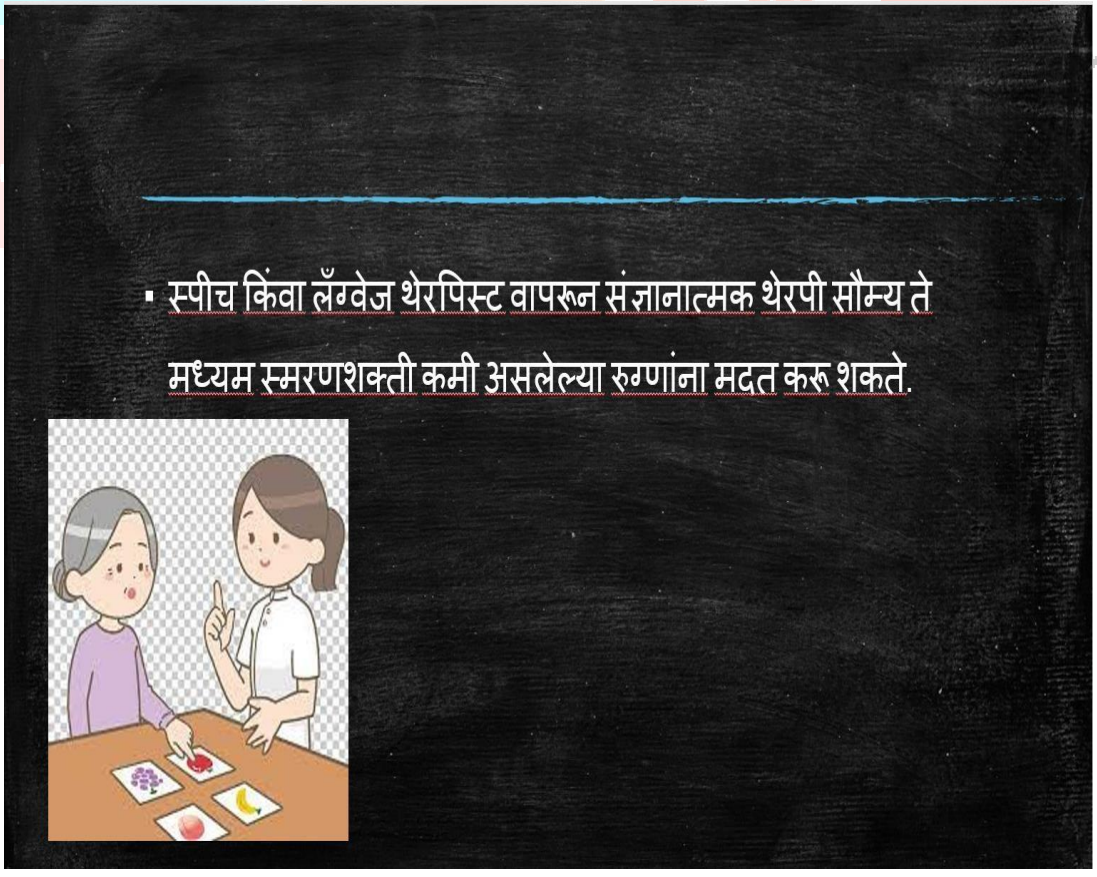

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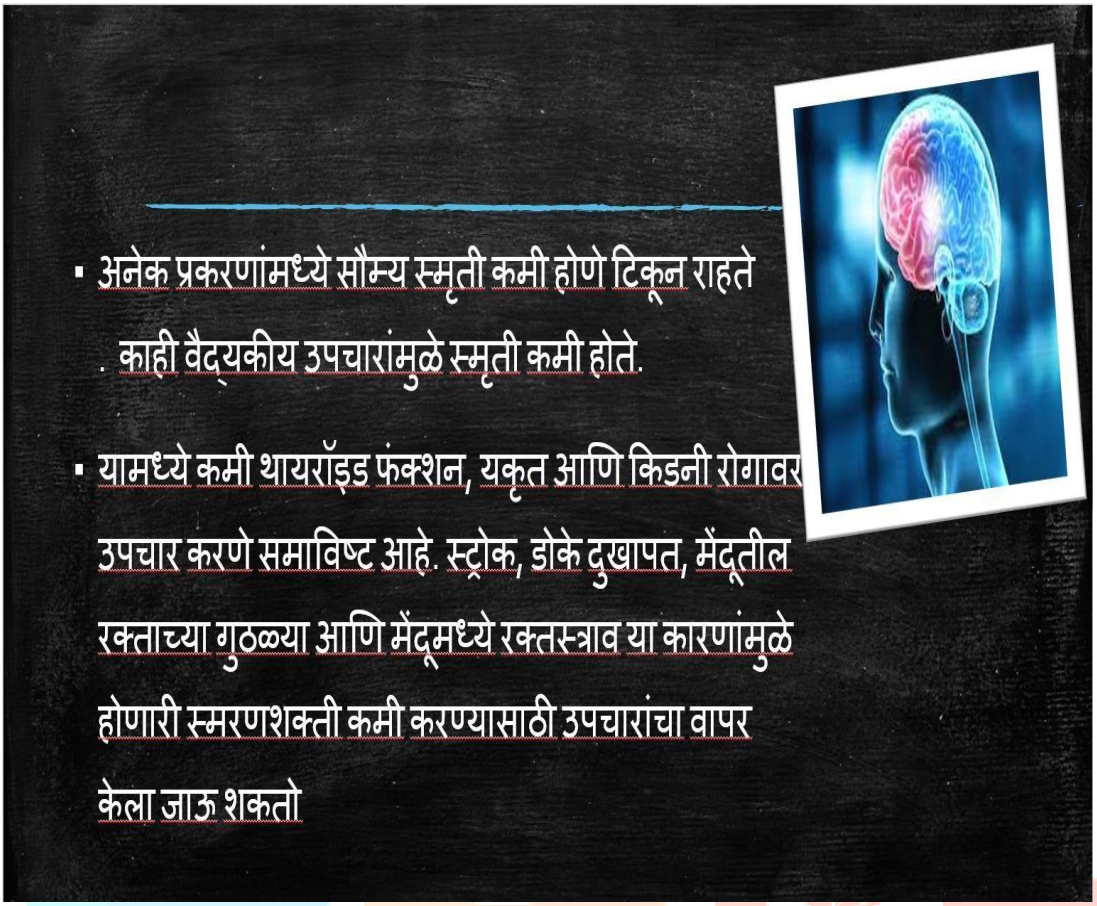

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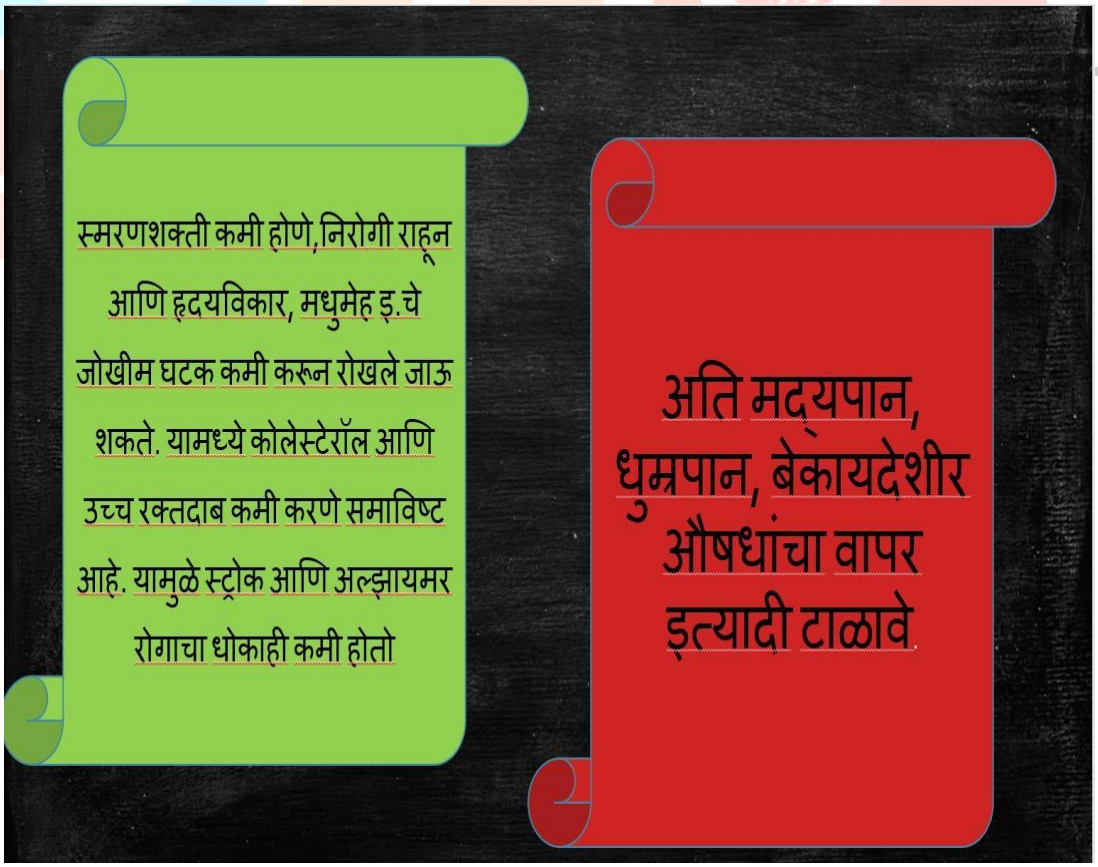

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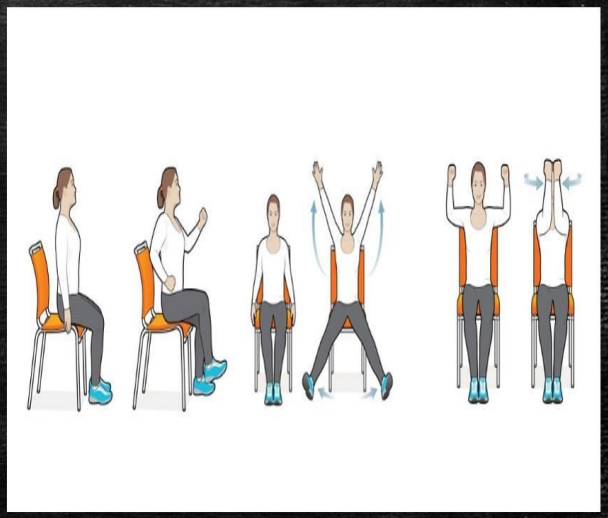
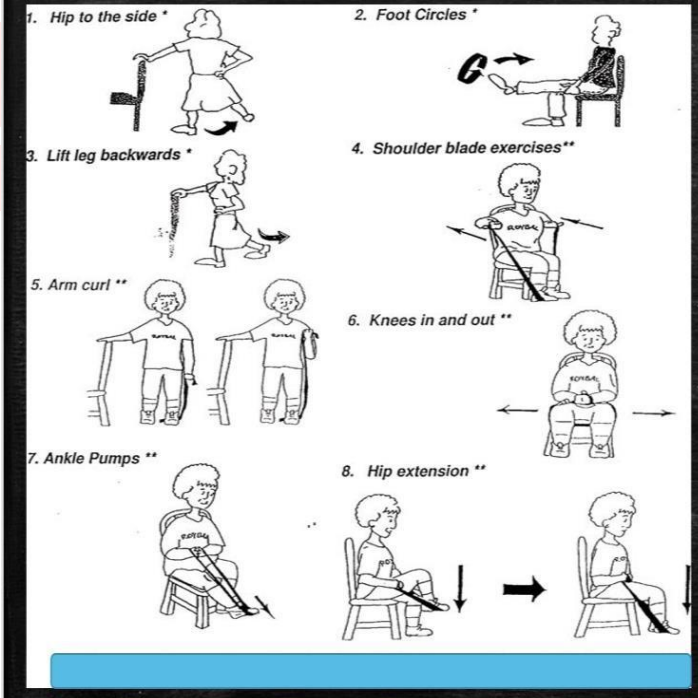
नियमित शारीरिक हालचाली मेंदूला रक्त प्रवाह राखण्यास मदत करतात आणि स्मरणशक्ती कमी होण्याचे जोखमीचे घटक कमी करतात.





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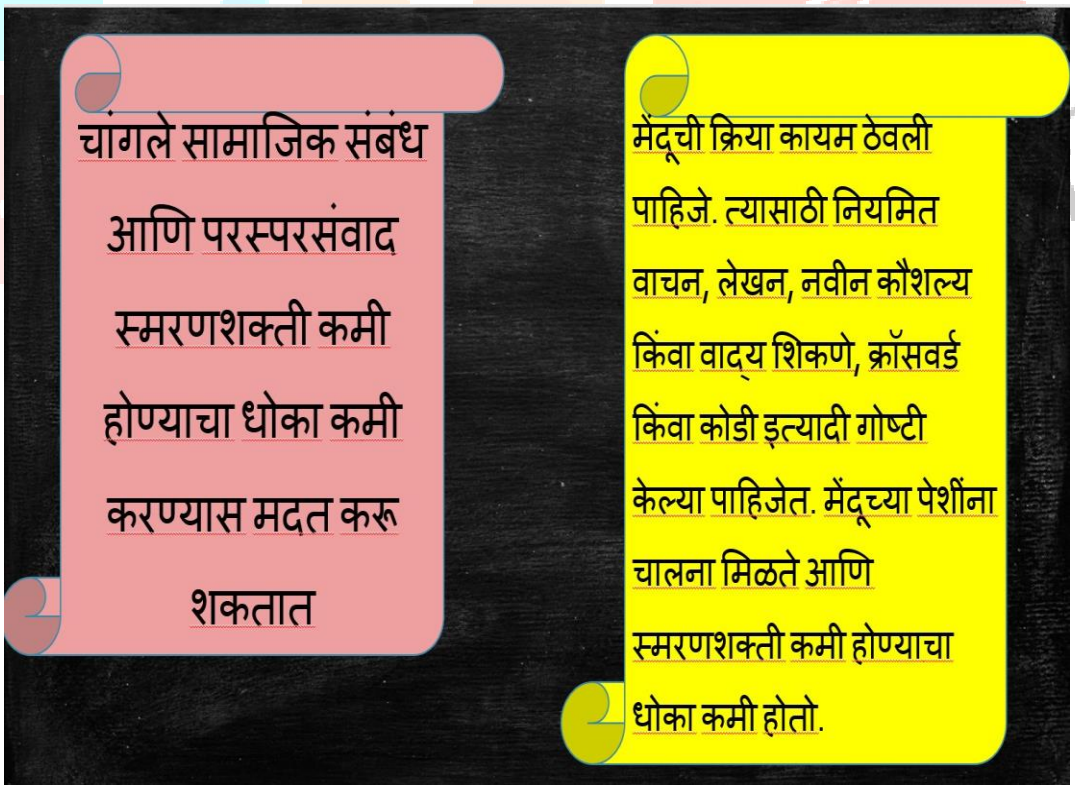

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संक्षेप

- स्मृतिभ्रंशाच्या प्रकारांची यादी करा.
- तुम्ही स्मृतीभ्रंशाचे निदान कसे कराल?
- स्मृतिभ्रंशासाठी प्रतिबंधात्मक उपाय काय आहेत?

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निष्कर्ष : -

- स्मृतिभ्रंश म्हणजे आंशिक किंवा पूर्ण स्मरणशक्ती कमी होणे. एखाद्या व्यक्तीच्या वयानुसार विस्मरण होणे सामान्य आहे, तथापि, जेव्हा स्मरणशक्ती कमी होणे दैनंदिन जीवनातील क्रियाकलापांमध्ये व्यत्यय आणू लागते, तेव्हा ते एखाद्या सखोल आजाराचे लक्षण असल्याचे डॉक्टरांनी मूल्यांकन करणे आवश्यक आहे.

सारांश : -

- आता आणि नंतर विस्मरणाचा क्षण अनुभवणे अगदी सामान्य आहे आणि आपल्यापैकी प्रत्येकाला आता आणि नंतर घडते. तथापि, जर ही स्मरणशक्ती कमी होणे हा ट्रेंड बनू लागला तर ते चिंतेचे कारण असू शकते. त्याच वेळी, आरोग्याच्या स्थितीमुळे प्रगतीशील स्मरणशक्ती कमी होणे हे चिंतेचे गंभीर कारण असू शकते. तुमची स्मरणशक्ती कमी झाल्याचा तुमच्या दैनंदिन जीवनावर परिणाम होऊ लागला आहे, किंवा इतर लक्षणांसोबत सुद्धा तुमच्या लक्षात आल्यास, तुम्हाला या परिस्थितीकडे अधिक लक्ष द्यावे लागेल.


Thank You!
Peca ©

स्मृतभ्रंश साठी घ्याियाची घरगुती काळजी

- फॉल्स प्रमतबंध - स्मृती किी होणे पासून अनेकदा वृद् ग्रस्त असतात. चांगली प्रकाियोजना आमण गोधळ टाळणे याची इथे िदत होत.े
- दारे उघडी ठे वली पामहजेत आमण अनेक घरांिध्ये धोकादायक वस्तू लॉक करून ठे वण्याची सोय असते अिावेळी वृद् व्यक्ती स्वत ला खोलीत लॉक करू िकणार नाही याची काळजी घ्यायला पामहजे. रुग्ण हरवण्यापासून रोखण्यासाठी खोल्या लेबल के ल्या पामहजेत.
- रुग्णाने त्याचे नाव आमण पत्ता मकं वा संपक क्रिांकासह ओळखपत्र बाळगणे आवश्यक आहे.
- स्वयंपाकघरातील साियान्य मचंता म्हणजे स्टोव्ह चालू सोडणे. ठरामवक वेळे नंतर गॅस मकं वा वीज कापण्यासाठी स्टोव्ह कट ऑफ वापरला जाऊ िकतो.
- रुग्णांना औषधे घेण्याची आठवण करून देण्यासाठी औषधी संयोजक आमण गोळ्याअलाि आहेत. आयोजकांिधे औषधांच्या म नममत डोससाठी कप्पे आहेत. इलेरकल मपल अलाि दे खील आहेत ज्यात लोकांना त्यांच्या गोळ्या घेण्याची आठवण करून देण्यासाठी उपयोग होतो.
- सव-िहत्वाचे क्रिांक, जसे की टुंब आमण आपत्कालीन संपक, टे मलफोन जवळ असावेत. व्यक्तीला वेळे वर लक्ष केंमित ठे वण्यासाठी िोठ्या संख्येसह घड्याळे आमण िोठ्या मण्टसह कॅ लेंडर असावे त्याियुळे मचंता आमण मनराियाची किी होण्यास िदत होऊ िकते.
- घरात मदिाि बाण दररोजच्या उपक्रिांसाठी अिलात आणणे.
- समवत्र तक्ते जे मदिाि देण्यास िदत करतात आमण पुढील प्रमक्रया करण्याची आठवण करून देतात त्यांचा वापर करावा.
- घराच्या सेमटंगिध्ये बदल करू नये.
- काही मक्रयाकलाप करण्यासाठी िोबाइल अलाि वापरा.
- नवीन कौिल्य मिका.
- रोजची मदनचया पाळा.
- कायाची योजना करा, काियाच्या सूची बनवा आमण कॅ लेंडर आमण नोट्स यासारखी िेिरी साधने वापरा.
- िन आमण िरीर दोघांनाही िदत करू िकतील अिा मक्रयाकलापांिध्ये गुंतून रहा.
- तुिच्या साियदायाियिध्ये, िाळे त मकं वा तुिच्या प्राथनास्थळी स्वयंसेवक म्हणून साध्या काि िध्ये िदत करा.
- मित्र आमण कुटुंमबयांसोबत वेळ घालवा.
- पुरेिी झोप घ्या, साधारणपणे प्रत्येक रात्री सात ते आठ तास.

- व्यायाि करा आमण चांगले खा, {संपूण धान्य (तपमकरी तांदूळ, बाली, बाजरी),ि ांस ,अंडी आमण दुग्धजन्य पदाथ, ि ेंगा,सूयफ ु लाच्या मबया, बदाि, महरव्या पालेभाज्या फळे (मलंबूवगीय फळे, के ळी)} **इतर आजारांना लक्षात घेऊन.**