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NURSING CARE FOR NY 'S WITH IMPAIRED SENSE OF SECURITY AND COMFORT ACUTE PAIN ASSOCIATED WITH PHYSICAL INJURY AGENTS POST-SECTION CAESAREA

Rizki Dian Cahyawati[1], Dewi Erna Marisa[2], Sumarni[3], Dikha Sazilli[4], Mahendra[5]
Institut Teknologi dan Kesehatan Mahardika, Jawa Barat, Indonesia

E-mail: diancahyawati58@gmail.com[1], dewi.erna@mahardika.ac.id[2], sumarni.vini22@gmail.com[3], dikhasazilli@gmail.com[4], mahendrahellbell99@gmail.com[5]

KEYWORDS

Nursing Care, Acute Pain, Sectio Caesarea.

ABSTRACT

The World Health Organization has determined that the average rate of sectio cesarean delivery in a country is around 5-15% per 1,000 births. Sectio cesarean delivery is the process of giving birth surgically by making incisions in the mother's abdomen (laparotomy) and uterus (hysterotomy) to remove the baby. One of the effects of SC is post-SC pain, which is caused by an incision or tear in the tissue of the front abdominal wall. Pain is an unpleasant sensory and emotional experience that results from actual and potential tissue damage, regardless of the nature, pattern, or cause of the pain. This study aims to describe the disturbance of a sense of security and comfort due to pain in post-Sectio Caesarea patients at Sumber Kasih Cirebon Hospital. This study uses a case study method by applying nursing care to the patient Mrs. for assessment, diagnosis, intervention, implementation, and evaluation. The results showed that the patient's comfort and pain disorders could be overcome, with the patient no longer complaining of pain and the pain scale reduced from 5 to 1. Thus, the patient's problem can be said to be resolved. The implications of this study indicate that appropriate nursing interventions can significantly reduce post-sectio cesarean pain, thereby improving the quality of life of postoperative patients.

INTRODUCTION

Labor is a series of events that ends with the expulsion of a full-term or near-term baby, followed by the expulsion of the placenta and fetal membranes from the mother's body through the birth canal or other ways, taking place with or without assistance (the mother's strength) (Mintaningtyas et al., 2023). One of the ways of delivery by sectio caesarea is the process of delivery by surgery by cutting the mother's abdomen (laparotomy) and uterus (hysterectomy) to remove the baby (Ratnasari, 2020). Sectio caesarea surgery is generally performed when normal vaginal delivery is not possible due to the risk of other medical complications (Amita et al., 2018).

Based on the patient's condition, sectio caesarea (SC) can be divided into two: planned sectio caesarea (elective) and emergency sectio caesarea (emergency) (Sari, 2018). Planned sectio caesarea (elective) is an operation that has been planned long beforehand, while emergency sectio caesarea (emergency) is an operation based on the mother's condition at that time (Sari, 2018).

Sectio Caesarea is performed on two indications, namely maternal and fetal factors (Sudirman, 2018). Maternal factors include narrow pelvis and mechanical dystocia, previous uterine surgery, history of SC, bleeding, and toxemia gravidarum (Farlikhatun & Supardi, 2024). Fetal factors include fetal distress, previous fetal defects or death, placental insufficiency, malpresentation, large fetus, rhesus incompatibility, postmortem cesarean, and herpes virus infection (Amelia et al., 2018).

To overcome the impact, nurses must provide comprehensive nursing care to postpartum women with post-section Caesarea, including assessment, diagnosis, planning, implementation, and evaluation (Rimadeni et al., 2022). Nurses also play a big role in non-pharmacological pain management (Aprina & Puri, 2016), namely training deep breath relaxation techniques that will reduce the intensity of post-SC mothers' pain, help muscle relaxation, and improve breathing. This is a form of nursing care (Prasastia LD et al., 2023).

Family support is also very important for patient motivation in dealing with pain; in fact, many families do not understand how to care for sick relatives (Amalia & Yudha, 2020). Therefore, the family's role is very necessary to support patients so that they are free from diseases and complications that may arise after surgery (Nadziroh et al., 2023).

To the stated background, the objectives of this study include the following: a. The results of the documentation study regarding the assessment of acute pain in patients with Post-Sectio Caesarea;b. The results of the documentation study regarding the Nursing Diagnosis of acute pain in patients with Post-Sectio Caesarea; and c. The results of the documentation study regarding acute pain planning in patients with Post-Sectio Caesarea.

RESEARCH METHOD

This research employs a qualitative case study approach, focusing on exploring the nursing care provided to Postoperative Section Caesarea patients at Sumber Kasih Cirebon Hospital. The subject of this case study is a patient identified as Mrs. S, who underwent a Caesarean section (SC) at Sumber Kasih Cirebon Hospital due to Early Rupture of Fertilization at 37-38 weeks gestation. The patient had a history of ambient disease, and the study was conducted starting from her transfer to the postpartum room on October 31, 2023. The inclusion criteria for this case study were: patients who have undergone a Caesarean section at Sumber Kasih Cirebon Hospital, patients who are willing to participate in the study, and patients experiencing post-operative pain and related discomfort. The exclusion criteria were: patients with complications that might interfere with the study outcomes and patients who did not consent to participate. Data collection was performed through direct observation, patient interviews, and review of medical records. Specific data collected included the patient's vital signs, pain levels, and responses to nursing interventions. The assessment covered the patient's physical condition, pain intensity, and mobility before and after the interventions. Data analysis involved qualitative methods to interpret the observations and interview results. The nursing diagnoses, interventions, and outcomes were evaluated based on standards from the Indonesian Nursing Diagnosis Standards (SDKI, *Standar Diagnosis Keperawatan Indonesia*). The effectiveness of the nursing interventions was determined by comparing the patient's condition before and after the interventions, focusing on pain levels, mobility, and overall comfort

RESULT AND DISCUSSION

Discussion of the results of the study related to acute pain comfort disorder with post-cesarean section

Table 1. Data Analysis

Analysis	Causes	Problem
Ds: 1. The patient said he complained of pain in the post-SC wound. 2. The patient complains of pain on movement. Do: 1. Visible grimace 2. Scale 6 3. Decreased appetite 4. Sleeplessness	Physical injury agent ↓ incision in the mother's abdomen (laparotomy) and uterus (hysterectomy) ↓ pain receptor stimulus ↓ Grimace in pain ↓ anxious ↓ discomfort ↓ acute pain	Acute Pain b.d Physical Injury Agent (Post et al.)
Ds: 1. The patient says it is difficult to move 2. Reluctant to perform movements Do: 1. Decreased range of motion (ROM) 2. Seemingly limited movement	post SC surgery ↓ incision in the mother's abdomen (laparotomy) and uterus (hysterectomy) ↓ pain on exertion ↓ discomfort ↓ activities assisted by family ↓ impaired physical mobility	Physical mobility impairment Post SC pain

The discussion is based on the results of the assessment in the Kuta Room of Sumber Kasih Hospital, Cirebon City, namely acute pain associated with physical injury agents. The implementation carried out is for 2 x 24 hours to Mrs. S. This discussion includes activities carried out, namely assessment, enforcement of nursing diagnoses, how these nursing diagnoses can arise, nursing implementation carried out, and nursing evaluation.

Assessment

The assessment was carried out by the author on Mrs.S on October 31, 2023; the client was transferred to the postpartum room after a sectio caesarea operation for indications of Early Rupture of Fertilization at 37-38 weeks. The patient had a history of ambient disease as large as a bean. Vital signs of the patient: Blood Pressure: 130/70 mmHg, Body temperature: 36.7OC, BP: 89 x/min, Respiration: 20 x / min; the patient complained of post-op wound pain, pain like stabbing, pain in the lower abdomen, pain scale 6 seemed to grimace in pain when moving, the pain was felt intermittent but frequent. The baby was born male, with a birth weight of 2950 at 06.55 and a length of 4 cm.

Diagnosis

After the assessment, the author writes about the health patterns and nursing problems experienced. The mine is to determine what will be done to prevent, reduce, and overcome p, problems in patients.

The results obtained from the assessment data are that the patient has difficulty in movement because of a surgical wound, and the patient feels pain in the post-section caesarean wound. So, the diagnosis prioritized by the author is acute pain b.d physical injury agent (surgical procedure). The diagnosis is taken in accordance with the Indonesian nursing diagnosis standards (SDKI, *Standar Diagnosis Keperawatan Indonesia*) in accordance with the predetermined characteristic limits.

According to (SDKI, 2016), Acute pain is the limited physical movement of one or more extremities independently. The pain felt by postpartum mothers with sectio caesarea comes from wounds from the abdomen. Research says that pain is a mechanism for the body, arises when tissue is damaged, and causes the individual to react to eliminate pain stimuli (Yanti & ST, 2015). Pain usually occurs 12 to 36 hours after surgery and decreases on day 3 (Parmadi & Pratama, 2020).

Intervention

Table 2. Intervention

Diagnosis	Objectives and Criteria	Intervention	Rational
Acute pain b.d pecendra physical agent post-SC surgery	After taking nursing action, it is hoped that acute pain can be resolved with the outcome criteria: **Indicator** **A** **T** 1. Complaints of pain-relieving 1 5 2. Difficulty sleeping 1 5 3. Decreased appetite 1 5	Pain management observation 1. Identify the location of the pain 2. Identify the pain scale 3. Identify factors that aggravate and alleviate pain Therapeutics 1. Provide non-pharmacological techniques to reduce pain 2. Control of the environment that aggravates pain	1. To determine the location of pain in the patient 2. To determine the patient's pain scale 3. To provide appropriate treatment 4. To reduce drug side effects 5. To provide comfort so that patients can rest 6. To manage pain/reduce pain 7. To speed up the healing process

Diagnosis	Objectives and Criteria	Intervention	Rational
		Education 1. Teach non-pharmacological techniques to reduce collaboration pain 2. Collaboration with a physician for analgesic administration	
Impaired physical mobility due to postoperative SC pain	After taking nursing action, it is hoped that physical mobility disorders can be resolved with outcome criteria: **Indicator** **A** **T** 1. Decreased range of motion (ROM) 1 5 2. Limited movement 1 5	Mobilization Support Observation 1. Identify physical tolerance for movement Therapeutics 1. Facilitate mobilization activities with assistive devices (e.g., bed railings) 2. Facilities 3. station performs movement 4. Involve the family to assist the patient in improving movement Education 1. Describe the mobilization procedure 2. Teach early mobilization	- To find out what movement activities the patient does - To prevent muscle stiffness - To provide comfort for patients - To increase knowledge related to the actions provided - To speed up the patient's recovery

The nursing problem of acute pain associated with physical injury agents that occur is addressed by the author based on SDKI, SLKI, and SIKI. Nursing interventions to address these problems are pain management (I.08238). Observation: Identify the location, characteristics, duration, frequency, quality, and intensity of pain; identify the pain scale; identify nonverbal pain responses; identify factors that alleviate and aggravate pain; and identify knowledge and beliefs about pain. Therapeutic: Facilitate sleep rest; give non-pharmacological techniques to relieve pain (aromatherapy, massage therapy, guided imagery

technique, deep breath technique). Educate by explaining the causes, periods, and triggers of pain and pain relief strategies and actions. Collaborate in giving analgesics if necessary.

Nursing Evaluation

Table 3. Nursing Evaluation

Day/Date	Diagnosis	Action and Response	Evaluation
31/10/2023 and 01/11/2023	Acute Pain b.d Agent Pecedra physical post-SC	1. Identifying the patient's pain location 2. Identify factors that aggravate pain and alleviate pain Observation response: 1. The patient said he had post-sc wound pain 2. Initial scale 6 3. The patient says severe pain on movement and reluctance to lie down. Teraupetik: 1. Providing non-pharmacological pain control techniques, namely deep breathing. 2. Controlling the environment that aggravates pain Response: 1. The patient followed the teaching of deep breathing and said the pain was slightly reduced. 2. Patients feel more comfortable. Collaboration: 1. Kaltrofen 3x1 2. Cefixime 1x1 3. Ketorolac 3x1 4. Metrodinazole 3x1	Date 31-10-2023 S: - Patient says post-sc pain on movement O: - Initial pain scale 6, post-action scale 3 A: - Problem not resolved P: - Continue intervention Date 01-11-2023 S: - The patient says the pain is slight and intermittent O: - Initial pain scale three after treatment scale 1 A: - Problem solved P: - Stop Intervention
31/10/2023 and 01/11/2023	Physical mobility impairment b.d pain post-SC surgery	Observation 1. Identifying physical tolerance for movement 2. Identify the patient's ability to move Therapeutics 1. Facilitate activities with assistive devices (bed railings) 2. Teaching early mobilization to move	31/10/2023 S: - The patient said he could mobilize slightly with assistance. O: - The patient is seen walking to the toilet with the help of the family A: - Problem partially resolved P: - Continue intervention

Day/Date	Diagnosis	Action and Response	Evaluation
		with right tilt, left tilt, and sitting. 3. Explain the procedure and purpose of early mobilization to the patient. Education 1. Advise the family to assist with the patient's activities 2. teaching simple mobilization to the patient	Date 01/11/2023 S: - The patient said he can do bathroom activities by himself O: - View of the patient coming out of the bathroom A: - Problem solved P: - Stop intervention

The results of the evaluation of acute pain obtained after treatment for two days on client Mrs.S on the first day after the action was obtained. The patient said the pain felt reduced. Objective data obtained from a pain scale of 3: no longer anxious, no grimace of pain, and pain that feels lost arises. It can be concluded that the nursing problem was partially resolved on the first day, and further intervention planning continued on day 2.

On day two, the patient said the pain was no longer felt, felt comfortable with the initial pain scale of 3-1, and looked relaxed and calm. Nursing problems have been resolved so nursing interventions can be stopped the next day.

The evaluation results on the diagnosis of impaired physical mobility in Mrs.S. On the first day, the patient said that she could do simple mobilization with the help of her family. Objective data shows the patient can tilt right and left, half sitting. Nursing problems are partially resolved and continued for the next intervention. On the second day of treatment, the patient said he could go to the bathroom alone. Objective data can move independently. Nursing problems in patients have been resolved, so nursing interventions for patients with physical mobility disorders have stopped.

CONCLUSION

This study concludes that the application of nursing care effectively addresses the basic needs of patients, ensuring their safety and comfort. Ny's theory and case are the same. This can be proven in the application of theory to clients. Through the implementation of nursing care, including assessment, diagnosis, intervention, and evaluation, patients experience significant improvements. In this case, the effective application of nursing care resulted in resolving the patient’s acute pain and impaired physical mobility, demonstrating the practical application of nursing theory to patient care. This confirms that nursing interventions, when correctly applied, can lead to successful patient outcomes.

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