Pelvic inflammatory disease

Business

Octopi pregnancy, also known as an extra uterine pregnancy is a potentially life- threatening form of pregnancy. It occurs when the implantation of the zygote is outside the uterine cavity (Walker & Jones 2002).

The commonest location is within the fallopian tubes (Abbott 2002). In the I-J there are around eleven thousand cases per year resulting in four maternal deaths (DOD 1998). Several predisposing factors increase the potential of an octopi pregnancy occurring Including: previous octopi pregnancy, tuba damage as a result of abdominal surgery or an infection such as

Pelvic Inflammatory Disease, smoking and with Increased age. However, In most cases the cause Is unknown (ATA et al 2000). Stacy (actual name withheld to maintain confidentiality) the patient, is a twenty five year old female. She lives with her partner of five years.

Stacy presented via the ultrasound scan department. The day prior to admission she had discovered that she was pregnant. The scan was requested by her general practitioner due to her previous history of an octopi pregnancy four months prior. The scan confirmed that there was no evidence of an intra uterine gestation sac.

Appearances suggested awards an extra uterine gestation sac adjacent to the right ovary containing an embryo of three millimeters in size with heart pulsations. The conclusion of the scan showed there to be present an octopi pregnancy In the right fallopian tube.

Subsequently, Stacy was admitted as an emergency to a specialist campanology ward to which the writer was based. She was Introduced to her

primary nurse and the members of the team to which she was allocated. The ward uses a team approach to nursing care to provide a consistency in the care given.

Stacy was scheduled to have an emergency syllabicating (removal of fallopian tube) to be preformed by paratroops under general anesthetic which is the passing of an endoscope through the abdominal wall. The nursing model used to plan Stack’s care was based on the Roper, Logan and Tierney Activities of Living Model (Appendix 1).

It is the model of use on the ward to provide a holistic approach to care. This model was first published in 1980 as a result of a research project undertaken by Nancy Roper In 1976 (Roper et al 2002).

The theories underpinning the model are Mason’s Hierarchy of Needs (1943) and the work of nursing theorist Virginia Henderson (1969). Mason’s Healthcare AT Needs (43) Is tenure AT unman motivation. In order to reach one’s full potential, to which he refers as self-actualization, basic physiological needs must be met.

Achievement of theses basic physiological needs provides the motivation to progress through the different levels of need. Nursing is required to facilitate the achievement of the basic needs in order to reach self-actualization (Roper et al. 2002).

Roper et al developed the model from Virginia Henderson theory of nursing. Her theory proposes that there are fourteen basic needs of an individual

which incorporate the fundamentals of nursing care. Roper et al derived from this twelve ‘ Activities of Living’ (Roper et al 2002, Toomey & Alligator 2002).

Nursing encompasses four pivotal concepts influencing the development of nursing theory and its application to practice. These are collectively known as the four intermarriages of nursing: the individual, environment, health and nursing (Toomey & Alligator 2002).

The models focal point is on the twelve ‘ Activities of Living’ (Alls). The authors perceive these to be fundamental to living a normal existence, providing the foundation for nursing care. It states that the individual is engaged in these ALLS urine their lifespan, progressing through a dependence / independence continuum which can be influenced by several factors.

The model describes the influencing factors as biological, psychological, coloratura, policewoman’s and environmental (Roper et al 2002).

In conjunction with the nursing process of assessing, planning, implementing and evaluating it provides the foundation for the plan of nursing care. Nursing intervention is required when an individual’s independence in one or more of the ALLS is restricted with the intention of re-establishing previous state of independence (Walsh 2002). The initial assessment in collaboration with the patient on admission provides a baseline for future assessments enabling actual and potential problems to be identified (Roper et al 2002).

This involves collecting subjective data from Stacy.

In order to obtain a holistic assessment of the patient each AL was assessed from biological, psychological, coloratura, policewoman’s and environmental perspective, the purpose of this is to provide an appropriate plan of individualized nursing care. The ward employs the use of a standard care plan for all patients undergoing surgery, this is much generalized and the use of a manual are plan to document any further requirements is utilized frequently.

The assessment highlighted several health care needs: sexuality was not initially noted as a problem. Problems relating to sexuality were recognized by the writer through subsequent discussions with the patient. The nursing care needs identified pre- operatively for Stacy were; the impact psychologically of the loss of pregnancy (actual) and the effect on her future fertility (potential).

Sexual desire and sexual intercourse are essential to sustain human existence. However, the concept of sexuality incorporates further components than merely production Cooley 2002).

It includes male and female identities from a biological Ana campanological perspective, sexual preference, counterblasts Tanat Transliterate between male and female behavior including cultural acceptance, and attractiveness towards ourselves and others (Roper et al 2002, Wells et al 2000, Gregory 2000). Sexuality during assessment is frequently ignored. A comprehensive assessment must be completed to provide holistic nursing care (ARC 2001).

Sexuality and sexual health do not constantly need to be exhausted; often a general assessment provides sufficient information.

The extent to which sexuality is assessed depends entirely on the relevance to the clinical setting, the reason for admission and the needs of the patient. Cooley 2002, Gregory 2000). The method utilized to assess sexuality with Stacy was through conversation. A full sexual history was taken including previous history of pregnancies. The nursing goals established with Stacy were (Appendix AAA, b): for Stacy to voice her feelings and show emotion.

To reduce episodes of tearfulness.

To assist in the achievement of these goals Stacy would be involved with the planning of her care insuring that an understandable explanation of the operation was provided, Hughes (2002) states that information given to the patient per operatively can help reduce anxiety. To ensure this goal was being achieved Stacy would be observed for signs of psychological distress. It was ensured that Stacy knew that the members of staff were available for her to talk to, encouraging her to voice any fears. Counseling was arranged post operatively.

A leaflet by the Octopi Pregnancy Trust was given to Stacy. This was to provide her with details of support groups. In the days succeeding her urge, Stacy did not appear to be depressed. She requested that the counseling arranged would be cancelled as she felt that it was no longer required. Information about her future fertility was not discussed until post-operatively when the full extent of the operation was known. The operation preformed was a syllabicating, the removal of the fallopian tube and the gestation sac.

It was explained to Stacy that her fertility would potentially be compromised. She expressed relief post operatively that one remaining fallopian tube was

present and conceiving a child would not be impossible. No intervention from associate members of the multidisciplinary team was required. The psychological repercussions of an octopi pregnancy are not typically viewed in the same manner as other losses of pregnancy such as miscarriage (ATA et al 2000). Legally in the I-J octopi pregnancy is not considered a true ‘ pregnancy’ as the embryo is implanted outside the uterus (Dickens et al 2003).

Does this suggest the same emotions of loss are or cannot be experienced? Or the pregnancy was unwanted? Not in all circumstances, often the woman was unaware of the pregnancy, here is additional trauma of the emergency admission, subsequent surgery and future fertility is potentially compromised (ATA et al 2000, Webb 1986). In 2001 a patient satisfaction study was conducted in France regarding the management of octopi pregnancy, the pregnancy was desired in seventy nine per cent of the women questioned (Ego et al 2001).

The Octopi Pregnancy Trust was established in 1998, prior to tons tenure was no special support group Tort tense patients Ana tenet Tamales, they were referred to the miscarriage support groups suggesting that the women were experiencing similar grief (ATA et al 2000). Stacy had expressed a desire for a child and was worried about the effect of a second octopi pregnancy on her future fertility. The psychological effects of the loss of pregnancy were evident.

She confided that after the previous octopi pregnancy she had suffered from depression.

The purpose of assessment is to identify the patient’s needs, subsequently producing an individual care plan. The use of a standard care plan proved inappropriate since it does not produce a nursing care plan which is individual to the patient. It invalidates the purpose of assessment since further problems identified are rarely commenced due to excessive paper work. Sexuality was not initially noted as a problem, not due to the absence of but due to the lack of assessment.

This poses the question why sexuality is often not assessed.

Is this due to difficulty in approaching the subject because of embarrassment, lack of knowledge about sexual problems, the relevance of sexuality to provide nursing care? The nursing assessment paperwork provided sexuality with a diminutive space for which problems were to be noted. Why is there not the space provided to note theses such problems? Could this be suggesting that the sexuality issues of patients are relevant or possibly not a problem? Sexuality issues amongst genealogical patients undoubtedly relevant.

If sexuality is not discussed with a patient nurses do not have the ability to assess or provide care for the patient’s needs (Guthrie 1998). Although psychological support was offered to Stacy, her partner’s emotions were not considered. The psychological effects can have a profound effect on relationships; it can divide or bring the couple closer together.

Octopi pregnancy does not only involve the woman (Walker & Jones 2002). The management of Octopi pregnancy does not always require surgical intervention.

Non-surgical intervention such as the administration of metamorphose appears to be effective in early cases, thus avoiding surgery and complications (ROCCO 1999). The ward could benefit of applying the principles of the PLISSES Model (Anon 1974) to practice. It encourages the user to explore their own attitudes and values towards sexual issues. Future assessments carried out by the writer will utilizes the model to facilitate discussions regarding sexuality according to level of capability.

The PLISSES Model (Anon 1974) is a framework frequently used for sexual therapy hat proves useful for nurses when discussing sexuality.

It suggests means of initiating sexuality in discussion (Katz 2003). It is comprised of four sections. P: Permission from the client to discuss sexuality. Katz (2003) gives the example question Women undergoing this procedure often have questions or concerns about sexuality.

Is there anything you would like to talk about? ‘ Even with limited knowledge of sexual issues the nurse should be able to demonstrate this level. L’: Limited International. I Nils level Is to prove Tactual International to ten assessors level AT competency.

AS: Specific suggestions. This requires a superior level of knowledge to relate specifically to a sexual issue.

This level and the subsequent should only be undertaken by professional who possess the relevant training (ARC 2000). IT: Intensive Therapy. This stage of assessment is to address complex underlying causes of sexual problems. The RL model undeniably has a sound theoretical base, although

the effectiveness of application in practice has long been debated (Walsh 2002, Jukes 1988, Fraser 1996). The model is commonly used in the I-J.

However, it is not established as to the efficiency of the model in practice. Is it the favored model due to the fact that the authors are from the I-J? Nurses should possess knowledge of a wider range of models and select a model to suit patient needs rather than the model commonly employed on the ward (Murphy et al 2000). The model views the patient as divided into twelve fragments. When a particular AL is not being achieved it is considered negatively (Rouge 1990, Galleon and Chalmers 2000). The absence of a psychological dimension to the model has been questioned.

Users of the model perceive the emphasis to be on the physical aspect of disease or illness Murphy et al 2000, Galleon & Chalmers 2000).

However, it could be argued that it is the assessors inadequate knowledge of the model’s theoretical base leads to incorrect implementation (Bellman 1996). The authors clearly state that each AL has a psychological dimension to which are well documented (Roper et al 2002, Bellman 1996). The simplistic nature of the model has generated both positive and negative comments. Bellman (1996) believes it to be a major strength enabling the model can be applied to a diverse range of clinical situations.

In developing the model the tutors were conscious of providing a framework that is easily understood and practical. They applaud the simplicity but are anxious to state that neither living nor nursing are simple terms, in fact they are extremely complex (Roper et al 2002).

In contrast, the simplicity could provide a major flaw within the model. The vagueness created by the author’s aspiration to create a simplistic model results in the inadequate understanding and implementation (Walsh 1998). This in turn can result in its use merely as a checklist of the achievement of activities of living (Reed and

Robins 1991, page 1995). Although not a direct criticism of the model, it is important to note. The adaptation of the model by hospital trusts can have an impact on the use of the model.

In this example the limited space provided for sexuality could possibly result in the lack of assessment, since the space is not there for problems to be noted. In conclusion, there is limited research into the psychological manifestations of an octopi pregnancy. I Nils Is an area Tanat needs to De recognizes as a problem Ana explored further.

The use of the RL model to assess a patient presenting with an octopi pregnancy could be deemed inappropriate due to the emergency nature of the situation and the relevance of normal Activities of Living. With regards to assessing sexuality it appears that the lack of assessment is still evident despite being noted as a problem in the sass’s (Webb 1988). With the prevalence of HIVE the concept of sexuality has been extensively researched.

Nurses need to look beyond the constraint of sexuality in relation to reproduction. It is not acceptable to dismiss the assessment of sexuality especially on a genealogical ward.

The personal mandarins that inhibit nurses from discussing sexuality need to be conquered. Communication skills are vital in addressing and assessing this personal subject. Genealogical nurses should ensure that they are equipped with sufficient knowledge to use the RL model effectively.

Extra training in sexual issues maybe required. In conjunction with the PLISSES model sexual issues are easier to discuss empowering the nurse to challenge her own attitudes and beliefs. Nurses need to be exposed to other nursing models and apply them in practice; one model does not have to be used exclusively.