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Edited by
Edmond Hajrizi

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Pristina, Kosovo 30-31 October 2020

Editor: Edmond Hajrizi


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Editor Speech of IC - BTI 2020

International Conference is the 9th international interdisciplinary peer reviewed conference which publishes works of the scientists as well as practitioners in the area where UBT is active in Education, Research and Development. The UBT aims to implement an integrated strategy to establish itself as an internationally competitive, research-intensive institution, committed to the transfer of knowledge and the provision of a world-class education to the most talented students from all backgrounds. It is delivering different courses in science, management and technology. This year we celebrate the 19th Years Anniversary. The main perspective of the conference is to connect scientists and practitioners from different disciplines in the same place and make them be aware of the recent advancements in different research fields, and provide them with a unique forum to share their experiences. It is also the place to support the new academic staff for doing research and publish their work in international standard level. This conference consists of sub conferences in different fields: - Management, Business and Economics - Humanities and Social Sciences (Law, Political Sciences, Media and Communications) - Computer Science and Information Systems - Mechatronics, Robotics, Energy and Systems Engineering - Architecture, Integrated Design, Spatial Planning, Civil Engineering and Infrastructure - Life Sciences and Technologies (Medicine, Nursing, Pharmaceutical Sciences, Physcology, Dentistry, and Food Science).- Art Disciplines (Integrated Design, Music, Fashion, and Art).

This conference is the major scientific event of the UBT. It is organizing annually and always in cooperation with the partner universities from the region and Europe. In this case as partner universities are: University of Tirana – Faculty of Economics, University of Korca. As professional partners in this conference are: Kosova Association for Control, Automation and Systems Engineering (KA – CASE), Kosova Association for Modeling and Simulation (KA – SIM), Quality Kosova, Kosova Association for Management. This conference is sponsored by EUROSIM - The European Association of Simulation. We have to thank all Authors, partners, sponsors and also the conference organizing team making this event a real international scientific event. This year we have more application, participants and publication than last year.

Congratulations!

Edmond Hajrizi,

Rector of UBT and Chair of IC - BTI 2020
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Epidural Hematoma Surgery at the University Clinical Centre of Kosovo (2015-2020)

Besnik Elshani1, Salih Krasniqi2, Arion Elshani2, Fëllënza Spahić2
1 UBT – Higher Education Institution, Lagija Kalabria, 10000 p.n., Pristina, Kosovo,

Abstract: Hematoma is a common problem that occurs as a result of damage to one of the larger blood vessels in the body. A hematoma can look like a bruise, but bruises occur due to damage to small blood vessels rather than large ones. Hematomas are often described based upon their location. The most dangerous hematomas are those that occur inside the skull. There are three categories of hematoma: Epidural Hematoma, Subdural Hematoma, Intracerebral (intraparenchymal) Hematoma. Epidural hematoma is when bleeding occurs between the tough outer membrane covering the brain (dura mater) and the skull. Purpose: The purpose of this research was the analysis of epidural hematomas operated and treated in the University Clinical Center of Kosovo in the Neurosurgery Clinic. Materials and methods: In this retrospective clinical study-research, are taken into account the cranio-traumas presented at the UCCK Emergency Center during the period 2015-2020, specifying the traumas with epidural hematomas in which the neurosurgical intervention was performed and a small number of traumas that were treated conservatively. Results: In the neurosurgery clinic in UCCK since 2015-2020, were operated and treated a total of 107 cases with epidural hematomas. The smallest number of cases recorded was in 2015 with a total of 14 cases, out of which 12 were operated on and 2 were conservatively treated, while the largest number was on 2018 with 27 cases, out of which 21 were operated and 6 were treated conservatively. Conclusion: Craniocerebral traumas with epidural hematomas, as well as some of those associated with other brain traumas, are more common in men than women with a ratio of almost 2:1. The operated cases (86) underwent surgery on the day of admission after clinical and radiological examination and had a 5-10 day hospital stay. Keywords: Epidural Hematoma, Cranial Traumas, Neurosurgery clinic in UCCK

Introduction

Hematoma is a common problem that occurs as a result of damage to one of the larger blood vessels in the body. Most people experience a hematoma at some point in their lives. A hematoma can look like a bruise, but bruises occur due to damage to small blood vessels rather than large ones.[1]

The most common cause of a hematoma is injury or trauma to blood vessels. This can happen as a result of any damage to blood vessels that can disrupt the integrity of the blood vessel wall. Symptoms of a hematoma generally depend on its size and location. Pain, swelling, redness, and disfiguring bruises are common symptoms of hematoma in general. [2]

Hematomas are often described based upon their location. The most dangerous hematomas are those that occur inside the skull. Because the skull is an enclosed container, anything that takes up space increases pressure within and potentially impairs the ability of the brain to function.[3]

There are three categories of hematoma:

- Epidural Hematoma
- Subdural Hematoma
● Intracerebral (intraparenchymal) Hematoma [4]

**Fig.1 Picture of an epidural, subdural, and intracerebral hematomas**

**Epidural hematoma** is when bleeding occurs between the tough outer membrane covering the brain (dura mater) and the skull. The cause is typically head injury that results in a break (fracture) of the temporal bone[5] and it is commonly result from a blow to the side of the head. The pterion region, which overlies the middle meningeal artery, is relatively weak and prone to injury.[6]

**Fig.2 Layers of the Scalp and Meninges**

Epidural bleeds from arteries can grow until they reach their peak size 6–8 hours post-injury, spilling 25–75 cubic centimeters of blood into the intracranial space.[7] Many people with epidural hematomas experience a lucid period immediately following the injury, with a delay before symptoms become evident. As blood accumulates, it starts to compress intracranial structures, which may impinge on the third cranial nerve, causing a fixed and dilated pupil on the side of the injury.[8]

Epidural hematomas usually appear convex in shape because their expansion stops at the skull's sutures, where the dura mater is tightly attached to the skull.[9] Diagnosis is typically by CT scan or MRI.[10]
Purpose

The purpose of this research was the analysis of epidural hematomas operated and treated in the University Clinical Center of Kosovo in the Neurosurgery Clinic. The specific goals were to analyze the way these cases were treated, their association with other cranial traumas, postoperative complications and deficient neurological problems.

Materials and methods

In this retrospective clinical study-research, are taken into account the cranio-traumas presented at the UCCK Emergency Center during the period 2015-2020, specifying the traumas with epidural hematomas in which the neurosurgical intervention was performed and a small number of traumas that were treated conservatively. The results obtained are presented in tables and graphs.

Results

In neurosurgery clinic in UCCK since 2015-2020, were operated and treated a total of 107 cases with epidural hematomas. The smallest number of cases recorded was in 2015 with a total of 14 cases, out of which 12 were operated on and 2 were conservatively treated, while the largest number was on 2018 with 27 cases, out of which 21 were operated and 6 were treated conservatively.

Table 1: Epidural Hematomas operated and conservatively treated during the years 2015-2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Operation Performed</th>
<th>Conservatively Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>14</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>2016</td>
<td>20</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>2017</td>
<td>22</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>2018</td>
<td>27</td>
<td>21</td>
<td>6</td>
</tr>
<tr>
<td>2019</td>
<td>24</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>86</td>
<td>21</td>
</tr>
</tbody>
</table>
The time that patients spent hospitalized on the Neurosurgery clinic in UCCK, was 5-10 days, where the lowest values are shown in 2019 with an average of 6.6 days.

Table 2: The average number of postdays patients spent hospitalised

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average stay (in days)</td>
<td>7.6</td>
<td>6.7</td>
<td>7.6</td>
<td>7.6</td>
<td>6.6</td>
</tr>
</tbody>
</table>
The number of patients who were observed during this research, shows that males have almost twice as much tendency to suffer cranial trauma with a total of 66.36%, compared to females with 33.64%. Values vary in different years where the highest value recorded by males was in 2019 with 75%, while that of females in 2017 with 40.91%

Table 3: Performance of cases with epidural hematoma operated by UCCK, sorted by year and sex, 2015-2020

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>M</th>
<th>F</th>
<th>M  N</th>
<th>F  N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>2015</td>
<td>14</td>
<td>9</td>
<td>64.29</td>
<td>5</td>
<td>35.71</td>
</tr>
<tr>
<td>2016</td>
<td>20</td>
<td>14</td>
<td>70.00</td>
<td>6</td>
<td>30.00</td>
</tr>
<tr>
<td>2017</td>
<td>22</td>
<td>13</td>
<td>59.09</td>
<td>9</td>
<td>40.91</td>
</tr>
<tr>
<td>2018</td>
<td>27</td>
<td>17</td>
<td>62.96</td>
<td>10</td>
<td>37.04</td>
</tr>
<tr>
<td>2019</td>
<td>24</td>
<td>18</td>
<td>75.00</td>
<td>6</td>
<td>25.00</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>71</td>
<td>66.36</td>
<td>36</td>
<td>33.64</td>
</tr>
</tbody>
</table>

Out of 107 cases of epidural hematomas in the period 2015-2020, 19 cases have been associated with other cranial traumas such as subdural, intracerebral hematomas and hemorrhagic contusions. During the analysis of the number of cases with other accompanying traumas we notice that the highest values were presented in 2018 with a total of 7 cases, and the most common accompanying traumas encountered were intracerebral hematomas with a total of 7 cases, where 3 of them were only in 2017.

Table 4: Performance of cases with Epidural Hematoma associated with other cranial traumas
In Decompressive Cranioectomies which are 9 cases in total, a part of the skull bone is removed in order to release the pressure from the swelling of the brain. Most often cases of this type were seen during 2018 with a total of 4 cases which were caused by epidural hematomas accompanied by subdural ones in 2 cases and hemorrhagic contusions in 2 cases. All 98 of the other 107 cases were osteoplastic craniotomies.

Table 5: Osteoplastic Craniotomies and Decompressive Cranietectomy cases based on the associated cranial traumas

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Osteoplastic Craniotomy</th>
<th>Decompressive Cranioectomies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Subdural</td>
<td>Intercerebral</td>
</tr>
<tr>
<td>2015</td>
<td>14</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>2016</td>
<td>20</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>2017</td>
<td>22</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>2018</td>
<td>27</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>2019</td>
<td>24</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>98</td>
<td>3</td>
</tr>
</tbody>
</table>
Cases with complications which have been re-operated, are 4 in total or 3.73%, where every year there is one case (0.93%), except in 2015 which has none.

*Table 6: Performance of cases with complications that got re-operated*

<table>
<thead>
<tr>
<th>Year</th>
<th>Complications</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2016</td>
<td>1</td>
<td>0.93</td>
</tr>
<tr>
<td>2017</td>
<td>1</td>
<td>0.93</td>
</tr>
<tr>
<td>2018</td>
<td>1</td>
<td>0.93</td>
</tr>
<tr>
<td>2019</td>
<td>1</td>
<td>0.93</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>3.73</td>
</tr>
</tbody>
</table>
In the structure of patients with epidural hematomas we see that 35 cases or 32.71% are associated with neurological deficiency, where the highest number was in 2018 with 12 cases or 44.44% and the lowest in 2016 with 4 cases or 20%.

Table 7: Performance of cases associated with Neurologic Deficiency

<table>
<thead>
<tr>
<th>Year</th>
<th>Cases</th>
<th>Neurologic Deficiency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>14</td>
<td>5</td>
<td>35.71</td>
</tr>
<tr>
<td>2016</td>
<td>20</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>2017</td>
<td>22</td>
<td>8</td>
<td>36.36</td>
</tr>
<tr>
<td>2018</td>
<td>27</td>
<td>12</td>
<td>44.44</td>
</tr>
<tr>
<td>2019</td>
<td>24</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>35</td>
<td>32.71</td>
</tr>
</tbody>
</table>
Discussion

The results obtained from patients in the Neurosurgery Clinic at UCCK we see that the number of cases with epidural hematomas during 2015-2020 is 107 cases of which 86 were operated and 21 were treated, while in a study published in the Open Journal of Modern Neurosurgery is said that 46 consecutive cases of epidural hematomas were operated at the University Hospital Center of Yaoundé, Cameroon, between February 2006 and December 2013 [11].

Postoperative patients had an average hospital stay of 7.6 days (a range of 5-10 days) before being discharged, and a study published in the journal World of Neurosurgery found that patients spent an average of 15.4 postoperative days in hospital (7.5 in the ICU) [12]

The number of patients who were observed during this research, shows that males have almost twice as much tendency to suffer cranial trauma with a total of 66.36%, compared to females with 33.64%. A similar result was shown on an article published on starpearls website, which says that an epidural hematoma occurs in 2% of all head injuries and up to 15% of all fatal head traumas and that males are more often affected than females. Furthermore, the incidence is higher among adolescents and young adults. [13]

Out of 107 cases of epidural hematomas in the period 2015-2020, 19 cases were associated with other cranial traumas such as subdural, intracerebral hematomas and hemorrhagic contusions. A research has been published on the publication platform “frontiers in neurology” which has analyzed hemorrhagic contusions after decompression craniectomy in traumatic brain injury, where in its research it has resulted that out of 182 cases of hemorrhagic contusions 17 have been associated with epidural hematomas.[14]

In Decompressive Cranioectomies which are a total of 9 cases, a part of the skull bones is removed in order to relieve the pressure from the swelling of the brain, the other 98 cases were Osteoplastic Craniotomies. In a conference paper published in Acta Neurochirurgica Supplementum it was researched on Eighty consecutive patients treated surgically with AEDH (Acute Epidural Hematoma) who were evaluated retrospectively. Patients were
divided into two groups: (a) hematoma evacuation (HE: 46 cases) and (b) HE + an external decompression (ED: 34 cases) [15]

Only 4 cases or 3.73% in 107 are complications of epidural hematomas which had to be re-operated. A reference to epidural hematomas has been published on the well-known medical reference website Medscape, which states that epidural hematomas complicate 2% of head trauma cases (approximately 40,000 cases per year). Alcohol and other forms of intoxication have been associated with a higher incidence of epidural hematoma. The incidence has remained stable for many years. [16]

Conclusion

Our research on Epidural Hematomas in the period 2015-2020 comes to a conclusion that craniocerebral traumas with epidural hematomas, as well as some of those associated with other brain traumas, are more common in men than women with a ratio of almost 2:1. The operated cases (86) underwent surgery on the day of admission after clinical and radiological examination and had a 5-10 day hospital stay. All epidural hematomas that have been associated with other traumas have been more prone to decompressive craniectomy compared to those that have not been associated with other cranial traumas and have been performed as Osteoplastic Craniotomies. A small number of these Epidural Hematomas have led to postoperative complications, which had to be reoperated. A large proportion of cases with Epidural Hematomas after surgery have recovered but some of them have ended up with Neurological deficiencies, especially those cases which have been associated with other cranial hematomas.

References


Nursing care in the quality of life of patients with stoma-colostome and patient education outside hospitals.

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Abstract The colon is the last part of the human digestive tract. It consists of the colon, rectum and anus which is the last part that realizes defecation. The task of the colon is to absorb fluids, residual nutrients, pass fecal materials and dispose them. When the colon, rectum or anus are unable to perform this function due to various diseases or traumatic injuries, another way must be found to eliminate fecal materials. Colostomy consists of an opening (stoma) of the colon and its attachment to the abdominal wall, creating a new communication to eliminate gases and feces. Colostomy can be temporary, meaning that after a few weeks or months a surgery is performed and it is closed in order to restore the normalcy of intestinal transit, but it can also be permanent. When the colostomy is permanent it means that the patient will no longer be able to defecate from the anus, as it is impossible to restore the normalcy of intestinal transit. Purpose: To understand patients’ self-care and health education needs for patients with colostomy after rectal carcinoma surgery to provide basic information for improving the quality of nursing. In some cases, unfortunately, complications can occur after stoma formation surgery, these are discussed and nursing advice is given to the nurse. One of the most important ways a nurse can support a patient is to teach the patient his/her stomach care, ensuring independence before being discharged and showing empathy and compassion. Methodology: The research was conducted in UCCK, Prishtina leads with more cases of colorectal cancer than other municipalities in Kosovo. The research was conducted with 20 UCCK patients who suffer from rectal carcinoma after colostomy. Some patients experienced defecation disorders and distress. Only a few of the patients could achieve self-care for the colostomy before leaving the hospital. The first patient need for health education was to understand how to train up to regular defecation. Results: There were significant results between nursing interventions and different dimensions 1 month and 6 months after surgery. Routine nursing care plus full-course intervention can significantly improve the quality and quality of life of patients after colostomy.

Keywords: colorectal cancer, colostomy, nursing care, patient education.

Introduction

Understanding the colon
The colon is the last part of the digestive tract located from the ileocecal valve to the anus. It consists of the following parts:
- Cecum
- Ascending column
- Transverse column
- Colony decedent n
- Sigmoid colony and Rectum.
Colorectal cancer is a tumor formation with atypical cells that grows in the wall of the colon, and as it develops gradually affects its entire wall, spreading locally and remotely to other organs of the body. It has been genetically proven that colon and rectal cancers are the same. This occurs due to genetic mutations mainly in the gene APC, TGF-b, DCC, TP53, which turn the adenoma into carcinoma. It is the third most diagnosed disease among tumor diseases and it is ranked the second for tumor deaths in men and women, while anal cancer accounts about 4% of cases diagnosed with colon cancer. The incidence increases with age and is slightly higher in males than females.

Ways of surgical intervention
Surgery is the most common treatment for colorectal cancer. There are several ways of surgical intervention:

**Colonoscopy:** Through this method any small malignant polyp can be removed from the colon or upper rectum. Some small tumors in the lower part of the rectum can also be removed through the anus without a colonoscope.

**Laparoscopy:** The early stages of colon cancer can be removed with the help of a thinly illuminated tube (laparoscope). The tube is inserted into the colon through several holes made in the abdomen. Besides the tumor, the doctor removes a healthy part as well. Lymph nodes in the vicinity can be removed.

**Open surgery:** The surgeon creates a large incision in the abdomen to remove the tumor and a nearby healthy part of the colon and rectum. Some nearby lymph nodes are also removed. The surgeon will also check the rest of the colon and liver to see if the cancer is spread. When a part of the colon or rectum is removed, the surgeon can reconnect the healthy parts. However, sometimes reconnection is not possible. In these cases the surgeon creates a new path through which the feces leaves the body. The surgeon creates an opening (stoma) in the abdominal wall, connects the upper part of the colon with the stoma, and closes the other end. The surgery done to create the stoma is called a colostomy.
The word "stoma" derives from the Greek, and means mouth, or opening. It is used to refer to the externalization of any internal organ. Intestinal stoma is the externalization of the intestine through the abdominal wall. There are different terms, depending on the segment exposed. For example, if it is placed in the colon, it is called a colostomy; if in ileum, ileostomy, if in jejunum, jejunostomy.

Different types of colostomies are related to the location of the colon where the surgery was performed. The localization of the intervention depends on the health conditions and the reasons that make it necessary to perform a colostomy.

**Ascending colostomy:** This colostomy has a stoma (opening) that is located on the right side of the abdomen. The material (feces) in this case is drained from the stoma in liquid, aqueous form.

**Transverse colostomy:** This colostomy has a stoma (opening) that is located above the abdomen toward the middle of the left side. The outlet drains in solid form.

**Descending or sigmoid colostomy:** This colostomy has a stoma (opening) that is located on the left side of the abdomen. The exit drains in a solid form. Surgery is the result of one of three types of colostomy: Final colostomy: The functional end of a bowel, the section of the bowel that connects to the gastrointestinal tract, is brought to the surface of the abdomen to form a stoma (an artificial opening) by folding the back of the bowel toward itself and

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1 ACS Medical Content, Editorial, and News Staff  Senior Director, Medical Content  Tracy Wyant, DNP, RN-BC, AOCN, CHPN, EBP-C, CPPS
attaching the end to the skin. A final colostomy is usually a permanent colostomy, as a result of trauma, cancer, or other pathological condition. **Double – barrel colostomy**: This colostomy involves the creation of two separate stomata in the abdominal wall. The proximal is the stoma in the last function which is connected to the upper gastrointestinal tract, and will excrete stools. Lateral stoma, associated with recurrence, drainage in small amounts of mucous materials. This is usually a temporary colostomy, performed to calm a part of the intestine and then it is closed. **Loop colostomy**:  This colostomy is created by bringing the bowel loop through an incision in the abdomen. The loop is held on the outside in a place outside the abdomen with a plastic holder under it. An incision made in the bowel allows the passage of feces through a curved colostomy. The retainer is removed approximately 7 to 10 days after the surgery, once healing has been completed this will prevent the loop from being inserted back into the abdomen. A curved colostomy is most commonly used to create temporary stomata to shift the direction of stool from an area of the bowel that is blocked or damaged.

Stoma is temporary for a large number of patients. It is only needed until the colon or rectum is healed from surgery. After healing, the surgeon connects the parts of the intestine and closes the stoma. Some people, especially those with a tumor in the lower part of the rectum, need permanent stoma. A thin sac is caught in the stoma to collect fecal debris. The recovery time after surgery varies from person to person. The patient may not be comfortable in the first few days. Ostomy patients need specific care, specialized multidisciplinary follow-up that meets their biopsychosocial needs, and qualified nursing care, which should begin in the preoperative period and continue throughout the period in which the patient should have stoma, and this may be permanent. Colon and rectal surgeons and certified ostomy nurses are the optimal clinicians to select and mark stomach locations, as this skill is part of their education, practice, and training. However, these providers are not always available, especially in emergency situations. Many suspicions may arise in the first few days after discharge from the hospital, such as issues related to the treatment, onset or maintenance of signals and symptoms, and the appearance of new problems. The nurse has a closer relationship with the patient and family members, and for this reason this professional is essential to help the stomp patient. Practical advice on nursing care before and after surgery of a patient with a newly formed ostomy is given by the nurse. In some cases, unfortunately, complications can occur after stoma formation surgery; these should be discussed and nursing advice given. One of the most important ways a nurse can support a patient is to teach the patient his / her stomach care, ensuring independence before being discharged and showing empathy and compassion.

**NURSING PROCESS FOR PATIENTS WITH STOMA OR CONTINENTAL STOMA.**

**Nursing care before surgery**

This gives the patient time to discuss surgery and aspects of stoma with the nurse. Any questions the patient may have can be addressed and this can help reduce the patient's anxiety. Often in preoperative counseling sessions the nurse will address a variety of issues, such as surgery, body image, risk of sexual dysfunction, hobbies and practical care  (Davenport, 2003a). Counseling is essential for the patient to cope psychologically and physically with stoma (Black, 2000).

The nurse has a very important role in ensuring that the preoperative patient has adequate information. Thus, it is essential that nurses maintain up-to-date knowledge (Nursing and

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3 Section of Colon and Rectal Surgery, Division of Gastrointestinal and Oncologic Surgery, Department of Surgery, Northwestern University Feinberg School of Medicine, Chicago, Illinois

Find articles by Molly A. Wasserman
Midwifery Council, 2002) on preoperative aspects of stoma care, including the need for bowel cleansing before surgery to reduce the risk of fecal contamination during surgery, and the importance of placement stoma before surgery.

**Stoma location**

The stoma should be placed in a flat area of the abdomen, avoiding scarring and wrinkles to reduce the risk of leaking device (Black, 2000). Ideally, the stoma should be placed through the rectus muscle (Davenport, 2003b) to reduce the risk of prolapse (Meadows, 1997). Most importantly, the nurse should ensure that the patient is able to reach out and look for his/her new stoma. This should enable the patient to be independent with his/her post-surgery stoma care.

**Postoperative care**

The nurse caring for the patient after surgery will need to make various stoma observations. Usually the stoma should be edematous after surgery due to the bowel being treated during the operation. Swelling and size of the stomach will decrease for approximately 6-8 weeks after surgery (Collett, 2002). Thus, the patient should be reminded by the nurse to remeasure the stoma size regularly during this period, at least every week. When stoma-sized contraction is noted the aperture cut in the stoma device should be reduced accordingly. The nurse should observe the dentures in the postoperative period through a clear device. Patients with new stoma need a lot of nursing care. In addition to routine postoperative evaluation, the stoma should be inspected every 8 hours. The stoma should be pink to red, moist, and well adhered to the surrounding skin. A blue stoma tells us about inadequate circulatory support, a black stoma tells us about necrosis. Any complication should be reported to the doctor for immediate treatment, which may require the patient to return to surgery once more. I should look for the presence of edema in the stoma. The size of the stoma gradually decreases over the week, so the presence of an edema indicates a possible complication. The skin is evaluated for irritation around the stomach bag and below it whenever it is changed. The discharge of the bag should be monitored and documented. Unexpected changes such as changes in fecal material should be reported to the nurse card and to the physician. For patients with continental ostomy, regular bag evaluation should be done, this is because it prevents rupture and spillage of the sack. Fecal characteristics should be observed in any type of continental stoma in order for the problem to be reported.

Fig British Journal of Nursing Vol. 14, No. 6Stoma Management. 3. Introducing a sack type

**Patient Education for colostomy replacement**
Once the patient recovers, his education must begin. The patient is need to demonstrate to the nurse how to care for the stoma. Determine the patient's ability and ingenuity to learn and perform self-care Patients experiencing pain, nausea, or vomiting are not eligible to see a stoma or receive health education. Patients with special needs, such as deafness, dumbness, language barriers, severe arthritis or other physical conditions that limit the ability to perform self-care, require special instructions or specific types of stoma, so that the patient is able to perform self-care. If the patient is unwilling or unable to learn, it is important to engage family members or caregivers at home. Provide references to be given to the home care nurse.

Use of colostomy bag

Depending on the type of bag, it should be changed every 3-5 days. If ejaculation occurs from the sac, it should be replaced immediately to prevent skin irritation around the stoma. The skin barriers that are placed on the skin should stay at a distance from the base of the stoma, this to prevent the feces from coming into contact with the skin. The stoma must be measured first before being replaced, because the stoma can become edematous at the time of removal. Explain to patients who have a left colostomy that the bowel can be adjusted with diet.

Hygiene care

Empty the bag when 2/3 of the bag is full. The filling flow and the frequency of emptying depend on the location of the stoma in the intestine. Once the bag is empty, the inside of the back of the bag should be cleaned and dried before the clamp is re-inserted to help control odors. During the bath or shower, the tools should be carefully stored because they can be damaged, this by imposing protective measure. Explain dietary considerations, identify foods that contribute to odors and gases. If foods that cause heavy odors are known, the bag should be emptied first before the meal.

Sexual disorders related to changes in body image and erectile dysfunction.

The patient will need to discuss a pleasurable and acceptable sexual practice for themselves and their partner. Identify if the patient is male who has an abdominal-perineal resection for rectal cancer and who has an erectile dysfunction. This impotence is transient, depending on the nerve damage and edema associated with surgery. Get advice from a urologist if you have erectile dysfunction. Encourage the patient to talk about sexuality with the partner.

Nutritional considerations

Patients with colostomy have few dietary restrictions after the initial post-surgery period (Schreiber, 2016). Patients who have undergone ostomy surgery will need to eat a balanced diet that includes calories, protein, vitamins, and minerals, and drink six to eight glasses of fluids a day to aid in post-surgery healing. The goal is to return to a diet that is well balanced from a nutritional point of view and rich in fiber (Cronin, 2012). The colostomy should work before leaving the hospital and the patient should expect at least one bowel movement once a day at home in the first few weeks. As the patient begins to heal, it is not essential that the colostomy work every day. Because these patients have undergone major abdominal surgery, many patients have no appetite to eat three regular meals a day so they will benefit from eating the six smaller meals. Dietary learning is a key to rehabilitation and adaptation.
Purpose of the paper

The purpose of this study was to determine how socio-demographic and clinical changes affect quality of life and to assess the validity of a disease rate. To understand patient self-care and health education needs for patients with colostomy after colon cancer surgery to provide basic information on improving the quality of nursing. Therefore, support services for patients with stoma play an important role, as they include the entire care process towards the continuation of the actions started in the admission phase, with the aim of rehabilitation based on self-care and better quality of life. However, nowadays these services are not advertised enough. Thus, it is necessary to establish policies aimed at evaluating ostomy patients, including information about their conditions and needs, social support and employment, among others.

Presentation and discussion of findings
Table 1: What is the most affected sex by colostomy

<table>
<thead>
<tr>
<th>Total</th>
<th>60 patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>22</td>
</tr>
<tr>
<td>Male</td>
<td>38</td>
</tr>
</tbody>
</table>

Figure 1: The most affected gender are men with 38 and women with 22, the total number of patients is 60 for 2019

Table 2: Age groups of patients with colostomy at the Abdominal Surgery Clinic at UCCK
By age which years are most affected by colostomy

<table>
<thead>
<tr>
<th>Year Range</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1930-1937</td>
<td>4</td>
</tr>
<tr>
<td>1941-1948</td>
<td>13</td>
</tr>
<tr>
<td>1950-1959</td>
<td>17</td>
</tr>
<tr>
<td>1960-1967</td>
<td>14</td>
</tr>
<tr>
<td>1970-1980</td>
<td>7</td>
</tr>
<tr>
<td>1982-1989</td>
<td>1</td>
</tr>
<tr>
<td>1990-2000</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

**Figure 2:** The table shows that the years most affected by colostomy are from 1950-1959 with 29%, then 1960-1967 with 24%, 1941-1948 with 22% and the others with a lower %.

**Table 3:** Kosovo municipalities affected by colostomy patient

<p>| Deqan | 1 |</p>
<table>
<thead>
<tr>
<th>Location</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drenas</td>
<td>6</td>
</tr>
<tr>
<td>F.Kosov</td>
<td>1</td>
</tr>
<tr>
<td>Ferizaji</td>
<td>5</td>
</tr>
<tr>
<td>Gjakove</td>
<td>1</td>
</tr>
<tr>
<td>Gjilani</td>
<td>3</td>
</tr>
<tr>
<td>Istog</td>
<td>2</td>
</tr>
<tr>
<td>Kamenic</td>
<td>1</td>
</tr>
<tr>
<td>Kastriot</td>
<td>1</td>
</tr>
<tr>
<td>Lipjan</td>
<td>4</td>
</tr>
<tr>
<td>Mitrovica</td>
<td>2</td>
</tr>
<tr>
<td>Peja</td>
<td>2</td>
</tr>
<tr>
<td>Podujeva</td>
<td>4</td>
</tr>
<tr>
<td>Prishtina</td>
<td>20</td>
</tr>
<tr>
<td>Shtime</td>
<td>2</td>
</tr>
<tr>
<td>Skederaj</td>
<td>1</td>
</tr>
<tr>
<td>Suharek</td>
<td>3</td>
</tr>
<tr>
<td>Vushtrri</td>
<td>1</td>
</tr>
</tbody>
</table>
Figure 3: According to the graph it turns out that Prishtina is the municipality with the most colostomy patients with 33%, followed by Drenas and other municipalities.

Table 4: How do you get information about your health?

<table>
<thead>
<tr>
<th>Health professionals</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health professionals</td>
<td>15</td>
</tr>
<tr>
<td>Internet</td>
<td>4</td>
</tr>
<tr>
<td>Family</td>
<td>1</td>
</tr>
<tr>
<td>Colleagues</td>
<td>0</td>
</tr>
</tbody>
</table>
In Figure 4: Fifteen patients show that they receive the first information from health professionals

Table 5. Who did you consult before deciding on surgery for colostomies?

<table>
<thead>
<tr>
<th>Consulted By</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>With the doctor</td>
<td>9</td>
</tr>
<tr>
<td>With the nurse</td>
<td>2</td>
</tr>
<tr>
<td>With the family</td>
<td>9</td>
</tr>
</tbody>
</table>

Figure 5: In this graph patients state that they have consulted with the doctor and family about the placement of the colostomy.

Table 6: Who has trained you about placement of colostomies?

<table>
<thead>
<tr>
<th>Trained By</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>0</td>
</tr>
<tr>
<td>Nurse</td>
<td>12</td>
</tr>
<tr>
<td>Family</td>
<td>8</td>
</tr>
</tbody>
</table>
Figure 6: This graph shows that 12 patients received training on colostomy from nurses, and 8 of them from family members.

Table 7: Were you trained during the hospital stay, or after leaving?

<table>
<thead>
<tr>
<th>Training by</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the hospital by the nurse</td>
<td>1</td>
</tr>
<tr>
<td>In the hospital by family</td>
<td>5</td>
</tr>
<tr>
<td>At the hospital by the doctor</td>
<td>0</td>
</tr>
<tr>
<td>At home by family</td>
<td>5</td>
</tr>
</tbody>
</table>
Figure 7: According to the graph 10 patients answered that the training was done in the hospital by the nurse, and with equal percentage from family to hospital and home from family

Table 8: Is dietary food necessary if you have colestom?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Of course</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Maybe</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
</tr>
</tbody>
</table>
**Figure 8:** Fifteen patients responded that dietary food is essential if you have colostoma.

**Table 9:**
Over the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>4</td>
</tr>
<tr>
<td>A little</td>
<td>3</td>
</tr>
<tr>
<td>Average</td>
<td>4</td>
</tr>
<tr>
<td>Very little</td>
<td>3</td>
</tr>
<tr>
<td>Extremely bad</td>
<td>6</td>
</tr>
</tbody>
</table>
**Figure 9:** In this graph 6 of them answered that it had an extremely bad effect, on average and not at all by 4, and a little or very little by 3 answers.

**Table 10:** How much body pain have you had over the past 4 weeks?

<table>
<thead>
<tr>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
</tr>
<tr>
<td>Very mild</td>
<td>2</td>
</tr>
<tr>
<td>Mild</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>4</td>
</tr>
<tr>
<td>Severe</td>
<td>5</td>
</tr>
<tr>
<td>Very severe</td>
<td>6</td>
</tr>
</tbody>
</table>

**Figure 10:** In the graph of how much bodily pain you have had over the past 4 weeks, most of them have responded very severe, severe, moderate.

**Table 11:**
During the past 4 weeks, how much time from your physical health or emotional problems has interfered with your social activities (such as visiting friends, relatives, etc.)?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All the time</td>
<td>7</td>
</tr>
<tr>
<td>Most of the time</td>
<td>5</td>
</tr>
<tr>
<td>A little</td>
<td>4</td>
</tr>
<tr>
<td>Not at all</td>
<td>4</td>
</tr>
</tbody>
</table>

**Figure 11:** In the graph that during the past 4 weeks how has physical or emotional health and social activity affected you, 7 patients have answered all the time, while most of the time with 5, and equally from 4 answers are little or no time.

**Table 12:** How many times in 24 hours do you empty the colestome?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2-3 times a day</td>
<td>4</td>
</tr>
<tr>
<td>3-5 times a day</td>
<td>6</td>
</tr>
<tr>
<td>5-8 times a day</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Figure 12: In the graph of how many times during the day you empty the colostomy, 10 patients answered 5-8 times a day, while 3-5 times a day with 6 and 2-3 times a day only 4 patients.

Table 13:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes, very limited</th>
<th>Yes, somewhat limited</th>
<th>Not limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powerful activities, such as running, lifting heavy objects, participating in strenuous sports.</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf</td>
<td>8</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Lifting or holding food items.</td>
<td>4</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Walking with friends</td>
<td>5</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Holidays on the coast</td>
<td>15</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Poor relationship</td>
<td>11</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Wound pain</td>
<td>4</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Severe body odor due to stoma</td>
<td>10</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Food restriction</td>
<td>12</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Maintaining body hygiene</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>
Figure 13: In the graph of how much daily activity you do during the day and does it limit you in daily life, most of them answered with 15 on the beach vacation, food restriction with 11 answers, poor regulation of sexual intercourse with 11, with 10 answered severe body odor due to this colostomy, as well as with other activities are with 8, wound pain with 6.

Table 14:

During the last 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The reduced amount of time you spend on work or other activities</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Finished less than you want</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>You have not done work or other activities as carefully as usual</td>
<td>13</td>
<td>7</td>
</tr>
</tbody>
</table>
Figure 14: During the last 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious, blue shows us that most of patients have had limited activities as a result of emotional problems, and brown indicates that few of them have been active and have not been hindered at all by the presence of the colostomy sac.

Table 15:

These questions are about how you feel and how things have been with you over the last 4 weeks. For each question, please provide an answer that comes close to how you felt.

<table>
<thead>
<tr>
<th>Did you feel sad?</th>
<th>All the time</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Partly</th>
<th>A while</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Were you angry?</th>
<th>All the time</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Partly</th>
<th>A while</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you felt so broken in grief that nothing can delight you?</th>
<th>All the time</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Partly</th>
<th>A while</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you feel calm?</th>
<th>All the time</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Partly</th>
<th>A while</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Did you feel desperate?

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>5</th>
<th>4</th>
<th>4</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

Did you feel scared?

<table>
<thead>
<tr>
<th></th>
<th>3</th>
<th>4</th>
<th>6</th>
<th>4</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
</table>

Have you been a happy person?

<table>
<thead>
<tr>
<th></th>
<th>6</th>
<th>8</th>
<th>5</th>
<th>0</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
</table>

Did you feel tired?

<table>
<thead>
<tr>
<th></th>
<th>7</th>
<th>5</th>
<th>6</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
</table>

Do you feel discriminated against?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>4</th>
<th>4</th>
<th>3</th>
<th>6</th>
</tr>
</thead>
</table>

**Figure 15:** In the graph of how you felt during these weeks according to the patients most of them were happy "sometime" with 8 answers, did you feel broken, in a situation where nothing makes you happy, with 6 answers "sometime". According to this chart, patients with colostomy are mostly desperate for their current condition.

**Table 16:**
How TRUE or FALSE is each of the following statements for you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>Mainly true</th>
<th>I don’t know</th>
<th>Mainly false</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>I seem to get sick a little easier than other people</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am as healthy as anyone I know</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>I expect my health to deteriorate</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>My health is excellent</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement</th>
<th>Tru e</th>
<th>Mainl y true</th>
<th>I don’t know</th>
<th>Mainl y false</th>
<th>Fals e</th>
</tr>
</thead>
<tbody>
<tr>
<td>I seem to get sick a little easier than other people</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am as healthy as anyone I know</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>I expect my health to deteriorate</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>My health is excellent</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
Figure 16: In this graph of how True or False as claimed patients have stated that most of them are optimistic about their health and accept it as it is. “I am as healthy as anyone I know” with 6 answers, the same are also with “my health is excellent”.

**Conclusion**

Routine nursing care plus full-course intervention can significantly improve patients' quality of life after colostomy. Shorter hospital stays mean that more patients with a new colostomy may have increased educational needs after returning home. It is imperative that Home Care Nurses adhere to best practices in managing this population of patients after surgery and prepare them physically and emotionally for self-care discharge. This is no small task. Using role play is a creative way to help patients build confidence, which can positively impact quality of life and a faster path to adaptation. It is safe to say that nurses who have confidence in caring for patients with colostomy make a patient feel even more secure. There are many opportunities to conduct research in this area of nursing, especially in non-acute settings.

**Recommendation**

Work as part of a multidisciplinary team for the rehabilitation of people with stoma. Clinical responsibilities: Pre-operative, post-operative by the surgeon and the nurse To form the Association of Wound, Ostomy and Continuum Nurses in Kosovo because it does not exist. The goal of developing specialized nursing skills is to ensure better patient / client outcomes. Educating the patient in the hospital by the nurse for the maintenance of the stoma, not to come to the wound-stoma infection. Educating the patient about discharging / emptying the colostomy. Educate family members about stoma care and colostomy replacement Give emotional support Give the patient another important education: problem solving, diet, fluid balance, increased fluid intake, what a normal stoma should look like, clothes, costs, and sexuality. Review and research current practices. Provide evidence-based nursing.

**Discussion**
According to the literature, colostomy individuals face a great deal of despair, which brings negative feelings into their relationships. In particular, social mutilation and humiliation make it difficult for patients to cope with this situation, which can affect their lifestyle and quality of life. Caring for these patients can present a challenge for health professionals because it requires preparing patients to live with ostomy. Academic courses do not focus on stoma physical care and, thus, professionals are not prepared to deal with the changes they present in one’s lifestyle.

**Methodology**

This study has been conducted with the quantitative method for processing numerical data that are usually presented in the form of statistics. A total of 60 patients with Stoma were registered in 2019. The most affected gender were men with 38 cases with 63.3%, while women were 22 cases with 36.6%. Most of the patients belong to the age group from 1950-1959. Most cases of stoma were the Municipality of Prishtina with 33%, followed by Drenas and other municipalities. Twenty patients were interviewed for the study; the average age was 45-65 years, 60% were male, 40% female were Stoma (colostoma). The placement of the stoma was a consequence of colon cancer. The stoma in some patients was permanent and in some temporary. There were significant correlations between nursing interventions and different dimensions, results in dimensions 1 month to 6 months after surgery were higher in the intervention group than that in the control group. Twenty patients participated in the study. Spiritual well-being was significantly associated with psychosocial regulation, predictive, disease severity, self-esteem, time since surgery, and spiritual well-being accounted for 60% of the variance in psychosocial regulation. 40% reported a moderate level of spiritual well-being. Participants reported adjustment to extended family, social relationships, but poor sexual adjustment.

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HEALTH POLICIES AND THE
CHALLENGES OF THE
IMPLEMENTATION OF
LEGISLATION IN THE REPUBLIC
OF KOSOVO

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Abstract The situation in Kosovar healthcare continues to be critical two decades after the war and 12 years after the declaration of independence. Low level of development of the health sector, lack of political will, inadequate health policies and non-implementation of legislation, unsustainable financing is reflected in poor results, even alarming in terms of public health in Kosovo. The lack of a serious approach to the health sector has led to this sector, of primary importance, to be degraded to alarming proportions at the three levels of Kosovo's health system.

The purpose of this paper is to assess the achievements, stagnation, the need for reforms in the health system and to improve the parameters and indicators that make the health system of a stable country, through a qualitative and comparative method, with reviews of Kosovo's health policies and legislation, as well as evaluation reports of relevant international institutions.

Key words: reform, legislation, system, evaluation.

Introduction

An ideal health system would be one that is able to provide basic health care, easily accessible and qualitatively acceptable to the citizen - the patient and with high efficiency.

Health policies, health sector strategies, adequate legislation and the practical implementation of policies, strategies and legislation in the health systems of countries in transition continue to be significant challenges that are hampering the quality delivery of health services, equality, inclusion and care adequate for public health challenges these, that are following the Republic of Kosovo.

After profound political, constitutional and socio-economic changes, in 1999 under international administration and with the help of international institutions, Kosovo as a country in transition began drafting a basic package of health policies, thus beginning a new cycle of legislative norms in the health system in completely different circumstances. In that time period the international community and numerous donors such as, the WHO that developed basic guidelines for health projects. The "Interim Health Policy Guidelines" were released in September 1999. These policy guidelines, known informally as the "Blue Book", included concrete objectives related to primary health care, reorganization of health institutions, the way of supply of medicines and other important aspects for that period of
time. The demands of the time and the dynamic trends would impose the need to continue the reorganization and reform of the health system, as well as the pressure of the internal but also the external one and the donors, after the necessary consultations resulted in Kosovo’s health-policy document, informally “The Yellow Book.” The Yellow Book outlined an ambitious vision for the health system in Kosovo, and its basic components are outlined below. This important document for the time would have a greater focus on the reform of secondary and tertiary health care as well as with the organization of the demographic component where secondary care would be provided by six regional hospitals while for the tertiary University Clinical Center of Kosovo organization of which continues to be functional to this day.

Currently, 18 laws, 17 sectorial strategies and dozens of administrative instructions are in force, which regulate and cover in the legislative aspect the health system of the Republic of Kosovo. Currently, some laws in the field of health are in the process of amending and I estimate that it is necessary to draft a number of important laws in certain segments where there is a lack of legal infrastructure.

Methodology

During the work process of this paper I have used quantitative and qualitative research methods in the field of monitoring and implementation of legislation by the competent institutions and mechanisms of the health system of the Republic of Kosovo. We have analyzed the work of the Parliamentary Committee on Health, Labor and Social Welfare of the Assembly of the Republic of Kosovo, as an institutional mechanism that drafts legislation but also monitors the implementation of legislation in the health sector for the period 2016-2019, using qualitative, quantitative and comparative methods for the time period analyzed and the statistical aspects of monitoring the implementation of the monitored laws.

Using the qualitative method we have analyzed the practical implementation of health system legislation nationwide by analyzing the work of the relevant parliamentary committee, institutions implementing this legislation such as the Agency for Medicinal E and Products, Pharmaceutical Inspectorate, local manufacturers and international representatives of relevant pharmaceutical companies, as well as numerous local and international decision-makers including professional structures and the non-governmental sector.

Discussion

The institution responsible for overseeing the implementation of laws is the Assembly of the Republic of Kosovo, whereas the implementation of legislation in the health sector is overseen by the Parliamentary Committee on Health and Social Welfare. Using the
comparative method and no statistics, we have analyzed the monitoring of legislation for the health sector by the relevant parliamentary committee for the period 2016 - 2019. During this period, the implementation of 4 laws has been monitored, two of the social sector and two of health sector\textsuperscript{10}. The Committee for Health, Labor and Social Welfare during 2017 has monitored the implementation of the law on health - Law no. 04 / L-125\textsuperscript{11}, and in 2019 the monitoring of the implementation of the Law no.04 / L-190 on Medical Products and Equipment\textsuperscript{12}. Following the findings by the parliamentary committee responsible for monitoring laws, it is a regular procedure to prepare a final report by the parliamentary committee and this report is sent for debate in the plenary session of the Assembly of the Republic of Kosovo and after the debate is subject to approval for voting by conclusions. The report on the Law on Health did not go to the plenary session for review at all, while the report on the Law on Medical Products and Equipment was not approved by the plenary session\textsuperscript{13}. These findings from the statistical and comparative aspect expressed in graphic form look like this:

![The number of monitored health care laws in Kosovo (2016-2019)](image)

\textbf{Figure 1.}

\textsuperscript{10} Burimi: Administrata dhe stafi mbështetës i Komisionit Parlamentar për Shëndetësi dhe Mireqenie Sociale.


\textsuperscript{13} Burimi: Autori ka qenë referues i mbikqyrjes së këtij ligji në seancën plenare.
Figure 2.

The first figure shows in graph form the number of laws monitored in the field of health from the total number of laws in this field which indicates a very symbolic monitoring by the responsible parliamentary committee, while in the second figure we present the percentage of implementation of monitored laws for the time period we analyzed.

Conclusion

From the literature review, analysis of existing legislation and methodology applied in this paper, I assess that Kosovo continues to be one of the countries in which the deep political, constitutional and socio-economic transition has created barriers but has also left consequences on the effectiveness of the monitoring, implementation of legislation in the field of health, as well as in the design, planning and development of necessary strategies and capacities in this field. I believe that the adaptation of models of legislation by countries with democracies, GDP and health systems much more developed than Kosovo, which do not correspond to the reality and conditions necessary for the implementation of this legislation in practice, has affected the frequent change of legislation in in the field of health and in case of improper implementation of this legislation in practice. The statistics of monitoring the implementation of laws in this field for the analyzed period 2016 - 2019 speak of a low percentage of monitoring the implementation of these laws in practice and from the two monitored laws their final reports suggest amendment of the two laws of monitored covering very important sectors of the Kosovo health system. I believe that the Ministry of Health of the Republic of Kosovo should increase the capacity for drafting, managing and implementing legislation and sectoral strategies of the health system of Kosovo in accordance with the trends and needs of the time, as well as the Parliamentary Committee on Health, Labor and Social Welfare to increase the efficiency of monitoring laws by overseeing the most efficient and fair
implementation of this legislation and significantly advance the working methodology of monitoring the implementation of legislation of the health system of Kosovo, which leaves much to be desired.

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Experiences of clinical nurses caring for patients with COVID-19 in Kosovo. A phenomenological study

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Abstract. The outbreak of Sars-Cov 2 virus and the disease it causes - COVID-19 has challenged the health system, especially the medical staff of the front line of confrontation with this virus. Nurses constitute the largest group of health care workers and together with doctors they are directly exposed to the risk of infection from this virus. This qualitative study aimed to understand the experiences of clinical nurses who have been engaged in providing health care services to patients with COVID-19 in Kosovo. The data analysis was based on Colaizzi’s model for the analysis of phenomenological studies. Eight (8) nurses from three (3) different clinics of the University Clinical Center of Kosovo were interviewed for this study. The data analysis identified nine (9) topics which were grouped into three thematic categories: 1) stressors; 2) supporters and 3) nurses’ attitudes towards COVID-19 patient.

Keywords: outbreak, COVID-19, University Clinical Center of Kosovo, Colaizzi’s model

Introduction

COVID-19 is an infectious disease caused by the Sars-CoV-2 virus. This disease started in Wuhan, China, in December 2019, and has already turned into a pandemic spread worldwide (Sanders et al., 2020). Most people with COVID-19 experience mainly mild to moderate symptoms of respiratory tract disease and heal on their own, while in the elderly and people with chronic diseases (such as diabetes, cancer, respiratory diseases) COVID-19 has tendency to result in complications and septic diseases (World Health Organization, 2020). To date there is no proven anti-viral treatment for COVID-19, therefore the clinical treatment of patients consists mainly of symptom management and oxygen therapy (Cao, 2020). This virus has caused a public health emergency, increasing among other things the demands and pressure on health personnel. Nurses, being at the forefront of coping with such emergencies tend to experience higher levels of occupational stress compared to other occupations (Maben & Bridges, 2020a). Previous studies of the spread of other types of viruses have also identified adverse effects on medical staff, such as "increased stress (acute and post-traumatic)" and psychological disorders (Kisely et al., 2020). The high psychological burden caused by COVID-19 on nurses caring for infected patients has in some cases also resulted in suicide (Kisely et al., 2020).

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Research on the COVID-19 pandemic has so far mainly focused on the epidemiological examination of the disease or its treatment, while a smaller number of studies have addressed the experiences of clinical nurses in their care for persons infected with COVID-19. Such studies are lacking, especially in Kosovo, so this study aims to understand the experiences of clinical nurses at the University Clinical Center of Kosovo (UCCK). UCCK consists of 37 clinics and provides health services for patients with COVID-19 in Kosovo. Four of these clinics: the Infectious Diseases Clinic (CLI), the Pulmonology Clinic (KLP), the Dermatology Clinic (HCJ) and the Neurology Clinic (KLN) have provided services to patients with COVID-19. KLP, HCJ and KLN were put in place to treat patients with COVID-19 in order to cope with the large influx of patients. For the same reason, the UCCK management had also decided that a part of the nursing staff of other UCCK clinics work in these three clinics for temporary periods of time (2-4 weeks).

Identifying the challenges, barriers and needs of nurses in relevant clinics creates opportunities for intervention to improve health services to patients with COVID-19 and potentially increase the efficiency of nurses in treating this disease.

Method

This study is qualitative in nature and is based on the phenomenological method of research. This method is particularly applicable in the fields of medical sciences (Toombs, 2001) and aims to describe and understand the experiences of people who have experienced the phenomenon of study (Dahlberg et al., 2008). Eight (8) clinical nurses from three UCCK clinics (KLI, KLP and HCJ) were interviewed in this study. The selection of informants was based on the purposeful sampling technique. The criteria for the selection of informants were: 1) job position (clinical or ambulatory nurse at UCCK) and 2) work experience in one of the UCCK clinics where patients with COVID-19 were treated. None of the informants were permanent staff in the clinics where COVID-19 patients were treated but were engaged in these clinics for short periods in order to cope with the large influx of infected patients. The age of the informants ranged from 35 to 43 years, while the nursing experience from 1 year to 20 years. Informed consent was provided by participants informing them of the purpose of the research, the procedure and the duration of the interview. The interview lasted between 30-45 minutes and was conducted through the electronic Zoom platform. The electronic platform interview was used in order to avoid exposure to the risk of infection of the participants. The interviews were semi-structured and combined with follow-up questions during the conversation. Informants were asked about their experiences and challenges during the period they served in the respective clinics where COVID-19 patients were treated. Audio recordings were transcribed, and data analyzed based on the phenomenological method of Colaizzi (1978) for data analysis. The data analysis process consisted, among other things, of familiarizing oneself with the data from the interviews, identifying important statements, formulating the meaning of these statements, and grouping the meanings into three thematic categories. Based on Colaizzi (1978) strategy, the findings of this study were presented to half of the participants for validation and to ensure that they represented their descriptions.

Findings and discussion

The analysis of the data of this study identified nine (9) topics which were grouped into three (3) thematic categories: 1) stressors; 2) supporters and 3) nurses’ attitudes towards COVID-19 patients. These findings will be presented and discussed in the following part of the paper.
Stressors

Various studies which have examined the previous outbreaks of various viruses and their effects on health personnel, have shown among others: increased stress (acute and post-traumatic) in health personnel, the presence of psychological disorders (Kisely et al., 2020) depression and somatization (Chen et al., 2005) In the current study, informants highlighted: fear of infection and transmission of the virus; limited staff; lack of working conditions; long hours and contact with patient attendants as the main stressors during their work in the respective clinics.

Fear of infection and transmission of the virus
The data show nurses' concerns about the risk of infection and transmission of the virus to family members. Most of the interviewed informants lived with their families during the period they worked in the respective clinics, therefore the fear of transmitting the virus has been one of their main concerns. Dealing with the COVID-19 virus has been described as an "unknown field" and at high risk. Informant 8 stated:

*My main challenge has been how to deal with this unknown virus... and not transmit the virus to family members. It so happened that I could not sleep all night because of anxiety. Psychologically, this condition is very serious for a nurse.* ...

Informant 4 added: *And fear I am sending the virus home.*
Similar concerns of medical staff about the risk of infection and transmission of viruses to family members have been shown in previous studies (see: Cai, et al., 2020; Khalid et al., 2016). The presence of fear and anxiety is to be expected in such circumstances, given the lack of sufficient information about the virus and media attention to patient deaths.

Limited staff

In the interview, especially those who have worked in the Pulmonology Clinic consider that the number of nurses has been disproportionate to the number of patients admitted. On average, two clinical nurses cared for 20 patients. This has caused nurses to experience physical and mental strain due to high work intensity. They also stated that in some cases the clinics have received outpatient nurses who have not been professionally trained to care for patients with COVID-19, and this has left the entire responsibility for caring for patients falling on the clinical nurses. Informant 4 stated:

*... [We] two nurses had to deal with 18 patients and due to the workload, we did not manage to complete the service properly... but still good because there was a lot of work. I have worked with an outpatient nurse who had no knowledge of the procedures... [therefore] there have been cases where in the night shift from the first patient to the last [30 patients] I should have taken care of them.* Informant 2
Working hours

Most interviewees rated the 12-hour schedule as long and tedious, given the severity of the patients’ illness. Informants said a shorter schedule would make them more effective at work:

... I think the ideal would have been for a nurse to care for those infected with COVID-19 for a maximum of 6 hours. This would be much more effective for nurses. Informant 6

Lack of proper conditions

The study data show a difference between the experiences of the informants who worked in the Infectious Diseases Clinic and those who worked in the other two clinics - the Pulmonology Clinic and the Dermatology Clinic. Informants who worked at KLI were relatively satisfied with working conditions, support received from staff, management and the work environment. These informants also reported a higher level of “sense of security at work” compared to the informants in the other two clinics. Meanwhile, informants from the HJC and the HCJ stressed the lack of basic working conditions, including the lack of protective equipment (gloves, disinfectants, masks) and the lack of an adequate space for clothing and food. Informant 7 said:

... in the Infectious Diseases Clinic, the conditions have been a little better; there were gloves, uniforms and disinfectants ... The moment we went to the Pulmonology Clinic it was a real horror. There were no gloves, no alcohol and we had to keep a pair of clothes for 12-13 hours. Patients have been in a more serious condition [and] the conditions have been terrible ...

Informant 2 added: ... [At the Pulmonology Clinic] there is no certainty. First there are no rooms, no tools [and] no [adequate care options] as in the Infectious Diseases Clinic ... There is no security at all in the Pulmonology Clinic.

One of the possible reasons for these findings may be the fact that KLI is designed and prepared for the treatment of communicable diseases, ranging from protective measures for infectious diseases to the organization of wards and clinics. Limited access to protective equipment, high patient influx, and risk of infection are some of the discouraging factors for nurses ’ work, manifested even in previous cases of public health emergencies (O’Boyle et al., 2006). Further research is needed in order to better understand the reasons for these attitudes of informants in the context of UCCK.

Contact with patients’ relatives / attendants

Another issue that has made the work of nurses difficult, especially in the HJC and the HCJ has been the contact with the attendants / relatives of patients, who according to informants in many cases have not respected the rules of clinics and have endangered their health and the health of nurses. The nurses also stated that in some cases there was a lack of understanding from the attendants / family members, who obstructed the work of the nurses, accusing and offending them for the lack of conditions in the respective clinics. Given the physical and mental overload of nurses in the circumstances and working conditions, the presence and misunderstanding by attendants may have most likely contributed to their discouragement of work:
... I think the family members have been a little incomprehensible; they never left you alone ... in vain [did you explain] that [you were] too busy [they] did not understand. Informant 7

... dealing with family members has been another challenge and burden for us. Informant 5

Supporters

Emotional and professional support are crucial to the performance of clinical nurses and the quality of services they provide to patients. The informants mentioned the family and the assistance of the management staff in the clinics where COVID-19 patients are treated as the main supporters during this period.

Professional help

In the professional aspect, the informants highly appreciated the support received from the management staff in the respective clinics and other clinical nurses who have been working in that period. The informants said that they were helped by the staff of the respective clinics to get accustomed and familiar with the nature of the work. Support and commitment to the physical and mental health of nurses is crucial, especially in cases of health emergencies which produce high levels of stress (Maben & Bridges, 2020). Leadership and support from management can curb stress levels among medical staff, and studies show that comprehensive leadership that provides assistance to medical staff contributes to reducing their psychological anxiety and distress (Zhao et al., 2020).

The support from the team has been great, especially the moral support that we will face together in this challenge. My family has also supported me to the maximum. Informant 5

Emotional help

Informants said that this was a very difficult period for them and mentioned family support as an important factor in their motivation for work.

... My family has supported me to the maximum during this period. Respondent 1

Recognition of contribution

Some of the informants praised the recognition of their dedication and contribution as a positive factor which has motivated them to work even harder. According to the informants, this assessment came from the patients’ relatives / attendants, the management and the citizens in general.

Yes, you feel good ... when patients thank you [and when] people realize that we are giving our best for these patients. Informant 2

Attitudes of nurses towards the care of persons with COVID-19
The study data show a satisfaction of nurses for their dedication and care to patients. On the other hand, the data also show a "feeling of helplessness" to help patients, mainly due to lack of adequate therapy and limited staff. Informants also said they had experienced "feelings of fear" due to the possibility of patients' condition worsening or dying.

**Commitment to patients**

Most nurses expressed that they feel satisfied with their care for COVID-19 affected patients and consider that they have given maximum commitment within their means. However, the nurses expressed that they would not be able to continue working in these clinics for a long time. According to them, the work in these clinics is difficult due to limited staff, long hours, lack of breaks and insufficient working conditions. Informant 8 expressed:

... We tried our best [to take care of the patients]. I can not say that we managed to complete all the services 100%, but 80% yes.

**Feeling powerless**

A feeling of powerlessness to provide enough help to patients with COVID-19 emerged from the data from this study. Nurses highlighted the lack of adequate therapy and limited staff as the main factors of this impotence. Informants described this feeling as a heavy emotional burden for them. Informant 5 said:

When I saw the patient in that serious condition, it was an indescribable feeling for me... when you saw the patient with those symptoms and could not help it, it was a very heavy feeling for me. ... When I offered the patient [medical] help and there was no improvement... I felt very bad. Informant 5

**Anxiety and fear**

The study highlighted a "presence of anxiety and fear" in nurses as a result of the dire situation of hospitalized patients in the respective clinics. The informants described the condition of the patients as very unstable and unpredictable which underwent major changes within a very short time:

It happened that patients were in good condition and got worse for a very short time. Informant 4.

The vast majority of informants said they had not chosen voluntarily and were reluctant to work in clinics where COVID-19 patients were treated. Similar results of nurses' reluctance appear in other studies (see Kim, 2018) who have treated previous viruses of the respiratory system, where as a result of fear and risk of infection the nurses had also considered resignation.

**Conclusions and recommendations**

The data from this study show that the involvement of nurses in clinics where patients with COVID-19 are treated is perceived as troublesome and stressful. The findings of this study highlight a physical and mental overload of nurses, which results from subjective and
objective reasons. Insufficient information about the disease and its treatment, high intensity of work and fear of transmitting the virus to family members has made nurses experience anxiety and fear during the period they have worked in the clinics where patients with COVID-19 have been treated. On the other hand, the lack of protective measures, the lack of proper working conditions and limited staff has made nurses feel endangered and overburdened. The data of this study signal the urgent need for intervention to improve working conditions in clinics where patients with COVID-19 are treated. The findings of this study highlight the need to review the management strategy of the UCCK and relevant clinics. The data also highlight the need to develop a comprehensive strategy that would address the needs of a technical nature and provide psychological and emotional support to nurses. Such a strategy is likely to increase the effectiveness of nurses and improve the quality of health services in UCCK.

Bibliography


Nursing care for the newborn and the mother after childbirth
- Postpartum phase, home care

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Abstract- Childbirth is a joyous event when a woman gives birth to a child she desires. Despite the pain
and embarrassment, childbirth is the long-awaited peak of pregnancy and the beginning of a new life.
However, childbirth is also a critical time for the health of the mother and her baby. The postpartum
phase is an essential period for a mother and her baby. The postpartum period includes a critical
transitional time for a woman, her newborn, and her family, on a physiological, emotional, and social
level.

The postpartum period, or puerperium, begins about an hour after birth and includes the following six
weeks. Postpartum nursing care should respond to the needs of mother and baby during this particular
phase which includes: prevention and early detection, treatment of complications and diseases,
counseling, parental education and breastfeeding services, immunization, maternal nutrition and all other
needs which lead to improved quality of maternal and infant health.

Problems such as postpartum (hemorrhage, pregnancy-related hypertension, pulmonary embolism and
puerperal sepsis, decay of wounds, breast abscess and constipation, and sexual problems) may also be
during this period. Unknown postpartum disorders can lead to physical distress, psychological
distress such as postpartum depression, and a poor quality of life for mothers who, if not treated promptly
and effectively by nursing staff in collaboration with medical staff, may lead to deteriorating health.
Postpartum care indicates the fact that most maternal deaths and disabilities occur during the postpartum
period and that early neonatal mortality remains high, therefore home nursing care remains essential
during this phase.
Key words: Postpartum phase, Nursing care, Home care, Complications, Parental education.

INTRODUCTION

Infant care activities can cause much anxiety for new parents. Support from nursing staff
members can be an important factor in determining whether new parents seek and accept help
in the future. Whether this child is the woman's or the couple's first newborn or an adolescent
whose mother will be the primary caregiver, and whether or not the parents attended
parenthood preparation classes, parents appreciate anticipatory guidance in the care of their
infant. The nurse should avoid trying to cover all the content at one time because the parents
can be over whelmed by too much information and become anxious. Deficient knowledge
should be identified before beginning to teach. Normal growth and development and the
changing needs of the infant (for personal interaction and stimulation, growth milestones,
exercise, injury prevention and social contacts), as well as the topics that follow, should be
included during discharge planning with parents.

Complications in newborns in the postpartum phase:
Sleepy baby - During the first few days of life, some babies need to be awakened for feedings. Parents are instructed to be alert for behavior signs or feeding cues such as rapid eye movements under the eyelids, sucking movements, or hand-to-mouth motions. These signs, when present, indicate a good time to attempt breastfeeding. If the infant is awakened from a sound sleep, attempts at feeding and more likely to be unsuccessful. Unwrapping the baby, changing the diaper, sitting the baby upright, talking to the baby with variable pitch, gently massaging the baby's chest or back, and stroking the palms or soles may bring the baby to an alert state.

Fussy baby - Babies sometimes awaken from sleep crying frantically. Although they may be hungry, they cannot focus on feeding until they are calmed. Parents can swaddle the baby, hold the baby close, talk soothingly, and allow the baby to suck on a clean finger until calm enough to latch on to the breast. Placing the baby skin-to-skin with the mother can be very effective in calming the fussy infant. Infant fussiness during feeding may be the result of birth injury such as bruising of the head or fractured clavicle. Changing the feeding position may alleviate this problem. Persistent crying or refusing to breastfeed can indicate illness, and parents are instructed to notify the health care provider if either circumstance occurs. Ear infections, sore throat, or oral thrush may cause the infant to be fussy and not breastfeed well.

Slow weight gain - Newborn infants typically lose 5% to 10% of body weight before they begin to demonstrate weight gain. Weight loss of 7% in a breastfeeding infant during the first 3 days of life needs to be investigated. After the early milk has transitioned to mature milk, infants should gain approximately 110 to 200 g/week or 20 to 28 g/day for the first 3 months. Health care providers should evaluate and monitor infants who continue to lose weight after 5 days, who do not regain birth weight by 14 days, or whose weight is below the 10th percentile by 1 month. Parents are taught the warning signs of ineffective breastfeeding, including inadequate weight gain, minimal output, and feeding constantly. If any of these warning signs are present, the parent should notify the health care provider.

Jaundice - The type of jaundice most often seen in term newborns is physiologic jaundice. Hyperbilirubinemia is caused by bilirubin levels that rise steadily over the first 3 to 4 days, peak around day 5, and decrease thereafter. This condition has been called early-onset jaundice or breastfeeding-associated jaundice, which in the breastfed infant may be associated with insufficient feeding and infrequent stooling. Colostrum has a natural laxative effect and promotes early passage of meconium. Bilirubin is excreted from the body primarily through the intestines. To prevent early-onset, breastfeeding-associated jaundice, newborns should be breastfed frequently during the first several days of life. Increased frequency of feedings is associated with decreased bilirubin levels. To treat early-onset jaundice, breastfeeding is evaluated in terms of frequency and length of feedings, positioning, latch, and milk transfer. Factors such as a sleepy or lethargic infant or maternal breast engorgement may interfere with effective breastfeeding and should be corrected. Any breastfeeding infant who develops jaundice should be carefully evaluated for weight loss greater than 7%, decreased milk intake, infrequent stooling (less than three to four stools/day by day 4), decreased urine output (fewer than four to six wet diapers/day), and serum bilirubin levels.

Nursing care and education

Dressing and warmth - A room temperature of about 70°F or 21°C is warm enough for the infant. The infant should be dressed as the parents would like to be dressed, with a receiving blanket added. The abdomen should be checked to see if the infant is warm enough. The hands and feet may be slightly cooler than the rest of the body but should not be mottled or blue. The infant's head should be kept warm because many thermal skin sensors are located in the scalp. A hat is appropriate in the infant is outside when it is cold or windy.

Umbilical cord care - The cord is clamped immediately after birth. The goal of cord care is to prevent or decrease the risk of hemorrhage and infection. The umbilical cord stump is an excellent medium for bacterial growth and can easily become infected. The cord clamp is
removed once the stump has started drying and is no longer bleeding, typically in 24 hours. Hospital protocol determines the technique for routine cord care. Common methods include the use of an anti-microbial agent such as bacitracin; some experts advocate the use of alcohol alone, soap and water, sterile water, povidone-iodine, or no treatment (natural healing). A one-time application of triple dye has been shown to be superior to alcohol, povidone-iodine, or topical antibiotics in reducing colonization or infection; the use of alcohol is associated with prolonged cord drying and separation. The stump and base of the cord should be assessed for edema, redness, and purulent drainage with each diaper change. The nurse cleanses the cord and skin area around the base of the cord with the prescribed preparation (e.g., sterile water, erythromycin solution, or triple-blue dye). The stump deteriorates through the process of dry gangrene; therefore odor alone is not a positive indicator of omphalitis (infection of the umbilical stump). Cord separation time is influenced by several factors, including type of cord care, type of birth, and other perinatal events. The average cord separation time is 10 to 14 days. Some dried blood may be seen in the umbilicus at separation. Doctors, midwives, or nurses add up these five factors for the Apgar score. Scores are between 10 and 0. Ten is the highest score possible, but few babies get it. That's because most babies' hands and feet remain blue until they have warmed up.

**Positioning and Holding**—The AAP Task Force on Infant Sleep Position and Sudden Infant Death Syndrome continues to recommend placing the infant in the supine position during the first few months of life to prevent sudden infant death syndrome (SIDS). Anatomically, the baby's flat, flat back allows the baby to rotate sideways in the prone position; therefore the lateral sleeping position is not recommended. When the infant is awake, "tummy time" can be provided under parental supervision so the infant may begin to develop appropriate muscle tone for eventual crawling; this tummy time is also effective in the prevention of a misshaped head (positional plagiocephaly).

**Sponge Bathing and Skin Care**—Bathing serves several purposes. It provides opportunities for (1) completely cleansing the infant, (2) observing the infant's condition, (3) promoting comfort, and (4) parent-child-family socializing. An important consideration in skin cleansing is the preservation of the skin's acid mantle, which is formed from the uppermost horny layer of the epidermis, sweat, superficial fat, metabolic products, and external substances such as amniotic fluid and microorganisms. At birth the skin has a pH of 6.4. Within 4 days the pH of the newborn's skin surface falls to within the bacteriostatic (pH less than 5). Consequently, only plain, warm water should be used for the bath during this 4-day period. Alkaline soaps (such as Ivory) and oils, powder, and lotions should not be used during this time because they alter the acid mantle, thus providing a medium for bacterial growth.

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**Rashes. Diaper rash**—The majority of infants will develop a diaper rash at some time. This dermatitis or skin inflammation appears as redness, scaling, blisters, or papules. The warm, moist atmosphere in the diaper area provides an optimal environment for Candida albicans.
growth; dermatitis appears in the perianal area, inguinal folds, and lower abdomen. The usual source of infection is from handling by persons who do not practice adequate handwashing. It may also appear 2 to 3 days after an oral infection (thrush). Therapy consists of applications of an antifungal ointment, such as clotrimazole or miconazole, with each diaper change.

**Immunizations** - The schedule for immunization should be reviewed with parents. HB vaccine is currently administered to newborns before hospital discharge or within 1 month of birth. Nurses should become familiar with this schedule and should provide written instructions to the parents about when and where to obtain immunization. An infant’s ability to protect him or herself against antigens by the formation of antibodies develops sequentially, therefore the infant must be developmentally capable of responding to these antibodies, which is the reason for planning sequential immunizations for infants.

**KALENDRI I OBLIGUAR I VAKSINIMIT, KOSOVË 2018/2019**

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**Nursing care for the mother** - The postpartum period, or puerperium, begins about an hour after birth and includes the following six weeks. Postpartum nursing care should respond to the needs of mother and baby during this particular phase which includes: prevention and early detection, treatment of complications and diseases, counseling, parental education and breastfeeding services, immunization, maternal nutrition and all other needs which lead to improved quality of maternal and infant health.

Problems such as postpartum (hemorrhage, pregnancy-related hypertension, pulmonary embolism and puerperal sepsis, decay of wounds, breast abscess and constipation, and sexual problems) may also be present during this period. Unknown postpartum disorders can lead to physical distress, psychological distress such as postpartum depression, and a poor quality of life for mothers who, if not treated promptly and effectively by nursing staff in collaboration with medical staff, may lead to deteriorating health. Postpartum care indicates the fact that most maternal deaths and disabilities occur during the postpartum period and that early neonatal mortality remains high, therefore home nursing care remains essential during this phase.

**Diet.** In general, the breastfeeding mother should eat a healthy, well-balanced diet that includes an extra 200 to 500 calories per day over nonpregnant requirements. According to the IOM the estimated energy requirement for lactating woman during the first 6 months is 2700 kcal/day, during the next 6 months estimated energy requirement is 2768 kcal/day. In most cases the woman can consume a normal diet, according to her personal preferences and cultural practices. The ideal diet for lactating mother is well balanced, consisting of nutrient-dense foods. The intake of calcium, minerals, and fat soluble vitamins should be adequate.
Woman may be told to continue taking their prenatal vitamins as long as they are breastfeeding. Mothers are encouraged to drink to quench thirst. Consumption of water by the mother does not increase milk supply, and overhydration can actually decrease milk production. **Weight loss** - Medications or diet that promote weight loss are not recommended for breastfeeding mothers. Many women will experience a gradual weight loss while lactating as fat stores deposited during pregnancy are used. This factor can be added incentive for breastfeeding. Another potential consequences of weight loss is reduced milk production. For most women, weight loss of 1 to 2 kilograms is safe, however, if weight loss exceeds this amount, careful evaluation of infant weight and feeding pattern is recommended.

**Rest** - The breastfeeding mother should rest as much as possible, especially in the first 1 or 2 weeks after birth. Fatigue, stress, and worry can negatively affect milk production and milk ejection (let-down). The nurse can encourage the mother to sleep when the baby sleeps. Breastfeeding in a side-lying position promotes rest for the mother. Assistance with household chores and caring for other children can be done by the father, grandparents or other relatives, and friends.

**Breast care.** The breastfeeding mother's normal routine bathing is all that is necessary to keep her breasts clean. Soap can have a drying effect on nipples; therefore the mother should avoid washing the nipples with soap. Breast creams should not be used routinely because they may block the natural oil secreted by the Montgomery glands on the areola. Modified lanolin with reduced allergens is safe to use on dry or sore nipples. Lanolin can be beneficial in moist wound healing of sore nipples. The breastfeeding mother may experience some common problems. In the majority of cases, these complications are preventable if the mother receives appropriate education about breastfeeding. Early recognition and prompt resolution of these problems is important to prevent interruption of breastfeeding and to promote the mother's comfort and sense of well-being. Emotional support provided by the nurse or lactation consultant is essential to help allay the mother's frustration and anxiety and to prevent care cessation of breastfeeding. Engorgement is response of the breasts to the sudden change in hormones and the onset of significantly increased milk volume. It usually occurs 3 to 5 days after birth when the milk "comes in" and lasts approximately 24 hours. The breasts are firm, tender, and hot and may appear shiny and taut. The areolae are firm, and the nipples may flatten, creating difficulty for the infant in latching on to the breast. Because back pressure on full milk glands inhibits milk production, if milk is not removed from the breasts, the milk supply may diminish. When engorgement occurs, it is a temporary condition that is usually resolved within 24 hours. The mother is instructed to feed every 2 hours, softening at least one breast, and pumping the other breast as needed to soften it. Pumping during engorgement will not cause a problematic increase in milk supply. Because of the swelling of breast tissue surrounding the milk ducts, ice packs are recommended in a 15 to 20 minutes on, 45 minutes off rotation between feedings. The ice packs should cover both breasts.

**Teaching Feeding Techniques Position of the Mother and Infant.** Both the mother and the infant must be positioned properly for optimal breastfeeding. Make the mother as comfortable as possible before she begins to nurse. Provide pain medications, if necessary. Pain or an awkward position may interfere with the let-down reflex and cause her to tire. To increase her comfort, use pillows behind the mother's back, over an abdominal incision, and to support her arms. Her shoulders should be relaxed, and she should not be in a hunched position. Arrange folded blankets or pillows to elevate the infant to the level of the nipple and to prevent pulling and tension on the nipple, which would cause it to become sore. The infant's head and body should directly face the breast with the infant's nose, cheeks, and chin lightly touching the breast. If the infant must turn the head to reach the breast, swallowing is difficult. The neck should be flexed because hyperextension also makes swallowing difficult. The mother's hand position is also important. The palmar or C hand position is most often taught to new mothers. The mother holds her breast with her thumb on top and her fingers under the breast. Her little finger is against the chest wall and the other fingers provide support to the breast. Her fingers should be behind the areola and her thumb should not press on the breast.
enough to make the nipple tip upward, or the infant will suck improperly and the nipple may become sore. Some women use the "scissors hold" or "V" hold. The woman uses her index and middle fingers to support the breast. She must be careful to place her fingers well behind the areola so her fingers do not slip down the wet areola and interfere with the placement of the infant's mouth. The mother should support her breast in place for the first few weeks.

**Latch-On Techniques.** Teach the mother techniques to help the infant latch on to the breast. The infant should be awake and hungry. Talking and cuddling can help a sleepy infant awaken and calm an upset infant. **Position of the Mouth.** Assess the position of the infant's mouth on the breast. The nipple and at least 2.5 to 3.8 cm (1 to 12 inches) of the areola should be in the infant's mouth to allow the nipple to be drawn toward the back of the mouth. This prevents the infant from sucking on the nipple only, which leads to sore nipples and insufficient milk production. **Suckling Pattern.** Teach the mother about the infant's suckling pattern. During nutritive suckling the infant sucks with smooth, continuous movements with only occasional pauses to rest. The infant may swallow after each suck or may suck several times before swallowing. Nonnutritive sucking often occurs when the infant is falling asleep. **Frequency of Feedings.** Breast milk moves through the stomach twice as fast as formula (Blackburn, 2007). Therefore infants are usually breastfed every 2 to 3 hours. Frequent feedings are especially important in the early days after birth, while lactation is being established and stomach capacity is small. Long periods between feedings increase the likelihood of breast engorgement. The resulting decreased stimulation of prolactin may reduce milk supply. Generally, the mother should nurse 8 to 12 times in each 24-hour period. Some infants vary the length of feedings and time between each feeding. **Length of Feedings.** Although early feedings were once limited to only a few minutes per breast to prevent sore nipples, improper positioning, rather than time at breast, is the usual cause of nipple trauma. When feedings are too short, infants receive little or no colostrum or milk. It may take as long as 5 minutes for the milk-ejection (let-down) reflex to occur during the early days after birth. Generally, mothers can allow infants to set the length of feedings. The infant should suckle vigorously for a period of time. **Feeding patterns with formula milk.** In the first 24 to 48 hours of life a newborn will typically take 10 to 15 ml of formula at a feeding. Intake gradually increases during the first week of life. Most newborns are drinking 90 to 150 ml at a feeding by the end of the second week, or sooner. The newborn infant should be fed at least every 3 to 4 hours, even if waking the newborn is required for the feedings; rigid feeding schedules, however, are not recommended. **Feeding technique.** Parents who choose formula feeding often need education regarding feeding techniques. Infants should be held for all feedings. During feedings, parents are encouraged to sit comfortably, holding the infant closely in a semi upright position with good head support. Feedings provide opportunities to bond with the baby through touching, talking, singing, or reading to the infant. Parents should consider feedings as a time of peaceful relaxation with the infant. A bottle should never be propped with a pillow or other inanimate object and left with the infant. This practice may result in choking, and it deprives the infant of important interaction during feeding. Teach parents to look for these cues and avoid overfeeding, which can contribute to obesity. Most infants swallow air when fed from a bottle and need a chance to burp several times during a feeding. Parents are taught various positions that can be used for burping. **Bottles and nipples.** Various brands and styles of bottles and nipples are available to parents. Most babies will feed well with any bottle and nipple. The bottles and nipples should be washed in warm soapy water, using a bottle and nipple brush to facilitate thorough cleansing. Boiling of bottles and nipples is not necessary unless some question exists about the safety of the water supply or if the infant has oral thrush.

**Complications in mothers after childbirth** can be numerous and requires close cooperation with the doctor in the rehabilitation of the woman. Complications that may occur are: Postpartum Hemorrhage (PPH), Hypertensive Disorders in Pregnancy (HDP), Obstetric Pulmonary Embolism, Puerperal Sepsis, Heart Disease, Depression, Anemia, Fatigue, Headache, Back Pain, Perineal Trauma, Urinary problems, Urinary Tract Infection (UTI), Wound rupture (in cesarean births), Constipation, Hemorrhoids. All these problems need proper consultation from the specialist and we as nurses should do nursing care by
administering the therapy given by the specialist improving the woman's health and quality of life.

Also other problems can be breast problems, where many problems appear and they are: Sore nipples, Monilial infections, Plugged milk ducts, Mastitis. So in cooperation with the doctor we can treat these problems by doing the right treatment in the administration of therapy and breast care so that the mother breastfeeds the baby. For sore nipples and plugged milk ducts the nurse should advise the mother to use fresh leaves and raw cabbage placed on the breasts can help reduce swelling. Cabbage leaves are washed, cooled in the refrigerator, and then placed on the breasts for 15 to 20 minutes. This treatment can be repeated for two or three sessions. Then washing with hot water helps a lot in freeing the milk ducts, also breast massage gives a very good effect. For sore nipples, it is advisable for mothers not to use different creams but to keep them clean by often washing them with water and massaging them with their milk.

**POSTPARTUM PSYCHOLOGIE COMPLICATIONS.** Mental health disorders have implications for the mother the newborn, and the entire family. Such conditions interfere family integration and some may threaten the safety and well-being the mother, newborn, and other children. Mood Disorders. Mood disorders are the predominant mental health disorder in the postpartum period, typically occurring within 4 weeks of childbirth. Many women experience a mild depression, or "baby blues," after the birth of a child. Others can have more serious depressions that can eventually incapacitate them to the point of being unable to care for themselves or their babies. Nurses are strategically positioned to offer differ anticipatory guidance, to assess the mental health of new mothers, to offer therapeutic interventions, and to referring when necessary. Failure to do so may result in tragic consequences. The Diagnostic and Statistical Manual of Mental Disorders contains the official guidelines for the assessment and diagnosis of psychiatric illness. However, specific criteria for postpartum depression (PPD) are not listed. Instead, postpartum onset can be specified for any bursts helps like his mood disorder either without psychotic features (i.e., PPD) or with psychotic features (i.e., postpartum psychosis) if the onset occurs within 4 weeks of childbirth (APA). **Postpartum depression with psychotic features.** Postpartum psychosis is a syndrome most often characterized by depression (as described previously), delusions, and thoughts by the mother of harming either the infant or herself. A postpartum mood disorder with psychotic features occurs in 1 to 2 per 1000 births and may occur more often in primiparas. Once a woman has had one postpartum episode with psychotic features, a 30% to 50% likelihood of recurrence exists with each subsequent birth. Symptoms often begin within days after the birth, although the mean time to onset is 2 to 3 weeks and almost always within 8 weeks of birth. Characteristically, the woman begins to complain of fatigue, insomnia, and restlessness and may have episodes of tearfulness and emotional lability. Complaints regarding the inability to move, stand, or work are also common. Later, suspiciousness, confusion, incoherence, irrational statements, and obsessive concerns about the baby's health and welfare may be present. Delusions may be present in 50% of all women with this disorder and hallucinations in approximately 25%. Auditory hallucinations that command the mother to kill the infant can also occur in severe cases. When delusions are present, they are often related to the infant. The mother may think the infant is possessed by the devil, has special powers, or is destined for terrible fate. Grossly disorganized behavior be exhibited as a disinterest in the infant or an inability to provide care. Some women will insist that something is Wrong with the baby or accuse nurses or family members of hurting or poisoning him or her. A specific illness included in depression with psychotic features is bipolar disorder. **Medical management.** A favorable outcome is associated with a good premorbid adjustment (before the onset of the disorder) and a supportive family network. Because mood disorders are usually episodic, women may experience another episode of symptoms within a year or two of the birth. Postpartum psychosis is a psychiatric emergency, and the mother will probably need psychiatric hospitalization. Antipsychotics and mood stabilizers such as lithium are the treatments of choice. If the mother is breastfeeding, some sources advise caution while prescribing some agents. Antipsychotics and lithium should be avoided in breastfeeding mothers, but other mood stabilizers may be compatible with breastfeeding. Having contact
with her baby is usually advantageous for the mother if she so desires, but visits must be closely supervised. Psychotherapy is indicated after the period of acute psychosis is past. CARE MANAGEMENT - Even though the prevalence of PPD is fairly well established, it often remains undetected because women are hesitant to report symptoms of depression even to their own health care providers. **Nursing Interventions** - Nursing care in the postpartum period assesses for any signs of boredom and makes fun assessments as needed. PPD must be discussed by nurse to prepare new parents for potential problems in the postpartum period. The family must be able to recognize the symptoms and know where to go for help. Written materials that explain what the woman can do to prevent depression could be used as part of discharge planning. Mothers are often discharged from the hospital before the blues or depression occurs. If the postpartum nurse is concerned about the mother, a mental health consultation should be requested before the mother leaves the hospital. Routine instructions regarding PPD should be given to the person who comes to take the woman home; for example, "If you notice that your wife (or daughter) is upset or crying a lot, please call the postpartum care provider immediately - don't wait for the routine postpartum appointment. NURSING ALERT - Because the newborn may be scheduled for a checkup before the mother's 6-week checkup, nurses in well-baby clinics or pediatrician offices should be alert for signs of PPD in new mothers and be knowledgeable about community referral rescue. **PATIENT INSTRUCTIONS FOR SELF-MANAGEMENT** - Activities to Prevent Postpartum Depression • Share knowledge about postpartum emotional problems with close family and friends. • Take care of yourself: Eat a balanced diet, exercise on a regular basis, and get enough sleep. Ask someone to take care of the baby so that you can get a full night's sleep. • Share your feelings with someone close to you; do not isolate yourself at home. • Do not overcommit yourself or feel as though you need to be a superwoman. • Do not place unrealistic expectations on yourself. • Do not be ashamed of having emotional problems after your baby is born, it happens to approximately 15% of women.

**The room of the mother and the newborn**

It is recommended that the room be clean and well ventilated, have a normal temperature of 21°C, be well lit by sunlight, because they are very important for the baby, especially in preventing the appearance of physiological jaundice.

The sheets and covers should be well washed and without the placement of any scented shampoo as it may cause allergies in the baby. Room visits should be avoided as much as possible as the baby is very sensitive and at risk of getting an infection, considering these days the Covid 19 virus pandemic is also prevalent, so visits should be reduced. It is also preferable that the room does not contain fragrant odors and also that there are no flowers placed in vases as it may cause allergies in the baby and mother.

All this information should be given by the nurse in order to prevent various infections that may be inside the room where the mother and baby are staying. Our task as health care educators is to prevent, treat and care, us properly as nurses and health educators at the same time.

**PURPOSE OF THE STUDY**

- Through this paper to create a program for care for children and mothers after childbirth, because one is missing in Kosovo.
- How should we as nurses counsel, care and educate young mothers in coping with the postpartum phase.
• With nursing care to create good health well-being, good quality of life and help in coping with every complication that the mother and the newborn have during the postpartum phase.

**HYPOTHESIS**

• Many mothers in the postpartum stage have many problems and complications in which they have difficulty going through them alone.
• Nursing care in collaboration with other medical staff are the factors that would affect the improvement of the quality of health of mother and child during the postpartum phase.

**LIMITATIONS**

Our paper had a limitation, and that is the failure to do statistical research, where we would have surveyed mothers after discharge from the hospital for all their needs in the postpartum phase, due to the outbreak of the Covid 19 virus pandemic, and we have not been able to do statistical research. But our paper is based on the current situation in Kosovo and seeing the need for new mothers who need special care, we have come to the conclusion that through this paper to take more seriously the postpartum phase from local institutions and start having a program where all mothers would be supported during this rather complicated period.

**DISCUSSION AND CONCLUSION**

The puerperium is an important period for post delivery mothers. Many complications following delivery can occur during this period up to six weeks postpartum. Unrecognized postpartum disorders can lead to physical discomfort, psychological distress, low self esteem and poor quality of life for the mothers. It is the duty of health care workers to provide quality postnatal care and to be able to identify the problems earlier so that proper intervention can be initiated. With good health care support, hopefully most mothers will be able to achieve full recovery to the pre pregnancy state sooner. A special phase involves special needs. Only scanty research data are available on the needs of women and babies in the postpartum period. Partly based on the data in the literature, results the needs of women and infants as follows:

In the postpartum period women need:

- information/counselling on care of the baby and breastfeeding, what happens with and in their bodies - including signs of possible problems, self care - hygiene and healing, sexual life, contraception, nutrition
- support from health care providers, partner and family – in the emotional and psychological shape, health care for suspected or manifest complications, time to care for the baby, help with domestic tasks, maternity leave, social reintegration into her family and community, protection from abuse/violence.

Women may fear: inadequacy, loss of marital intimacy, isolation, constant responsibility for care for the baby and others.

Newborn infants need: easy access to the mother, appropriate feeding, adequate environmental temperature, a safe environment, parental care, cleanliness, observation of body signs by somebody who cares and can take action if necessary, access to health care for suspected or
manifest complications, nurturing, cuddling, stimulation, protection from disease, harmful practices, abuse/violence, acceptance of sex, appearance, size, recognition by the state (vital registration system).

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‘Department of Maternal, Newborn, Child and Adolescent Health’ (no date).


Nursing care in patients with corneal inflammation

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Abstract - There are two types of keratitis, the one which includes substance loss (ulcer) and the one where the inflammation process develops in deep layers without epithelium damage (keratitis stromalis or parenchimatosa).

Common signs for all the types of keratitis are:
- ocular pain that is intensified during the movement of palpebra on cornea.
- photophobia, it occurs from the painful contraction of the inflamed iris,
- decrease on sight sharpness, and
- watering

According to etiology, keratitis is divided into bacterial, viral, mitotic, allergic and trophic keratitis. According to this study, masculine gender is much more affected with 41 cases in total or 68.33%, then comes female gender with 19 asesor 31.67%.

In the data regarding age, it is noticed that the most likely groups to be attacked are those of 60-79 years old, with 20 cases in total, 12 males and 8 females.
It is also worth mentioning that there were 4 patients with elongated hospitalization, 3 males and 1 female, who stayed in the hospital in the period 29-35 days. In order to have a desirable success, certainly the nurse should have an ethical and professional approach toward the patient. There is a great psychological difference in the patients’ attitude towards their disability regarding what we are dealing with: whether it is a born or gained disability.

Key words: cornea inflammation, gender, group-age, hospitalization, ethical approach
INTRODUCTION

ORGANUM VISUS (OCULUS) - The organ of the first eye is a pair of organs located in the orbital cavity (orbit).(1)

It consists of: -the eyeball (globe),
- the first nerve and
- the auxiliary organs of the eye.

Auxiliary parts of the eye are:
- eyelids,
- conjunctiva,
- tear glands,
- eyebrows,
- eyelids,
- eyes muscles. (2)

Sight is our main sensation, 70% of all sensory receptors in the body are found in the eye and almost half of the cerebral cortex is involved in some aspects of visual information processing. The visual receptor cells (photoreceptors) "capture" and encode the features of the light that enters the eye, while the brain "understands" these signals.

The eye is a sphere about 2.5cm in diameter. Only a part of its anterior surface is visible. The remaining part is wrapped and protected by a fatty cushion and the bone walls of the orbit.

The eye has a complex structure. Only a small part of its tissue really deals with photoreception. (4)

Receptors inform us about: -The shape, size, color, distance, and movement of the objects around us. From this it is concluded that the eye is a distance analyzer.

The cornea together with the sclera forms the outer covering of the eye (tunica fibrosa oculi). Also together with the sclera it gives shape and firmness to the pupil of the eye. And it has a special role in the optical system of the eye. It has a spherical shape with a horizontal axis of 11-11.5mm. The vertical axis is about half a millimeter shorter. In essence the cornea with its shape forms part of the ball with a radius of about 7.5 mm.

The thickness of the cornea is around 0.6mm. Its sharpest part of the vertex corneae is thinner, offering the sclera the thickness gradually increases so that in the limbus the thickness is close to 1 mm. The cornea is translucent and has a constant amount of water. The cornea histologically consists of 5 layers.

Keratitis is divided into those with loss of substance (ulcerative) and those where the inflammatory process develops in depth without damage to the epithelium (keratitis stromalis or parenchimatosa).

According to the etiology are divided into bacterial keratitis (pneumococcus, pyocyaneus, staphylococcus), viral keratitis (herpes simplex, herpes zoster opthalmicus, vaccinia), mycotic keratitis, allergic keratitis (keratitis maginalis, keratitis phlyctenular keratitis and keratitis neuritis), keratitis and lagophthalmos.

**Common signs for all types of keratitis are:**
- ocular pain that increases during the movement of the eyelids over the cornea,
- photophobia, occurs from painful contraction of the inflamed iris,
- reduction of image sharpness, and
- watering.

**The Importance of Nursing Care**

The role of the nurse is in the best, in the first place informing the patient by responding to the interventions they make if they exist, then it has the characteristics of relief, support and supervision of the patient.

Drops and ointments have a role to play in both treatment and service, as well as in maintaining eye hygiene, as well as their application and straightening.

Eye drops are the responses of sterile fluids, which are dosed in droplets. The drops sometimes have no herb or medicine but only serve to rinse the eye and can be used as a tear replacement. The drops are applied to the conjunctival sac and cornea. The amount of eye drops is up to 10 grams, while they will be selected for eye rinsing (collyria), applied in larger quantities.

Depending on the disease being cured, the drops may meet antibiotics and steroids (dexamethasone). The drops have fewer medical risks or effects than more with the application for oral.

Plan and care when using your points:
- environment and the patient are prepared,
- the necessary material is prepared,
- the patient is explained how to use the points,
- adjusts the proper position of the patient,
- aseptic measures are observed.

The most common reasons for applying drops or ointments on the eyes are cases of: dryness, redness, itching, allergies, swelling.

**Educating the patient about the correct application of eye drops includes the following steps:**

- wash your hands,
- do not touch the part where the drops come out,
- lift your head back, so that the drops stay in the eye and pull the lower eyelid near your nose to form a groove,
- keep your eyes open
- clean the eye from secretions (if are present) with a gas moistened with physiological sol. passing the gas from the inner corner to the outer corner of the eye,
- keep the point bottle away from the eye so that the bottle does not touch the eye, and then squeeze,
- pour the described amount of drops in the "groove"
- close your eye for a moment, and then open and close your eyes a few times to disperse the drops in the eye,
- Excess fluid should be removed with a sterile gauze but with extra care when the patient wears glasses, artificial eyes or contact lenses.
Depending on the etiology that causes the disease or inflammation of the cornea we also have specific treatment.

**PURPOSE OF THE STUDY**

The aims of this research are to analyze the presence of corneal inflammations in Kosovo during a certain period of time.

- How much do these numerical data change over the years,
- Which gender is most affected by these inflammations,
- What is the most attacked age group and
- How long have patients stayed in the hospital until complete recovery or discharge at home.

**HYPOTHESIS**

- Inflammation of the cornea is rare in Kosovo.
- Treatment of corneal inflammations is long.

**MATERIALS AND METHODS**

This retrospective research includes data which are taken from the protocol of the Ophthalmology Clinic, UCCK to the final annexes from January 2010 to December 2013.

The working method is descriptive-quantitative, and statistical analysis of data is used as a method for the most clear and concise presentation of this numerical information.

**RESULTS**

<table>
<thead>
<tr>
<th>Gender</th>
<th>F</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>19</td>
<td>31.67%</td>
</tr>
<tr>
<td>Male</td>
<td>41</td>
<td>68.33%</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100%</td>
</tr>
</tbody>
</table>

Participation in this research consists of a total of 60 patients, over a period of 4 years, of which 41 men or 68.33%, and 19 women or 31.67%.

*Table 1. Total number of cases by gender.*
Graph 1. Presentation in the diagram of cases by gender

Age group of patients with corneal inflammation

According to the research in question, the age group most affected by corneal inflammation is the age group 60-79 years with a total of 20 cases, followed by the male gender with a total of 12 cases, followed by the female gender with 8 cases.

The age group 40-59 years, based on the findings of the research, follows the second with a total of 13 cases, of which we have 10 men and 3 women diagnosed with corneal inflammation.

Then, according to statistics, comes the age group of 20-39 years with a total of 12 cases, of which 9 males and 3 females.

Next comes the age group 0-19 years with a total of 9 cases, where we have 6 males and again 3 females.

And finally the age group least attacked with inflammation of the cornea, age group 80+, with a total of 6 cases.

<table>
<thead>
<tr>
<th>Age group</th>
<th>F</th>
<th>M</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>20-39</td>
<td>3</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>40-59</td>
<td>3</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>60-79</td>
<td>8</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| 80+ | 2 | 33% | 4 | 67% | 6 | 100%
| Σ   | 19 | 32% | 41 | 68% | 60 | 100%

Table 2. Tabular data of patients with corneal inflammation, in the period: 01.01.2010-31.12.2013 (4 years), by age group and gender.

Graph 2. Presentation in the diagram of cases by age group female, male.

Presentation of cases according to the days of hospital stay

Based on the research results the treatment of corneal inflammation is quite long.

1-7 days of hospitalization had the largest number of patients, a total of 28 patients. Of them, the male gender leads with 23 patients or 82%, followed by the female gender with 5 patients or 18%.
There were patients with even longer hospital stays and a total of 8-14 hospital days. Here, too, the male gender leads with 12 patients or 57%, followed by the female gender with 9 patients or 18%.

Characteristic of this research is that 15-21 days and 29-35 days, there was the same number of patients with a difference in terms of gender, and from 4 patients for 15-21 days (2 females and 2 males), and 4 patient (3 males and 1 female) for 29-35 days of stay which is also the longest day-stay of patients in this research.

While 22-28 days of hospitalization had only 3 patients, and only here the female gender leads with 2 patients or 67%, followed by the male gender with only 1 patient or 33% of this time period.

<table>
<thead>
<tr>
<th>Hospital Days</th>
<th>F</th>
<th></th>
<th>M</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>1-7</td>
<td>5</td>
<td>18%</td>
<td>23</td>
<td>82%</td>
<td>28</td>
</tr>
<tr>
<td>8-14</td>
<td>9</td>
<td>43%</td>
<td>12</td>
<td>57%</td>
<td>21</td>
</tr>
<tr>
<td>15-21</td>
<td>2</td>
<td>50%</td>
<td>2</td>
<td>50%</td>
<td>4</td>
</tr>
<tr>
<td>22-28</td>
<td>2</td>
<td>67%</td>
<td>1</td>
<td>33%</td>
<td>3</td>
</tr>
<tr>
<td>29-35</td>
<td>1</td>
<td>25%</td>
<td>3</td>
<td>75%</td>
<td>4</td>
</tr>
<tr>
<td><strong>∑</strong></td>
<td><strong>19</strong></td>
<td><strong>32%</strong></td>
<td><strong>41</strong></td>
<td><strong>68%</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

Table 3. Presentation of cases by days of hospital stay.

Graph 3. Presentation of data by days of hospital stay.
DISCUSSION AND CONCLUSION

In this research that covers the period of four years (01/01 / 2010 - 31 /12/2013), participated a total of 60 patients, which can be concluded that fortunately these inflammations are not so common in our country. According to the research, the male gender is significantly more affected with a total of 41 cases or 68.33%, followed by the female gender with 19 cases or 31.67%.

In the age data it is noticed that the most attacked age groups are those 60-79 years old with a total of 20 cases, of which 12 males and 8 females. But also the age groups 40-59 and 20-39 years have a presence of infl. of the cornea where we have 13 respectively 12 cases for each age group, and in both age groups the male gender leads. It is worth noting that even young people are not unaffected by these inflammations, since the age group 0-19 years in the research comes out with a total of 9 cases, of which 6 males and 3 females. So even here the male gender leads.

But the age group 80+ does not remain unaffected, because the research has shown that 6 cases were at this age, of which 4 men and 2 women. The research also showed results in terms of patients staying in the hospital on certain days. The largest number of patients stayed in the hospital for a period of 1-7 days, a total of 28 patients, of which 23 men and only 5 females. Even in the longest period of time 8-14 days there were patients who stayed in the hospital environment a total of 21, of them 12 males and 9 females. It is worth mentioning that 4 patients had the longest stay in the hospital, of which 3 males and 1 female, who stayed in the hospital in the period of 29-35 days.

In order for the nurse to have the desired success, there must be an ethical and professional approach to the patient.

There is a big psychological difference in patients' attitudes towards their disability in relation to what we are dealing with: congenital or acquired disability. Insisting on spiritual values as enduring human goods, this is also the goal of any psychological-ethical work with disabled people.

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