

Family Support Improving Quality Of Life Leprosy Patients

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ABSTRACT

Background: Leprosy is a chronic disease caused by bacteria that attack the skin, peripheral nerves, in patients with type Lepromatosa attack the upper respiratory tract. Support from the family will increase the confidence of individuals to interact with others and motivate themselves in building a positive relationship. The purpose of this study was to explain the relationship of family support to the quality of life of leprosy patients in Leprosy Hospital Kediri.

Methods: Research design was correlational. Respondents in the research of leprosy patients who fulfilled inclusion criteria were 63 respondents using purposive sampling. Variable of this research was family support and quality of life. Instrument using questionnaire data analysis sheets using Spearman Rho ($\alpha = 0.05$).

Results: From this research, it was found that more than 50% of family support for leprosy patients had moderate family support that was 43 respondents (68.3%) and at most quality of life in enough category that were 31 respondents (49.2%) and the data analysis using Spearman's Rho test obtained $p = 0.036$ then H_1 accepted and H_0 rejected which meant there was a relationship of family support with quality of life with Correlation Coefficient $r = -0.265$ which meant that the relationship between the two variables was family support with quality of life had weak power, so family support related to the quality of life of leprosy patients.

Conclusions: Patient who has family support, has good quality of life. The conclusion of this study obtained leprosy patients with good family support will improve the quality of their life

INTRODUCTION

Leprosy is a chronic infectious disease, and the cause is intracellular obligate *Mycobacterium Leprae*. The parifer nerve as the first affinity, then the skin and mucosa of the upper respiratory tract, then can go to other organs except the central nervous system (Djuanda Adhi 2010 in Amin and Hardhi, 2015). The problem of leprosy which is very complex related to the lives of leprosy clients that occurs physically, psychologically, and socially in the community requires a comprehensive treatment. The physical problem of leprosy is related to the presence of lesions on the skin and leprosy patients also experience physical disabilities, stigma, labeling, and social discrimination so that it can affect the quality of life of leprosy patients (Susanto, 2013). Leprosy client disability conditions are also generally caused by the search for health

services by leprosy clients and wrong families such as the use of traditional medicine and interactions with health service interventions in the treatment of leprosy (Nicholls 2002 in Susanto's book, 2013). Lack of knowledge in the community and incorrect belief in leprosy have resulted in people still afraid of leprosy until now (Kemenkes RI 2010 in Susanto's book, 2013). Psychological and physical changes in leprosy patients will cause a decrease in quality of life.

The incidence rate of leprosy in the world according to WHO in 2011 was detected 192,246 people, which previously in 2010 there were 228,474 people affected by leprosy. The Southeast Asia region ranks first out of five WHO regions, with a total number of leprosy sufferers totaling 113,750 people (WHO2011 in Susanto's book, 2013). Indonesia as one of the regions in Southeast Asia, ranks third in the world after

the three most causes of injuries include falls (62.3%), land transportation accidents (24, 1%) and sharp / blunt object injuries (17.6%). The percentage of injuries to affected parts of the head in Kediri Regency was 16.2% and in Kediri City was 11%. According to the medical records of the Kediri Baptist Hospital in December 2015 to February 2016 of 37 adult patients suffering from minor head injuries (CKR) nursing problems that often arise and are actual in patients with minor head injuries (CKR) are pain associated with tissue trauma and secondary muscle spasm reflex. occur more heavily in only 1 in 1,000 pregnancies (Mitayani, 2009).

Head injury occurs due to a forced rash (trauma) that afflicts the structure of the head so that it can cause structural abnormalities and functional disorders of the brain, (Bararah and Jauhar, 2013). In head injury patients who may experience head damage namely the skin, skull and brain, (Octavian, 2014). As a result of brain hemorrhage will affect vascular pressure, where vascular pressure causes arterial blood vessels to contract, (Musliha, 2010). So that it can cause pulmonary edema and pulmonary vasoconstriction there is a decrease in CBF (cerebral blood fluid) causing brain edema resulting in brain death (ischemic) and high intra-cranial pressure (ICT), (Bararah and Jauhar, 2013). In head injury patients there is an increase in intracranial pressure (ICT) with clinical signs of headache, dizziness and vomiting, (Muttaqin, 2011). Minor head injury cases with a classification of Gasglow Coma Scale (GCS) 13-15, amnesia <30 minutes, no secondary trauma, (Kristanty, et.al, 2009). If what happens to the patient is not treated, including mild disorientation, post-traumatic amnesia, temporary memory loss, headaches, nausea and vomiting, vertigo in position changes, hearing loss. Nursing problems that often arise in mild head injury (CKR) are pain associated with tissue trauma and secondary muscle spasm reflexes. In patients with mild head injury (CKR) if the pain nursing problem is not treated immediately it will have an impact on other problems such as increased intracranial pressure (ICT), disturbed breathing patterns, and inadequate nutrient intake.

The role of nurses in the provision of Professional Nursing Care in patients with mild head injury (CKR) with nursing problems discomfort pain pain associated with tissue trauma and secondary muscle spasm reflexes is to perform independent nursing actions guided guided

imagery relaxation techniques that are expected to reduce pain. According to Muttaqin (2011), management includes providing explanations and helping clients with nonpharmacological and non-invasive pain relievers, teaching relaxation: techniques to reduce skeletal muscle tension, which can reduce pain intensity, teach methods of distraction during acute pain, provide the opportunity for rest when pain, increase knowledge about the causes of pain and connect how long the pain will last, observe the level of pain and motor response of the client, 30 minutes after administration of analgesic drugs to assess its effectiveness. According to (Tamsuri, 2012), besides that a very important thing done by nurses is to have the competence of how to manage pain with guided imagery relaxation techniques in mild head injury patients, especially in fulfilling the need for a comfortable feeling of headache by encouraging patients to do relaxation of guided imagery because it can reduce pain through various mechanisms such as headaches can be relieved by helping clients visualize pleasant experiences.

MATERIALS AND METHODS

The research subjects in this case study consisted of 2 patients with minor head injuries, the two patients who were the subjects of the study were adult patients who experienced headache nursing problems associated with increased intracranial pressure. These two patients will henceforth be called Respondent I and Respondent II.

Data collection was carried out for 2 days. Respondent I and Respondent II began on May 13-15, 2016 with a diagnosis of Minor Head Injury. Research data collection consists of collecting General Data (Demographic Data of respondents and families) and collecting Special Data consisting of assessment, nursing diagnoses, interventions, implementation and evaluation. Assessment data includes history of current disease, history of past illnesses, results of physical examinations, results of laboratory examinations and other supporting data results. The assessment can be done by IPPA (Inspection, Palation, Percussion and Auscultation). Nursing diagnoses include the determination of the nursing problem (problem), etiology and symptom (symptom). The implementation implementation data is documented according to the hours of the documentation implementation and is evaluated at each completion of the action. Patient development data are evaluated daily and documented in progress notes.

RESULTS

Theme 1 Assessment

Table 1 Data Analyze

Resp	Data Gayut	Masalah	Penyebab
1	<p>Data Subyektif : Pasien mengatakan nyeri kepala berdenyut dibagian kepala dan tengkuk dengan skala 5 tidak berkurang sejak tadi tetap nyeri berbaring maupun duduk.</p> <p>Data Obyektif : 1) Wajah tampak menyeringai menahan nyeri 2) Pasien tampak gelisah 3) Pasien memegang kepala dan leher 4) Pasien tampak berhati-hati dalam merubah posisi 5) Terdapat nyeri tekan pada kepala dan leher. 6) Hasil tanda-tanda vital S : 37° C P : 80 x / menit N : 20 x / Menit TD :100/60 mmHg</p>	Nyeri Akut	Trauma jaringan dan reflek spasme otot sekunder
	<p>Data Subyektif: Pasien mengatakan ada luka jahitan didagu serta memar didahi, pipi kanan dan bibir</p> <p>Data Obyektif : 1) Terdapat luka robek, Vulnus apertum dagu ± 2 cm tertutup kasa bersih. 2) Terdapat hematoma di dahi, pipi kanan dan bibir bagian atas dan bawah 3) Tidak terdapat tanda dan gejala infeksi seperti kemerahan dan panas</p>	Kerusakan integritas Jaringan	Hematoma pada kulit dan trauma jaringan (Kulit Rusak)
	<p>Data Subyektif : Pasien mengatakan nyeri kepala berdenyut di bagian kepala dan tengkuk.</p> <p>Data Obyektif : 1) Pasien tampak gelisah 2) Pasien memegang kepala dan leher 3) Tidak terdapat perubahan motorik dan persepsi sensasi 4) GCS 4-5-6 5) Kesadaran <i>composmentis</i>. 6) Hasil TTV : S : 37°C P : 80x/mnt N : 20x/ mnt TD : 100/60mmHg 7) Kedua pupil isokor, reflek pupil saat terkena cahaya miosis. 8) Pasien tidak mengeluh mual dan muntah 9) Pandangan pasien tidak kabur dan diplopia.</p>	Resiko tinggi peningkatan tekanan intrakranial	Desak ruang sekunder dari kompresi korteks serebri dari adanya perdarahan baik bersifat intraserebral hematoma sebdural hematoma dan epidural hematoma
	<p>Data Subyektif: Pasien mengatakan ada luka jahitan di dagu.</p> <p>Data Obyektif : 1) Tidak ada tanda-tanda infeksi seperti kemerahan dan panas disekitar luka. 2) Terdapat vulnus apertum di dagu ± 2 cm tertutup kasa bersih 3) Jumlah WBC meningkat 12,80 10³/ uL</p>	Resiko Infeksi	Ketidak adekuatan sistem pertahanan sekunder
2	<p>Data Subyektif: Pasien mengatakan nyeri berdenyut dibagian kepala dan tengkuk dengan skala nyeri 6, nyeri bertambah bila merubah posisi, berkurang bila berbaring</p> <p>Data Obyektif : 1) Pasien tampak menyeringai menahan nyeri 2) Pasien tampak gelisah 3) Pasien tampak memegang kepala dan leher 4) Pasien tampak berhati-hati dalam merubah posisi, memegang kepala dan leher 5) Terdapat nyeri tekan pada kepala dan leher. 6) Hasil tanda-tanda vital S : 36,5° C P : 80 x / menit N : 20 x / menit TD :120/80 mmHg</p>	Nyeri Akut	Trauma jaringan dan reflek spasme otot sekunder
	<p>Data Subyektif: Pasien mengatakan ada luka robek dipelipis kanan dijahit dan luka lecet diseluruh wajah kedua kaki dan tangan.</p>	Kerusakan integritas Jaringan	Hematoma pada kulit dan trauma jaringan (Kulit Rusak)
	<p>Data Subyektif : Pasien mengatakan nyeri kepala berdenyut di kepala dan tengkuk.</p> <p>Data Obyektif : 1) Pasien tampak gelisah</p>	Resiko tinggi peningkatan tekanan intrakranial	Desak ruang sekunder dari kompresi korteks serebri dari adanya

Resp	Data Gayut	Masalah	Penyebab
2) Pasien memegangi kepala dan leher 3) Tidak terdapat perubahan motorik dan persepsi sensasi 4) GCS 4-5-6 5) Kesadaran <i>composmentis</i> . 6) Hasil TTV : S : 36,5°C P : 80x/ mnt N : 20x/ mnt TD : 120/80 mmHg 7) Kedua pupil isokor, reflek pupil saat terkena cahaya miosis. 8) Pasien tidak mengeluh mual dan muntah 9) Pandangan pasien tidak kabur dan diplopia.			perdarahan baik bersifat intracerebral hematoma subdural hematoma dan epidural hematoma
Data Subyektif: Pasien mengatakan ada luka jahitan di kelopak mata kanan. Data Obyektif: 1) Terdapat oedema pada pelipis kanan 2) Palpebra kanan luka robek ± 2cm dijahit tertutup kasa bersih 3) <i>Excoriasi</i> pipi kanan ± 10cm x 7cm		Resiko Infeksi	Ketidak adekuatan sistem pertahanan sekunder

Theme 2 Nursing Diagnosis

Theory	Respondent I	Respondent II	Noted
Pain Acute	Acute pain associated with tissue trauma is characterized by the patient saying throbbing headache in the head and neck with a pain scale of 5 does not decrease since the pain still lying down or sitting, the face looks grinning pain, the patient holds the head and neck, the patient looks cautious in change position, there is tenderness in the head and neck.	Acute pain associated with tissue trauma is characterized by the patient saying throbbing headache on the head and neck with a pain scale of 6 increases when changing position decreases when lying down, the face looks grinning pain relief, the patient looks restless, the patient holds the head and neck, the patient looks cautious liver in changing positions, there is tenderness in the head and neck.	There is no gap. Nursing diagnoses are based on the theory that acute pain is experienced by both respondents.
Damage to network integrity	Damage to the integrity of the tissue associated with hematoma of the skin and tissue trauma (damaged skin) is characterized by the patient saying there is a torn wound in the chin stitched and bruises on the forehead, right cheek and lips, there is a torn wound, vulnus apertum chin ± 2 cm covered with clean gauze, there hematoma on the forehead, right cheek and upper and lower lip.	Damage to the integrity of the tissue associated with hematoma of the skin and tissue trauma (damaged skin) which is characterized by the patient saying there is a torn wound in the right stitched stitched and abrasions on the faces of both feet and hands, there is edema in the right temple, right palpebra wound torn ± 2cm closed clean gauze, excoriated right cheek ± 10cm x 7cm, blisters 2 places on the right cheek 2 cm x 1cm blisters on the philtrum, torn right lip 0.5cm closed gauze clean. Abrasions on the chin ± 2cm covered with clean gauze, abrasion lesions on the right chest ± 3cm, abrasion lesions on the right chest 4cm x 2 cm, abrasions on the backs of the hands and feet and right knee, fracture of the colist sinistra multiple excoriation and attached splint dressing.	There is no gap. Nursing diagnoses in accordance with the theory that the integrity of the tissue damage experienced by both respondents.
High risk of increasing ICT	The high risk of increasing ICT is associated with the urgency of the secondary space of cerebral cortical compression from bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma which is characterized by the patient saying throbbing headache in the head and neck, the patient looks restless, the	The high risk of increasing ICT is associated with the urgency of the secondary space of cerebral cortical compression from bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma which is characterized by the patient saying throbbing headache in the head	There is no gap. Nursing diagnoses in accordance with the theory that the high risk of increased ICT experienced by both respondents.

Theory	Respondent I	Respondent II	Noted
	patient holds the head and neck , there was no motor change and sensation perception, GCS 4-5-6, composmentist awareness, TTV S results: 37o C, P: 80 x / min, N: 20 x / Minute, TD: 100/60 mmHg, Both isochoric pupils pupillary reflexes when exposed to light miosis, the patient does not complain of nausea and vomiting, the patient's vision is not blurred and diplopia.	and neck, the patient looks restless, the patient holds the head and neck , there were no motor changes and perception of GCS sensation 4-5-6, composmentist awareness, TTV S results: 36.5o C, P: 80 x / min, N: 20 x / Minute, TD: 120/80 mmHg, both pupils pupillary reflex isokor when exposed to the light of miosis, the patient does not complain of nausea and vomiting, the patient's vision does not blur and diplopia.	
Risk of infection	The risk of infection is related to the inadequacy of the secondary defense system, which is indicated by the patient saying there is a suture wound on the chin, there are no signs and symptoms of infection in the wound such as redness and heat, there is vulnus apertum on the chin \pm 2 cm covered with clean gauze, the number of WBC increases 12,80 103 / uL	The risk of infection is related to the inadequacy of the secondary defense system, which is indicated by the patient saying there is a suture wound on the right eyelid, there is edema in the right temple, the right palpebra is torn wound \pm 2cm sewn closed clean gauze, Excoriation right cheek \pm 10cm x 7cm, 2 blisters place on right cheek 2cm x 1cm, blisters on philtrum, right upper lip ripped 0.5cm covered with clean gauze, blisters on the chin \pm 2cm covered with clean gauze, abrasion lesions on the right chest \pm 3cm, no signs of infection such as redness and heat around the wound , the number of WBC increased by 19.04 103 / uL.	There is no gap. Nursing diagnoses in accordance with the theory that the risk of infection is experienced by both respondents.

Theme 3 Nursing Intervention

In nursing problems Acute pain is associated with planned tissue trauma interventions in both respondents 7 interventions. On nursing problems Damage to tissue integrity is related to hematoma of the skin and tissue trauma (damaged skin) interventions are planned for respondent I (Mrs. J) 5 interventions and respondent II (Mrs. H) 6 interventions. In nursing problems the high risk of increasing ICT is related to the urgency of the secondary space of cerebral cortical compression from the presence of bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma interventions planned in respondent I (Mrs. J) and respondent II (Mrs. H) there are 12 interventions. On the issue of nursing, the risk of infection is related to the inadequacy of the secondary defense system. The interventions planned for respondent I (Mrs. J) have 8 interventions, and respondent II (Mrs. H) have 9 interventions.

Theme 4 Evaluation

Achievement of evaluation results on respondent I with nursing diagnoses Acute pain associated with tissue trauma, respondents said that pain was throbbing in the head and reduced with pain scale 1, with objective data

The patient appeared relaxed, Pain scale 1, Patient had not held his head and neck, there was no tenderness on the head and neck, patients can use guided imagery relaxation techniques to reduce pain. In the evaluation of respondent II said throbbing in the head and reduced with a pain scale 1, with objective data the patient looks relaxed, pain scale 1, the patient is not holding the head and neck, there is no tenderness on the head and neck, the patient can do guided relaxation techniques imagery to reduce pain.

DISCUSSIONS

Theme 1 Assessment

From the results of case studies conducted by researchers on respondents Ny. J and Ny. H on nursing problems Acute Pain obtained by both respondents said throbbing headache in the head and neck with a pain scale 5 in respondent I and pain scale 6 in respondent II, evidenced by a grinning face, the patient looked restless, holding the head and neck, looked cautious liver in changing positions, there is tenderness in the head and neck. Based on the theory of Muttaqin (2011), signs and symptoms for acute pain nursing problems that are verbally expressing or reporting (pain) with facial cues appear to be grinning. The case study results obtained during the assessment did not reveal a gap between

theory and fact. Hasil pengkajian yang didapatkan pada Ny. J dan Ny. H dengan masalah keperawatan kerusakan integritas jaringan berhubungan dengan hematoma pada kulit dan trauma jaringan (kulit rusak) didapatkan pada responden I (Ny. J) mengatakan ada luka robek di dagu dijahit serta memar di dahi, pipi kanan dan bibir hal ini dibuktikan dengan terdapat luka robek, vulnus apertum dagu ± 2 cm tertutup kasa bersih, terdapat hematoma di dahi, pipi kanan dan bibir bagian atas dan bawah, dan pada reponden II (Ny. H) mengatakan ada luka robek dipelipis kanan dijahit dan luka lecet diseluruh wajah kedua kaki dan tangan hal ini dibuktikan dengan terdapat oedema pada pelipis kanan, palpebra kanan luka robek ± 2 cm dijahit tertutup kasa bersih, *excoriasi* pipi kanan ± 10 cm x 7cm, lecet di pipi kanan 2 cm x 1cm, lecet di *philtrum*, bibir kanan atas robek 0,5cm tertutup

From the results of case studies conducted by researchers on respondents Ny. J and Ny. H on nursing problems Acute Pain obtained by both respondents said throbbing headache in the head and neck with a pain scale 5 in respondent I and pain scale 6 in respondent II, evidenced by a grinning face, the patient looked restless, holding the head and neck, looked cautious liver in changing positions, there is tenderness in the head and neck. Based on the theory of Muttaqin (2011), signs and symptoms for acute pain nursing problems that are verbally expressing or reporting (pain) with facial cues appear to be grinning. The case study results obtained during the assessment did not reveal a gap between theory and fact. Abrasion services on right chest ± 3 cm, abrasion lesions on right chest 4cm x 2 cm Abrasions on both back of hands and feet and right knee, fracture colles multiple excoriation sinistra and splint dressing. Based on the theory of Muttaqin (2011), signs and symptoms for nursing problems damage to tissue integrity are related to hematoma of the skin and tissue trauma (damaged skin). The case study results obtained during the assessment did not reveal a gap between theory and fact.

When reviewing the results obtained in Ny. J and Ny. H with nursing problems related to the urgency of the secondary space of cerebral cortical compression from the presence of bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma obtained in respondent I (Mrs. J) said headache throbbed in the head and neck, the patient looked restless, there were no motor changes and sensation perceptions, GCS 4-5-6, composmentist awareness, TTV S results: 37o C, P: 80 x / min, N: 20 x / Minute, TD: 100/60 mmHg, both pupils of reflex isochoric reflexes pupils when exposed to miosis light, the patient did not complain of nausea and vomiting, the view of the patient did not blur or diplopia and in respondent II (Mrs. H) said that the headache was throbbing in the head and neck, the patient looked restless, there were no motor changes and perception

of sensation, GCS 4-5-6, composmentist awareness, TTV S results: 37o C, P: 80 x / min, N: 20 x / Minute, TD: 120/80 mmHg, both pupillary pupillary reflex isochores when exposed to light myosis, patients not meng After nausea and vomiting, the patient's vision does not blur or diplopia. Based on the theory of Muttaqin (2011), signs and symptoms for nursing problems are related to the urgency of the secondary space of cerebral cortical compression from bleeding, both intracerebral hematomas, subdural hematomas, and epidural hematomas. The case study results obtained during the assessment did not reveal a gap between theory and fact.

The results obtained during the assessment of the two respondents with the problem of nursing risk of infection associated with the inadequacy of the secondary defense system were obtained in respondent I (Mrs. J) said there was a stitching wound on the chin. signs and symptoms of infection will appear on the second day, there is vulnus apertum on the chin ± 2 cm covered with clean gauze, the number of WBC increased by 12.80 103 / uL, and in respondent II (Mrs. H) said there was a suture wound on the right eyelid this is evidenced by edema in the right temple, right palpebra wound torn ± 2 cm sewn closed clean gauze, excoriated right cheek ± 10 cm x 7cm, abrasions 2 places on the right cheek 2cm and 2cm x 1cm, blisters on the philtrum, right upper lip ripped 0.5cm covered with clean gauze, blisters on the chin ± 2 cm closed clean gauze, abrasion lesions on the right chest ± 3 cm, abrasion lesions on the right chest 4cm x 2 cm abrasions on both backs of the tan gan and right leg and knee, the number of WBC increases 19.04 103 / uL. Based on the theory of Muttaqin (2011), signs and symptoms for nursing problems of infection risk are related to the inadequacy of the secondary defense system. The case study results obtained during the assessment did not reveal a gap between theory and fact.

Theme 2 Nursing Diagnosis

From the results of case studies conducted by researchers on respondents Ny. J and Ny. H on nursing problems Acute Pain obtained by both respondents said throbbing headache in the head and neck with a pain scale 5 in respondent I and pain scale 6 in respondent II, evidenced by a grinning face, the patient looked restless, holding the head and neck, looked cautious liver in changing positions, there is tenderness in the head and neck. Based on the theory of Muttaqin (2011), signs and symptoms for acute pain nursing problems that are verbally expressing or reporting (pain) with facial cues appear to be grinning. The case study results obtained during the assessment did not reveal a gap between theory and fact.

The results of the assessment obtained in Ny. J and Ny. H with nursing problems damage to tissue integrity associated with hematoma of the skin and tissue trauma (damaged skin) found in respondent I

(Mrs. J) said there was a torn wound on the chin stitched and bruises on the forehead, right cheek and lips, this is evidenced by the presence of a torn wound, vulnus apertum chin \pm 2 cm covered with clean gauze, there is a hematoma on the forehead, right cheek and upper and lower lip, and in Respondent II (Mrs. H) said there was a torn wound in the right thigh and was sewn and abrasions on the faces of both legs and hands this is evidenced by edema in the right temple, right palpebra wound torn \pm 2cm sewn closed clean gauze, excoriated right cheek \pm 10cm x 7cm, blisters on the right cheek 2 cm x 1cm, blisters on the philtrum, right upper lip torn 0.5cm closed clean gauze, abrasions on the chin \pm 2cm closed net gauze, abrasion lesions on the right chest \pm 3cm, abrasion lesions on the right chest 4cm x 2 cm abrasions on the backs of the hands and feet and right knee, multiple excoriated colles sinuses and attached splints. Based on the theory of Muttaqin (2011), signs and symptoms for nursing problems damage to tissue integrity are related to hematoma of the skin and tissue trauma (damaged skin). The case study results obtained during the assessment did not reveal a gap between theory and fact.

When reviewing the results obtained in Ny. J and Ny. H with nursing problems related to the urgency of the secondary space of cerebral cortical compression from the presence of bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma obtained in respondent I (Mrs. J) said headache throbbed in the head and neck, the patient looked restless, there were no motor changes and sensation perceptions, GCS 4-5-6, composmentist awareness, TTV S results: 37o C, P: 80 x / min, N: 20 x / Minute, TD: 100/60 mmHg, both pupils of reflex isochoric reflexes pupils when exposed to miosis light, the patient did not complain of nausea and vomiting, the view of the patient did not blur or diplopia and in respondent II (Mrs. H) said that the headache was throbbing in the head and neck, the patient looked restless, there were no motor changes and perception of sensation, GCS 4-5-6, composmentist awareness, TTV S results: 37o C, P: 80 x / min, N: 20 x / Minute, TD: 120/80 mmHg, both pupillary pupillary reflex isochores when exposed to light myosis, patients not meng After nausea and vomiting, the patient's vision does not blur or diplopia. Based on the theory of Muttaqin (2011), signs and symptoms for nursing problems are related to the urgency of the secondary space of cerebral cortical compression from bleeding, both intracerebral hematomas, subdural hematomas, and epidural hematomas. The case study results obtained during the assessment did not reveal a gap between theory and fact.

The results obtained during the assessment of the two respondents with the problem of nursing risk of infection associated with the inadequacy of the secondary defense system were obtained in respondent I (Mrs. J) said there was a stitching wound

on the chin. signs and symptoms of infection will appear on the second day, there is vulnus apertum on the chin \pm 2 cm covered with clean gauze, the number of WBC increased by 12.80 103 / uL, and in respondent II (Mrs. H) said there was a suture wound on the right eyelid this is evidenced by edema in the right temple, right palpebra wound torn \pm 2cm sewn closed clean gauze, excoriated right cheek \pm 10cm x 7cm, abrasions 2 places on the right cheek 2cm and 2cm x 1cm, blisters on the philtrum, right upper lip ripped 0.5cm covered with clean gauze, blisters on the chin \pm 2cm closed clean gauze, abrasion lesions on the right chest \pm 3cm, abrasion lesions on the right chest 4cm x 2 cm abrasions on both backs of the tan gan and right leg and knee, the number of WBC increases 19.04 103 / uL. Based on the theory of Muttaqin (2011), signs and symptoms for nursing problems of infection risk are related to the inadequacy of the secondary defense system. The case study results obtained during the assessment did not reveal a gap between theory and fact.

Theme 3 Nursing Intervention

In nursing problems Acute pain is associated with planned tissue trauma interventions in both respondents 7 interventions. Based on the theory of Arif Muttaqin (2011) there are 7 interventions planned for the problem of acute pain associated with tissue trauma. Based on this description, there is no intervention gap that is given according to theory.

On nursing problems Damage to tissue integrity is related to hematoma of the skin and tissue trauma (damaged skin) interventions are planned for respondent I (Mrs. J) 5 interventions and respondent II (Mrs. H) 6 interventions. Based on the theory of Arif Muttaqin (2011) there are 7 interventions planned for the problem of tissue integrity damage associated with hematoma of the skin and tissue trauma (damaged skin). Based on the description there is a gap between theory and facts, there is 1 intervention that was not given to respondent I (Mrs. J), that is, intervention to do wound care techniques with sterile is not planned because this is because there is no advice from the doctor to treat wound care. In the two respondents there was one intervention that was not given, namely the intervention of nutritionist collaboration in giving TKTP diet (high calorie high protein) because there was no advice from doctors who collaborated with nutritionists in giving TKTP diet (high calorie high protein).

In nursing problems the high risk of increasing ICT is related to the urgency of the secondary space of cerebral cortical compression from the presence of bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma interventions planned in respondent I (Mrs. J) and respondent II (Mrs. H) there are 12 interventions. Based on the theory of Arif Muttaqin (2011) there are 19 interventions planned for the problem. The high risk

of increasing ICT is related to the urgency of the secondary space from cerebral cortical compression from the presence of bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma. Based on the description there is a gap between theory and facts, there are 2 interventions that do not fit the theory given to the two respondents, namely: Give narcotic analgesic drugs. Example: Codeine because there is already a doctor's advice to provide analgesic drugs namely ketorolac and pragesol, Reduce extra stimulation and provide a sense of comfort such as back massage, a calm environment, friendly touch, and a non-rowdy atmosphere / conversation, overall the intervention can be done but back massage was not performed on both respondents because the patient could not mobilize to the maximum (prone or sitting) which can increase pain experienced by the patient as well as the risk of increased intracranial pressure, there were 7 interventions that were not given to the two respondents this was due to the intervention intervention client if coughing, vomiting this intervention is not planned because the two respondents did not experience nausea and vomiting problems, the intervention giving O2 in accordance with indications this intervention was not planned because in both respondents did not experience hypoxemia problems, as evidenced by the patient not experiencing i shortness of breath and frequency of breath 20x / minute, in interventions Collaboration for operative actions of evacuation of blood from within intracranial interventions was not planned because in the two respondents there were no signs of neurological deficits that indicate an increase in intracranial for example when the study found no pupillary reflexes to light normal (medriasis). Interventions giving diuretic osmosis drugs for example: mannitol, furosemide are not given to both respondents because there is no indication of edema in the brain, on intervention Give steroids for example: dexamethasone, methylprednisolon This intervention is not planned because there is no indication of inflammation in the patient, Give antipyretics for example: acetaminophen intervention This was not planned because the body temperature conditions in the two respondents were normal, the intervention monitored laboratory results according to indications such as prothrombin, LED intervention was not planned because there was no prothrombin, LED examination.

On the issue of nursing, the risk of infection is related to the inadequacy of the secondary defense system. The interventions planned for respondent I (Mrs. J) have 8 interventions, and respondent II (Mrs. H) have 9 interventions. Based on the theory of Arif Muttaqin (2011) there are 9 interventions planned for the problem of infection risk associated with the inadequacy of the secondary defense system. Based on the description, there is a gap between theory and

facts, there is 1 intervention that was not given to respondent I (Mrs. J), that is, the intervention Collaborating with the medical team to give antibiotics was not planned because this was because there were no signs and symptoms of infection in Ny. J.

Nursing implementation for both respondents for the problem of acute pain associated with tissue trauma, independent implementation given in accordance with the intervention that explains the guided imagery relaxation technique starting from understanding guided imagery relaxation technique is guided relaxation technique by guided clients to visualize scenes (eg relaxing on the beach), the purpose of doing guided imagery relaxation techniques is to help visualize pleasant experiences, divert attention to pain, relax the body, change perceptions of pain, and one of the benefits is to eliminate the source of pain (for example headache can be removed). Teach guided imagery relaxation techniques / guided imagery in reducing pain by using the following steps - Position the body as comfortable as possible (state of lying or sitting), relax / relax your body then close your eyes, choose the music you like, listen carefully, listen carefully, Begin to inhale, imagine something pleasant. Every time you breathe in, imagine healing energy flowing to the part of the body that is experiencing pain. Imagine each breath and breath will release tension and pain in the body. When the patient draws his shadow, ask about sounds, lights, objects that appear and smells imagined, Ask the patient to describe in more detail, Do this activity repeatedly and regularly in a few minutes (10-15 minutes). Teach the method of distraction to talk about fun things during acute pain.

Based on the description there is no gap between facts and theories, there is no difference in the results of the implementation of them in Ny. A decrease in pain scale from 5 to 1, in Ny. H decreased pain scale from 6 to 1.

Nursing implementation in both respondents for the problem of tissue integrity integrity related to hematoma of the skin and tissue trauma (damaged skin), there was a gap in respondent II (Mrs. H). The implementation was given in accordance with the intervention, namely advising the patient to wear loose clothing. sterile wound care, Give a position that reduces pressure on the wound, Keep the skin clean and dry, Teach the family about wound care, Observation of wounds 3 size locations, characteristics, fluid color, granulation, necronic tissue, signs of infection. In respondent I (Mrs. J), the implementation of the technique of wound care with sterile was not done but was replaced by giving health education. Teaching the family how to treat the wound verbally using leaflets so that the patient and family demonstrate understanding in the process of repairing

the skin and preventing recurrence of injuries to the wound. experienced by patients.

Nursing implementation in both respondents for the problem High risk of increasing ICT related to the urgency of the secondary space of cerebral cortical compression from bleeding, both intraserebral hematoma, subdural hematoma, and epidural hematoma there are gaps in the implementation given to the two respondents as a whole with the intervention but there are some implementations that are not done namely Reducing extra stimulation and providing a sense of comfort such as back massage, a calm environment, friendly touch, and atmosphere / talk that is not rowdy, back massage intervention is not implemented in the two respondents because the two respondents could not mobilization with a maximum (prone or sitting) that can increase the pain experienced, as well as the risk of increased intracranial pressure.

The implementation of nursing in both respondents for the problem of infection risk is related to the inadequacy of the secondary defense system, the implementation provided is in accordance with the intervention, namely Collaborating with the medical team to provide antibiotics because there is no doctor's advice to give antibiotics. Planned interventions are Monitor for signs of infection, Monitor laboratory results, Monitor vital signs every 4 hours, Maintain aseptic techniques, Wash hands before and after nursing actions, Inspect skin and mucous membranes for hot redness, Encourage fluid input, Collaborate with medical team to give antibiotics, Teach clients and families before and after being admitted to the hospital to wash their hands. Based on the description there is no gap between theory and facts, the two respondents can understand how to wash hands with the 6 steps of washing hands by handrub and handwash.

Theme 4 Evaluation

Analysis of the respondent's evaluation of the outcome criteria of Arif Muttaqin (2011) theory is subjectively reporting reduced pain, Can identify activity or reduce pain, Client is not restless. The results of the case study evaluation of respondent I partially resolved the problem evidenced by respondents reporting reduced pain, pain scale 1, relaxed face not fidgeting. Based on the results of the study found no gaps in the evaluation of the two respondents in accordance with the criteria of the results of the problem has been resolved as evidenced by respondents reporting reduced pain, pain scale 1, the face looks relaxed. As well as the factors that influence pain in reducing pain according to the theory of Tamsuri (2012), namely: 1. Factors that influence the perception of pain in an individual include: Age, Gender, Culture, Knowledge of pain and its causes, Meanings pain, client attention, anxiety level, stress level, energy level, previous experience, coping

patterns, family and social support. 2. Factors that influence pain tolerance include: Alcohol, drugs, hypnosis, heat, friction / scratching, distraction, strong belief. 3. Factors that reduce tolerance to pain include: Fatigue, Anger, Boredom, Depression, Anxiety, Chronic Pain, Pain / suffering. From the results of the evaluation of respondents I and respondent II with nursing problems Acute Pain related to tissue trauma guided imagery relaxation techniques are effective in reducing pain in patients with Minor Head Injury (CKR).

Achievement of evaluation results on respondent I with nursing diagnoses Damage to tissue integrity is related to hematoma of the skin and tissue trauma (damaged skin), respondents said there was a torn wound on the chin stitched and bruises on the forehead, right cheek and lips, There was a torn wound, vulnus apertum chin \pm 2 cm covered with clean gauze, there is a hematoma on the forehead, right cheek and upper and lower lip, in the wound there are no signs of infection such as redness and heat. In the evaluation of respondent II said there was a torn wound in the right temple stitched and abrasions on the face of both feet and hands, there was edema on the right temple right palpebra torn wound \pm 2 cm sewn closed clean gauze excoriated right cheek \pm 10 cm x 7 cm x 1cm, blisters in the philtrum, ripped 0.5cm upper right lip covered with clean gauze, blisters on the chin \pm 2cm covered with clean gauze, abrasion lesions on the right chest \pm 3cm, in wounds there are no signs of infection such as redness and heat. Analysis of respondents' evaluation of the results of the theory of Arif Muttaqin (2011) is normal tissue perfusion, there are no signs of infection, thickness and texture of normal tissue, shows understanding in the process of repairing skin and preventing the occurrence of repetitive injuries, indicating the occurrence of wound healing process. The results of the case studies on both respondent I and respondent II have not resolved the problem is proven by respondent I said there was a torn wound in the chin stitched and bruises on the forehead, right cheek and lip, There was a torn wound, Vulnus apertum chin \pm 2 cm covered with clean gauze, There was a hematoma on forehead, right cheek and upper and lower lip. In the wound there are no signs of infection such as redness and heat. In respondent II said there was a torn wound in the right thigh that was sewn and abrasions all over the face of both feet and hands, there was edema on the right temple of the right palpebra. 1cm, blisters in the philtrum, ripped 0.5cm upper right lip covered with clean gauze, chin blisters in \pm 2cm covered with clean gauze, abrasion lesions on the right chest \pm 3cm, in wounds there are no signs of infection such as redness and heat. Based on the results of the study found that there are gaps in the evaluation of the two respondents the problem has not been resolved in accordance with the results criteria.

Achievement of evaluation results on respondent I with nursing diagnoses High risk of increased ICT related to the urgency of the secondary space from cerebral cortical compression from bleeding, both intracerebral hematoma, subdural hematoma, and epidural hematoma, respondents said pain throbbing in the head and reduced with pain scale 1, Patient seemed relaxed, GCS 4-5-6, Composure consciousness, Examination of vital signs S: 37o C, P: 84 x / minute, N: 20 x / Minute, TD: 110/70 mmHg, Both pupils isochorically pupillary reflex when exposed to miosis light. In the evaluation of respondent II said the throbbing pain in the head and reduced with a pain scale 1, the patient looks relaxed, GCS 4-5-6, composmentist awareness, examination results of vital signs S: 36.5o C, P: 84 x / minute, N: 20 x / Minute, TD: 120/80 mmHg, Both pupils are isocorous pupillary reflexes when exposed to miosis light. Analysis of respondents' evaluation of the outcome criteria of Arif Muttaqin (2011) theory is that the client is not agitated, the client does not complain of headache, nausea and vomiting, GCS: 4,5,6, no papillary, TTV within normal limits. The results of the case studies on both respondent I and respondent II were resolved, as evidenced by respondent I, who said that the pain was throbbing in the head and reduced with a pain scale of 1, the patient appeared relaxed, GCS 4-5-6, compositional awareness, the results of the examination of vital signs S : 37o C, P: 84 x / minute, N: 20 x / Minute, TD: 110/70 mmHg, Both pupil isochoric pupillary reflexes when exposed to miosis light. In respondent II said throbbing pain in the head and reduced with a pain scale 1, the patient appeared relaxed, GCS 4-5-6, composmentist awareness, results of vital signs examination S: 36.5o C, P: 84 x / minute, N : 20 x / Minute, BP: 120/80 mmHg, Both pupil isochoric pupillary reflexes when exposed to miosis light. Based on the results of the study found no gaps in the evaluation of the two respondents in accordance with the criteria of the results of the problem has been resolved as evidenced by respondents reporting throbbing pain in the head and reduced with pain scale 1, the patient looks relaxed, GCS 4-5-6, and vital signs in normal limit.

Achievement of evaluation results on respondent I with nursing diagnoses. The risk of infection is related to the inadequacy of the secondary defense system, respondents said there was a torn wound on the chin stitched and bruises on the forehead, right cheek and lips, There was a torn wound, vulnus apertum chin \pm 2 cm covered with clean gauze, there was a clean gauze hematoma on the forehead, right cheek and upper and lower lip, in the wound there are no signs of infection such as redness and heat, the amount of WBC increased by 12,80 103 / uL. In the evaluation of respondent II said there was a torn wound in the right temple stitched and abrasions all over the face of both feet and hands, there was edema on the right temple of the right palpebra. x 1cm,

blisters in philtrum, upper right lip torn 0.5cm covered with clean gauze, chin blisters in \pm 2cm covered with clean gauze, abrasion lesions on the right chest \pm 3cm, in wounds there are no signs of infection such as redness and heat, the amount of WBC increased by 19.04 103 / uL. Analysis of respondents' evaluation of the outcome criteria of Arif Muttaqin (2011) theory is that the client is free from signs and symptoms of infection, shows the ability to prevent infection, number of leukocytes within normal limits, shows healthy living behavior, gastrointestinal immune status, genitourinaria within normal limits. The results of the case studies on both respondent I and respondent II have not resolved the problem is proven by respondent I said there was a torn wound in the chin stitched and bruises on the forehead, right cheek and lip, There was a torn wound, Vulnus apertum chin \pm 2 cm covered with clean gauze, There was a hematoma on forehead, right cheek and upper and lower lip. In the wound there are no signs of infection such as redness and heat, the amount of WBC increased by 12.80 103 / uL. In respondent II said there was a torn wound in the right temple stitched and abrasions all over the face of both feet and hands, there was edema on the right temple right palpebra ripped wound \pm 2 cm sewn closed net gauze excoriated right cheek \pm 10 cm x 7 cm cm and 2 cm x 1cm, blisters in philtrum, upper right lip ripped 0.5 cm covered with clean gauze, blisters on the chin \pm 2 cm covered with clean gauze, abrasion lesions on the right chest \pm 3 cm, in wounds there are no signs of infection such as redness and heat, the amount of WBC increased by 19.04 103 / uL. Based on the results of the study found that there are gaps in the evaluation of the two respondents the problem has not been resolved in accordance with the results criteria.

CONCLUSIONS

In conclusion, patients with mild head injury in acute pain can be implemented independently using health education of guided imagery relaxation techniques to reduce the pain.

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