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"A Study To Assess The Effectiveness Of Video Assisted Teaching Module On Knowledge Regarding Post-Operative Care among Patients Undergoing Hernioplasty In Selected Hospitals Of Indore M.P."

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ABSTRACT

Abdominal wall hernias are a protrusion of the abdominal contents, typically bowel or fat, through a muscular or fascial defect. The most common abdominal wall hernias are groin hernias, that is, inguinal or femoral hernias and inguinal hernias are more common. Inguinal hernias can be further subdivided into indirect or direct inguinal hernias. While these subtypes exist in close proximity and can be difficult to distinguish clinically, they have differing anatomy and aetiologies.The majority of the subjects 27 [27%] were at the age between 18 –25 years, The majority of the subjects 55 [55%] were male. The majority of the subjects 44 [44%] were Hindus, The majority of the subjects 66 [66%] live in rural settings. The majority of the subjects 63 [63%] were married. The majority of the subjects 30 [30%] have more than twochildren. The majority of the subjects 61 [61%] from joint family. The majority of the subjects 47 [47%] had a higher secondary education. The majority of the subjects 31 [31%] were government employees. The majority of the subjects 36 [36%] has monthly income ofrupees 5000 and above. The majority of the subjects 69 [69%] take mixed diet. The majority of the subjects 51 [51%] have no habits of alcoholconsumption, chewing betel leaves and smoking. The majority of the subjects 30 [30%] watch movies. The majority of the subjects 45 [45%] uses the communicationmedia such as television, newspaper, posters and radio. The majority of the subjects 82 [82%] has no family history ofcancer. The majority of the subjects 81 [81%] has no frequent exposure toradiation. Majority 61 [61%] subjects were having a moderate level of pretestknowledge regarding post operative care of patients undergoing hernioplasty. Majority 79 [79%] subjects were having moderate level of post test knowledge regarding post operative care of patients undergoing hernioplasty. There was a significant association between post test level of knowledge and selected demographic variables such as education and personal habits. The following conclusions are made based on the above finding that, at pretest, most of the subjects have inadequate level of knowledge regarding post operative care of patients undergoing hernioplasty. After assessing the post test level of knowledge, the intervention is proven effective. The study encouraged all the subjects in improving knowledge regarding post operative care of patients undergoing hernioplasty. Video assisted teaching showed a effect in improving the level of knowledge regarding post operative care of patients undergoing hernioplasty.

Key words: *Hernioplasty, M.P.*

INTRODUCTION

It"s health that is real wealth and not pieces of gold and silver

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-Mahatma Gandhi

Indirect inguinal hernias are a congenital defect resulting from the failure of obliteration of the processus vaginalis during embryonic development with the hernia arising lateral to the inferior epigastric vessels. Direct inguinal hernias are an acquired defect with weakening of the posterior wall of the inguinal canal medial to the inferior epigastric vessels, within the space bounded by Hasselbach's triangle.3,5 This space is bordered by the inferior epigastric vessels laterally, the lateral border of the rectus abdominis muscle medially and the inguinal ligament inferiorly. Other described inguinal hernias include pantaloon hernias with both indirect and direct components and sliding hernias, an acquired hernia where retroperitoneal fat or visceral organs comprise part of the wall of the hernia sac.

In the early days, high mechanical strength, not being carcinogenic, and not altered by tissue fluids were the minimum mesh requirements. In the 60 years since then, many lessons have been learned regarding mesh structure and use, and the introduction of laparoscopic hernia repair has introduced new demands on the ideal mesh including adhesion free, easy endoscopic handling, full visibility, and maintenance of abdominal wall compliance.The problem of mesh infection led to the introduction of biological prosthetic implants. The alleged indication for a biological implant was the presence of a contaminated field. The use of biological grafts varies worldwide. One limiting factor other than degradation is their expense. Some authors regard biological implants as a bridge to later surgery since they degrade. Biosynthetic meshes have recently reached the market. They are more favourable in price than the biologicals and results from a randomised study are not too disappointing.

NEED FOR THE STUDY

When a hernia containing bowel becomes strangulated, progressive ischaemia results in compromise of mural integrity, bacterial translocation and bowel perforation with a significant risk of sepsis and mortality. In a mechanical bowel obstruction, vascular compromise will develop over time secondary to mural oedema and eventually perforation may occur. Historical surgical practice was to repair all inguinal hernias including asymptomatic hernias, on the basis that repair was safe and averted the risk of hernia complications. Repairs were initially performed as tissue only repairs and later with use of implanted mesh products to provide a tension-free repair. Annually, 20 million inguinal hernia repairs are now performed worldwide. Given this significant number of surgeries, the costs associated with operating are large as is the potential for overtreatment. Investigation into complications post-hernioplasty have found higher rates of operative complication than was initially estimated, particularly chronic postoperative inguinal pain (CPIP) although this does reduce over time.

The role for watchful waiting in particular patient subgroups has been investigated and found to be safe in asymptomatic or minimally symptomatic patients although there is a high rate of progression to operation. A review of the literature conducted in 2018 by the HerniaSurge group concluded that it was not possible to determine the hernia complication rate in symptomatic hernias. Consequently, the safety of a watchful waiting strategy in symptomatic patients was not assessable. Hernia Surge recommend surgical treatment for symptomatic patients and individual decision making for asymptomatic or minimally symptomatic patients. The recommendation for individual decision making is made on the basis of low complication risk and consideration of patient age, preferences and comorbidities and acknowledges that most patients will develop symptoms necessitating repair.

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STATEMENT OF THE PROBLEM

A study to assess the effectiveness of video assisted teaching module on knowledge regarding post operative care among patients undergoing hernioplasty in selected hospitals of Indore M.P.

OBJECTIVES

- To assess the pre-test and post test level of knowledge regarding post operative care among patients undergoing hernioplasty.
- To evaluate the effectiveness of video assisted teaching module on knowledge regarding post operative care among patients undergoing hernioplasty.
- To findout the association between the pretest knowledge score with their selected demographic variables.

HYPOTHESIS

H1- There will be significant difference between pretest and post test knowledge score regarding post operative care of patients undergoing hernioplasty.

H2- There will be significant association between pretest level of knowledge score with their selected demographic variables.

OPERATIONAL DEFINITIONS

- **Assess:** It means judgment of the value of that which is being assessed. In this study, itmeans judging the the effectiveness of video assisted teaching module on knowledge regarding post operative care of patients undergoing hernioplasty.
- **Effectiveness:** It refers to the extent of which the video assisted teaching module on knowledge regarding post operative care of patients undergoing hernioplasty
- **Video assisted Teaching :** It is a teaching module developed by the researcher to impart knowledge regarding post operative care of patients undergoing hernioplasty.. In this study it is referred as organized content withrelevant audio visual aids to provide knowledge regarding post operative care of patients undergoing hernioplasty..
- **Knowledge:** It refers to the response received from the post operative care of patients undergoing hernioplasty as measured by a structured knowledge questionnaire.
- **Patints:** It refers a patients is suffering from hernia in admitted in selected hospitals of Indore .
- **Hernioplasty :** it refers means repair the inguinal hernia .it is a surgical procedure.

ASSUMPTIONS

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- Patient may have inadequate knowledge regarding post operative care of patients undergoing hernioplasty..
- VATS intervention is interactive and effective way to knowledge regarding post operative care of patients undergoing hernioplasty and related health problems.

DELIMITATIONS

The study is limited to

- Patients admitted in selected hospitals of Indore.
- Sample size is 100.
- Data collection period is limited to 4 weeks.
- Educational intervention will be evaluated by self administered questionnaire.

RESEARCH METHODOLOGY

RESEARCH APPROACH

The quantitative research approach was used to evaluate the effectiveness of VATS on knowledge regarding post operative care of patients undergoing hernioplasty.

RESEARCH DESIGN

The research design used for the study was Pre experimental one group pre test and post test design.

It is relatively straight forward research design in which there is a treatment group without control group. All subjects were given a pre test, receive the treatment and was given a post test.

The research design adopted for the present study was as follows

$$O_1 \quad X \quad O_2$$

O_1-Pre test assessment of knowledge.

X - Implementation of VATS.

O_2- Post test assessment of knowledge.

RESEARCH VARIABLES

- **Dependent variables**

knowledge regarding post operative care of patients undergoing hernioplasty.

- **Independent variables**

VATS on knowledge regarding post operative care of patients undergoing hernioplasty.

STUDY SETTINGS

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The study was conducted at Index Medical College, hospital & Research Centre, Indore.

STUDY POPULATION

The population for the present study was patients admitted in selected hospitals of Indore.

SAMPLE

In this study the sample was patients undergoing hernioplasty.

SAMPLE SIZE

The sample size was 100 patients undergoing hernioplasty was considered as the sample for the present study.

CRITERIA FOR SELECTION OF SAMPLES

Inclusion criteria:

patients undergoing hernioplasty who are

- Admitted in selected hospitals of Indore
- Able to communicate freely in Hindi/English
- Present at the time of data collection
- Willing to participate in this study.

Exclusion criteria:

- Not willing to participate in the study
- Not available during the time of data collection procedure
- Patients of critically ill
- Patients who are medical/ nursing profession

SAMPLING TECHNIQUE

Convenient sampling technique was used in this study. In this method the researcher selected those units of population in the sampling which appear convenient to her or to the management of the organization where she is conducting research.

RELIABILITY

The karl pearson's test and retest method was used to check the reliability of the tool andit was found to be reliable. The reliability value was 0.86

ORGANIZATION OF THE STUDY FINDINGS

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Section I: Distribution of samples according to their demographic variables.
Section II: Distribution of samples according to level of knowledge before and after video assisted teaching.
Section III: Effectiveness of video assisted teaching in improving knowledge.
Section IV: Association between pre test level of knowledge and selected demographic variables.

SECTION I

Table1: Distribution of the samples according to their demographicvariables.

[n=100]

S. No	Demographic variable	No of subjects	
		Frequency	Percentage (%)
1	**Age in years**		
	a. 18-25years	27	**27.0**
	b. 26-35 years	25	**25.0**
	c. 36-45 years	25	**25.0**
	d. 45 years and above	23	**23.0**
2	**Sex**		
	a. Male	55	**55.0**
	b. Female	45	**45.0**
3	**Religion**		
	a. Hindu	44	**44.0**
	b. Christian	35	**35.0**
	c. Muslim	21	**21.0**
4	**Place of residence**		
	a. Urban	66	**66.0**
	b. Rural	34	**34.0**
5	Marital status		
	a. Married	**63**	**63.0**
	b. Unmarried	**24**	**24.0**
	c. Widow	**7**	**7.0**
	d. Divorce	**6**	**6.0**

S. No	Demographic variable	No of subjects	
		Frequency	Percentage (%)
6	**Number of children's in the family**		
	a. One	29	**29.0**

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	b. Two	13	**13.0**
	c. Three	30	**30.0**
	d. Four and above	28	**28.0**
7	**Type of family**		
	a. Nuclear family	39	**39.0**
	b. Joint family	61	**61.0**
8	**Education**		
	a. Illiterate	11	**11.0**
	b. Primary school	15	**15.0**
	c. Higher secondary education	47	**47.0**
	d. Degree holder	27	**27.0**
9	**Occupation**		
	a. Unemployment	11	**11.0**
	b. Cooley	18	**18.0**
	c. Government employee	31	**31.0**
	d. Private employee	24	**24.0**
	e. Self employment	16	**16.0**
10	**Monthly income**		
	a. Less than Rs 1000	9	**9.0**
	b. Rs 1001-3000	23	**23.0**
	c. Rs 3001-5000	32	**32.0**
	d. 5001and above	**36**	**36.0**

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S. No	Demographic variable	No of subjects	
		Frequency	Percentage (%)
11	**Dietary pattern**		
	a. Vegetarian	15	15.0
	b. Non-vegetarian	16	16.0
	c. Mixed	69	69.0
12	**Habit**		
	a. Liquor	15	15.0
	b. Beetal leaves	14	14.0
	c. Smoking	20	20.0
	d. None	51	51.0
13	**Recreation**		
	a. Cinema	30	30.0
	b. Music	19	19.0
	c. Reading	15	15.0
	d. Conversation	20	20.0
	e. None	16	16.0
14	Exposure to Mass Media		
	a. Television	17	17.0
	b. News paper	15	15.0
	c. Advertisement	12	12.0
	d. Radio	11	11.0
	e. All the above	45	45.0

S. No	Demographic variable	No of subjects	
		Frequency	percentage
15	**Family History of Hernia**		
	a. Yes	18	18.0
	b. No	82	82.0
16	Any other Surgery		
	a. yes	19	19.0
	b. no	81	81.0

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SECTION II

Table: 2 Distribution of samples according to level of knowledgebefore and after intervention.

(n=100)

Sl .No	Level of knowledge	Pre test		Post test	
		f	**%**	**f**	%
1.	Inadequate	39	39.0	-	**-**
2.	Moderate adequate	61	61.0	79	**79.0**
3.	**Adequate**	**-**	**-**	**21**	**21.0**

The above table shows that pretest among the subjects, 39 [39%] were inadequate level of knowledge, 61 [61%] were moderate level of knowledge and none of them having an adequate level of knowledgeregarding post operative care of patients undergoing hernioplasty. In post test among the subjects,79 [79%] were moderate level of knowledge and 21 [21%] had an adequate level of knowledge regarding post operative care of patients undergoing hernioplasty .

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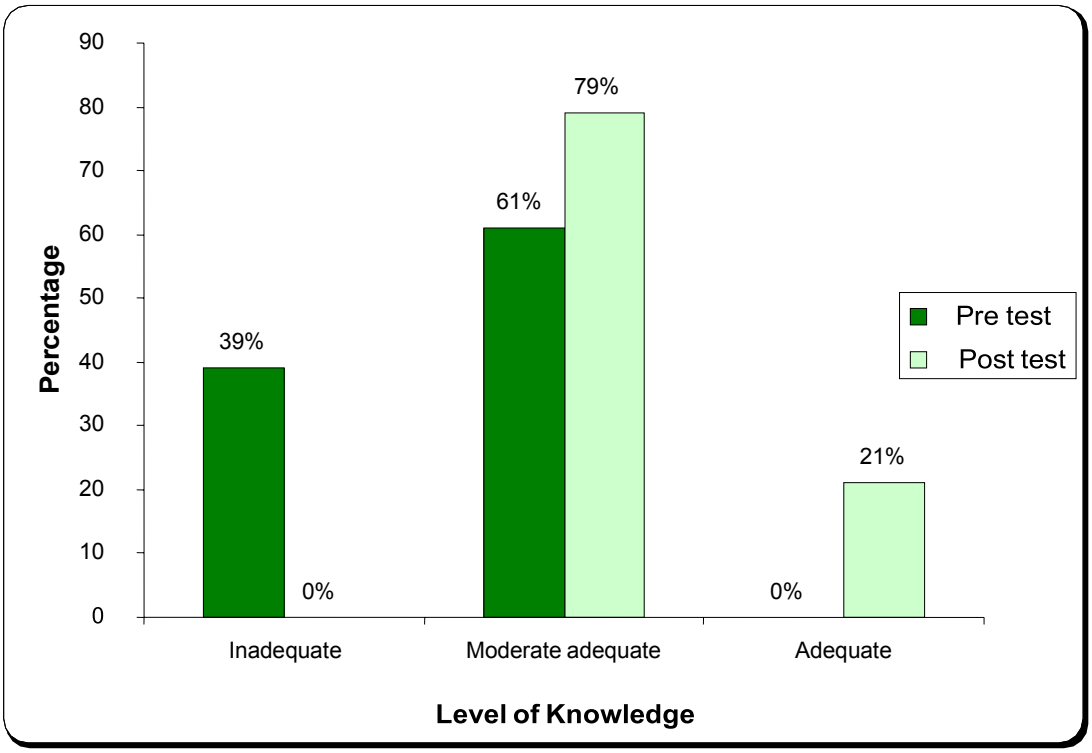
Fig-18. Distribution of samples according to level of knowledge ofPre test and Post test



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SECTION III

Effectiveness of video assisted teaching in improving knowledge onpost operative care of patients undergoing hernioplasty.

Table: 3 mean pretest and post test knowledge level.

(n=100)

Si. no	Level of Knowledge	Mean	standard deviation	t value
1.	Before Intervention	13.9300	4.78266	17.273*
2.	After Intervention	21.8500	2.20823	

***- Significant at 0.05 levels**

Mean score on level of knowledge regarding post operative care of patients undergoing hernioplasty was21. 8500 in post test which is significantly higher than, 13.9300 in pre test and computed value of t' is 17.273 is more than the table value [1.984] at DF [99] which is statistically significant at 0.05 levels. This data shows that video assisted teaching was effective in improving the knowledge regarding post operative care of patients undergoing hernioplasty.

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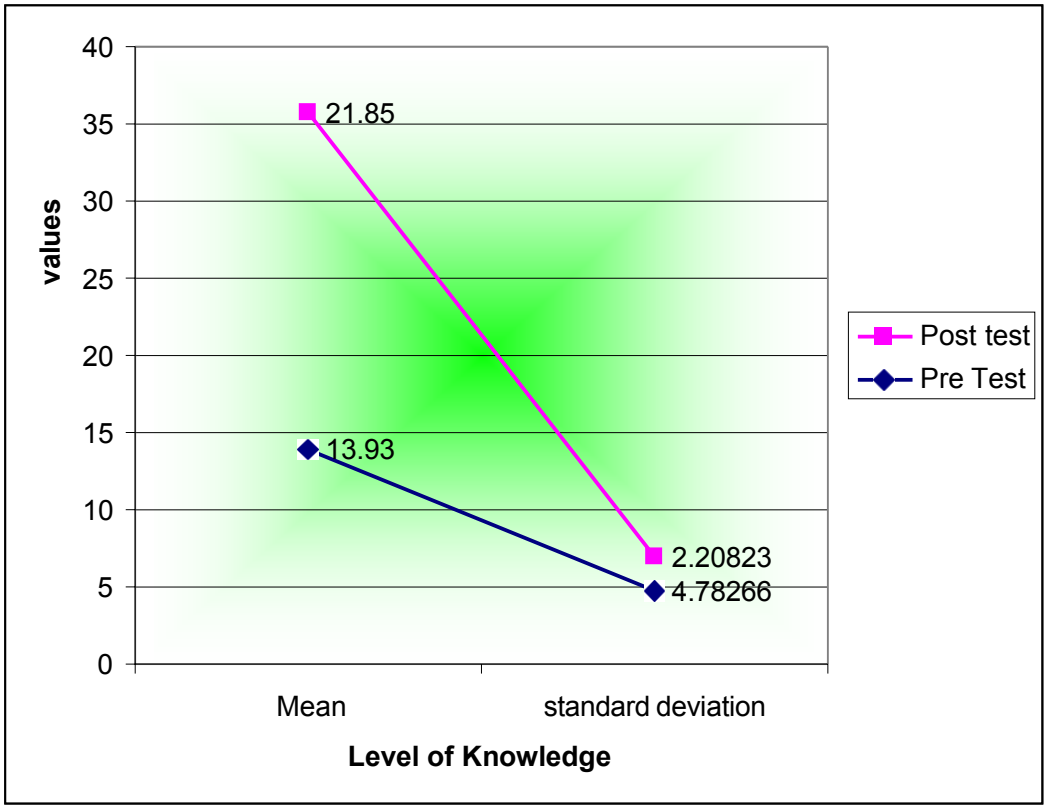
Fig-19.Mean and Standard Deviation of pretest and post testknowledge level.



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SECTION IV

Table: 4 Association between pre test level of knowledge and theirselected demographic variables

[n=100]

Sl. no	Demographicvariables	level of knowledge						table value	chi-square value
		Adequate		**Moderately adequate**		**In-Adequate**			
		f	**%**	**f**	**%**	**f**	**%**		
1.	Age								
	• 18-25years	-	-	24	24.0	3	3.0		
	• 26-36years	-	-	21	21.0	4	4.0		
	• 36-45 years	-	-	18	18.0	7	7.0		
	• 45 years andabove	-	-	16	16.0	7	7.0	7.82	**3.941**
2.	Sex								
	• Male	-	-	44	44.0	11	11.0	3.84	**0.074**
	• Female	-	-	35	35.0	10	10.0		
3.	Religion								
	• Hindu	-	-	33	33.0	1	11.0		
	• Christian	-	-	28	28.0	1	7.0		
	• Muslim	-	-	18	18.0	7	3.0		
						3		5.99	**1.016**
4.	Area of residence								
	• **Rural**	**-**	**-**	**52**	**52.0**	**1**	**14.0**	**3.84**	**0.005**
	• **Urban**	**-**	**-**	**27**	**27.0**	**4**	**7.0**		
						7			

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Sl. no	Demographicvariables	level of knowledge						tabl e valu e	chi- square value
		In-adequat e		Moderately adequate		Adequat e			
		f	%	f	%	f	%		
5.	**Marital status** • Married • Unmarried • Widow • Divorce	- - - -	- - - -	48 20 7 4	48.0 20.0 7.0 4.0	15 4 - 2	15.0 4.0 - 2.0	7.82	**2.982**
6.	**Number of children'sin the family** • One • Two • Three • Four and above	- - - -	- - - -	21 11 25 22	21.0 11.0 25.0 22.0	8 2 5 6	8.0 2.0 5.0 6.0	7.82	**1.384**
7.	**Type of family** • Nuclear family • Joint family	- -	- -	30 49	30.0 49.9	9 12	9.0 12.0	3.84	**0.166**
8.	**Education** • Illiterate • middle school • Higher secondary • Degree holder	- - - -	- - - -	19 24 36 -	19.0 24.0 36.0 -	1 2 5 15	1.o 2.0 5.0 15.0	7.82	**67.750 ***
9.	Occupation • **Unemployment** • **Cooley** • **Govt. servant** • **Private employee** • **Self employment**	**-** **-** **-** **-** **-**	**-** **-** **-** **-** **-**	**10** **15** **25** **18** **11**	**10.0** **15.0** **25.0** **18.0** **11.0**	**1** **3** **6** **6** **5**	**1.0** **3.0** **6.0** **6.0** **5.0**	**9.49**	**2.439**

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Sl.no	Demographicvariables	level of knowledge						table value	chi-square value
		In-adequate		Moderately adequate		Adequate			
		f	%	f	%	f	%		
10	**Monthly income**								
	• Less than Rs 1000	-	-	8	8.0	1	1.0	7.82	**1.806**
	• Rs 1001-3000	-	-	19	19.0	4	4.0		
	• Rs 3001-5000	-	-	26	26.0	6	6.0		
	• 5001and above	-	-	26	26.0	10	10.0		
11	**Dietary pattern**								
	• Vegetarian	-	-	10	10.0	5	5.0	7.82	**1.618**
	• Non-vegetarian	-	-	13	13.0	3	3.0		
	• Both veg and non-veg	-	-	56	56.0	13	13.0		
12	**Habit**								
	• Liquor	-	-	30	30.0	1	1.0	7.82	**60.186 ***
	• Beetal leaves	-	-	32	32.0	-	-		
	• Smoking	-	-	14	14.0	4	4.0		
	• None	-	-	3	3.0	16	16.0		
13	Recreation								
	• **Cinema**	**-**	**-**	**26**	**26.0**	**4**	**4.0**	**9.49**	**3.096**
	• **Music**	**-**	**-**	**16**	**16.0**	**3**	**3.0**		
	• **Redding**	**-**	**-**	**10**	**10.0**	**5**	**5.0**		
	• **Conversation**	**-**	**-**	**15**	**15.0**	**5**	**5.0**		
	• **None**	**-**	**-**	**12**	**12.0**	**4**	**4.0**		

Sl.no	Demographic variables	level of knowledge						table value	chi-square value
		In-adequate		Moderately adequate		Adequate			
		f	%	f	%	f	%		

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14	**Mass Media** • Television • News paper • Advertisement • Radio • All the above	- - - - -	- - - - -	14 12 10 9 34	14.0 1.0 10.0 9.0 34.0	3 3 2 2 11	3.0 3.0 2.0 2.0 11.0	9.49	**0.635**
15	**family history ofHernia** • Yes • No	- -	- -	14 65	14.0 65.0	4 17	4.0 17.0	3.84	**0.020**
16	Any other surgery • **Yes** • **No**	**-** **-**	**-** **-**	**16** **63**	**16.0** **63.0**	**13** **18**	**13.0** **18.0**	**3.84**	**0384**

***- significant at 0.05 levels**

The hypothesis states that there is an association between pre test level of knowledge and their selected demographic variables. In the table the chi square value shows that the calculated value is higher than thetable value for education and habits. So the researcher concluded thatthere is a significant association between pre test level of knowledge and demographic variables such as education and habits.

CONCLUSION

Nurse is a key person for providing care to the patients. Promotion of health, through education is one of the important roles of the nurse. Through education, the subjects can be helped to imbibe healthy practices in their day to day life thus promoting healthy life.

The following conclusions are made based on the above finding that, at pretest, most of the subjects have inadequate level of knowledge regarding post operative care of patients undergoing hernioplasty. After assessing the post test level of knowledge, the intervention is proven effective. The study encouraged all the subjects in improving knowledge regarding post operative care of patients undergoing hernioplasty. Video assisted teaching showed a effect in improving the level of knowledge regarding post operative care of patients undergoing hernioplasty.

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