PATIENT/FAMILY CARE STUDY

ON

MR. A.R

WITH

RIGHT INGUINO-SCROTAL HERNIA

BY

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PREFACE

The word nursing derives its meaning from the Latin word “nutricus” which means nourishing. Many people believed that nursing started with Florence Nightingale, however nursing itself dates back to the beginning of motherhood when nurses were traditionally females. The history of nursing has its origin in the care of the infants and children, so all mothers were nurses. Thus, nursing was considered as a traditional medicine.

Currently, nursing is considered as science and therefore makes use of the nursing process (which is similar to the scientific methods) as a tool for practice. The nursing process comprises of assessment of patient (data collection), analysis of data, planning of care, implementation and evaluation of care. It is therefore being made compulsory by the Nursing and Midwifery Council of Ghana that every final year student nurse presents a patient/ family care study which makes use of the nursing process, as a partial fulfillment for the award of Registered General Nursing certificate. The patient/family care study is a total nursing care rendered to a patient/family from the day of admission till the care is terminated during the last home visit.

The main aim of the study is to equip the student nurse with nursing knowledge and practices in order to render an individualized /family centered and comprehensive nursing care to the patient from the day of admission till termination of care. The patient/family care study helps the student to put into practice knowledge acquired from courses such as microbiology, psychology, sociology, basic nursing, pharmacology and medical-surgical nursing in taking care of the patient/family. It helps the student to gather important information on a disease condition to provide a comprehensive nursing care to the patient and family. The patient /family’s initials has been used instead of their full names to maintain confidentiality.

ACKNOWLEDGEMENT

My first thanks go to the almighty Lord for seeing me through all these years and giving me the strength and the knowledge to complete this work successfully.

My outmost thanks also to Mr. A.R. and his family for their co-operation throughout the care. My next thanks go to my supervisor Mr. Eric Obeng whose constructive corrections has made this study a success and the entire staff of Holy Family Nursing and Midwifery training college Berekum for imparting knowledge and creating an enabling environment for me to complete my study successfully.

I would like to also express my sincere appreciation to the entire staff of Sunyani Regional Hospital, especially medical director, nursing administrator, the nurse in- charge of Male Surgical ward, and the ward doctor for their support during the study; I say may God richly bless you all.

I would like to again extend my profound gratitude to my guardians; Mr. John Boateng and Mrs. Comfort Abaah and not forgetting my siblings who by their financial support and encouragement made this study a success.

I always remain thankful to all my colleagues of RGN 22 for contributing to the success of this study.

Last but not the least thanks go to the authors and publishers of whose text books I used for the care study as references, may the good Lord bless them all.

INTRODUCTION

For the purpose of confidentiality my patient shall be known as Mr. A.R and abbreviations shall be used for characters in this care study.

The patient and family care study give the account of total nursing care that was carried out on Mr. A.R, a 65-year-old man with the diagnosis of right inguinal hernia. He reported to the outpatient department of Sunyani Regional Hospital on the 1st December 2021 on account of scrotal swelling with intense pain. He was then admitted to the Surgical Ward to be prepared for surgery and for further management.

My interaction with him started on the day of his admission and continued until care was terminated. This was to ensure that his physical, psychological, social and spiritual needs were met. He was discharged on the 4th December, 2021, with much improvement in his condition. The nursing process was used in nursing the patient.

The care study consists of six chapters using the nursing process as a guideline. Chapter one consists of the assessment of the patient and family, chapter two is analysis of data, chapter three is nursing care plan, chapter four deals with implementation of care. Chapter five contains evaluation of care rendered and chapter six deals with summary of the care rendered to the patient and family and the conclusion drawn

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CHAPTER ONE

ASSESSMENT OF PATIENT/ FAMILY

1.0 Introduction

Assessment is the systematic collection of data to determine the patient health status and any actual or potential health problems (Smelter & Bare, 2014). It is the first step of the nursing process. It is basically an ongoing activity involving gathering and organizing information about the patient's health status in order to generate a database that will form the bases for diagnosis and planning of care. The data collected could be either subjective, objective or both. The data obtained through discussions with patient or patient relatives, interviewing, observation, laboratory investigations, patient's folder, physical examination and relevant literature. The assessment entails the patient's particulars, family medical/surgical history, family socio-economic history, patient's developmental history, patient's lifestyle and hobbies, patient's past medical/surgical history, the present medical/surgical history of the patient, admission process of the patient and family, patient/family's concept of his illness, literature review on the condition and validation of data.

1.1 Patient's Particulars

Mr. A.R. is a 65-year-old man, born on 1st January, 1956 at Odumasi, in the East-Sunyani District of Bono Region. He is married with four (4) children and stays with his wife at Odumasi, a suburb of Sunyani in Bono Region in a house with number PLT 64 BLK G. He comes from Odumasi in the Bono Region and speaks Bono and Twi language. Mr. A.R. is a Farmer, a Christian and worships at the church of Pentecost Odumasi.

He is dark in complexion, about 1.5 height in metres and weighs 71kg. He is the second of four children, three male and one female. The name of patient's parents are Mr.A.K and Madam A.A. Mr A. R. had his basic education at Odumasi Roman Catholic Junior High School. He was unable to further his education due to financial constraints.

1.3 Family's Medical History

Mr. A.R. indicated that there is no known history of hereditary diseases such as hypertension, diabetes mellitus, sickle cell anaemia, asthma or mental illness in his family. He also revealed that, none of his family members have been hospitalized before but they occasionally suffer from minor ailments such as, headache, abdominal pains and fever which they treat often mitigate with over the counter medications purchased from the pharmaceutical shop and seek medical attention from the hospital if symptoms persist. His siblings are alive and without any congenital abnormalities or chronic diseases. None of their family members have been hospitalized before. His grandparents are both deceased at very old age. Other siblings are doing well. Six (6) of his family members died their natural deaths at the age of 80 years. According to patient there are no known allergies in the family.

1.4 Family's Socio-economic

Mr. A.R is a farmer, he grows maize, cassava, beans plantain. His wife also sells vegetables at Odumasi market in Sunyani. Together with his wife, they care and provide for the needs of their nuclear family. His income is enough for the family due to small family size.

He is also a beneficiary of the NHIS which also supports his family greatly during their sick moments. Patient stated clearly that his family is one of a peaceful type. Due to their strong faith as Christians, Mr. A.R. stated that they do not believe in taboos and myths, but respect people from all religious backgrounds.

1.5 Patient's Developmental History

According to Mr. A.R, he was born at term, spontaneously per vagina by traditional birth attendant in their house at Odumasi and had no congenital abnormalities such as hydrocephalus, clubfoot, cleft palate or cleft lip at both. He was breastfed exclusively for two months and was given

supplementary feeds for one and half years. He received immunization against the vaccine preventable diseases and was circumcised two weeks after birth.

He went through normal developmental milestone without any complication. He developed teeth at the fourth (4) month, crawled at the eighth (8) month and started talking when he was one year old.

Secondary sex characteristics were developed at age fourteen. He started farming in his twenty (20s) and married at age 27. Theory of psychosocial development which describes the human life cycle as a series of eight ego developmental stages from birth to death, my patient falls in the middle adulthood stage (Generosity vs Stagnation) (35 to 65) where the primary developmental task involved contributing to society and helping to guide future generations. When a person makes a contributing during this period, perhaps by raising a family or working towards the betterment of society, develop sense of generativity; a sense of productivity and accomplishment of results. In contrast, a person who is self-centered and unable or unwilling to help society move forward develops a feeling of stagnation; a dissatisfaction with the relative lack of productivity. Mr. A. R is a successful at this stage as he has been able to work towards the betterment of his society through his hard work, kindness and generosity.

1.6 Patient's Lifestyle and Hobbies

Mr. A.R. usually wakes up around 4:00am; he prays, empties his bowel, brushes his teeth and takes his bath. He takes his breakfast and leaves for work (farm) around 8:00am. He usually returns home around 4:00pm. He often takes his lunch at the farm.

He takes his supper with his family at home and watches television for a while. He goes to bed around 10:00pm after brushing his teeth and taking his bath.

Mr. A.R is very active and has numerus friends. At his leisure time, especially on Sundays, he visits friends and spend time with them.

His hobbies are listening to music, radio, visiting friends and relatives, playing draught and watching soccer. His favorite food is banku, okro stew with tilapia.

1.7 Patient's Past Medical History

Medical history is a narrative or record of past events and circumstances that are or may be relevant to the patient's current state of health. Informally, an account of past diseases, injuries, treatments and other strictly medical facts. (Cahil, 2015). According to him, before this episode of sickness, he had not suffered any type of sickness or injury and has not been hospitalized before. Mr. A.R. revealed that he had no particular health problem. He however suffers from slight headache, fever and other minor ailments which were usually treated with drugs bought from the chemical shop. Mr. A.R. has no known allergy. My patient has no history of serious accident or any form of injury. My patient has no physical disabilities.

1.8 Patient's Present Medical/Surgical History

Mr. A.R. indicated that had a sudden onset of swelling on the right inguinal region which was very painful followed by abdominal pain, difficult breathing on and headache on 31st November, 2021. He took some pain medications given to him by some neighbor's he complained to which he could barely identify. However, symptoms persisted and was rather aggravating.

After all attempts to reduce pain and swelling failed, patient was rushed to Sunyani Regional Hospital. He was diagnosed right inguino scrotal hernia and was to be prepared for surgery the following day. On examination, Mr. A.R. was pale, had a swollen scrotum, abdominal pains, constipation and fully conscious. He was admitted to the surgical Unit through the out-patient unit by the doctor on duty.

1.9 Admission of Patient

On 1st December, 2021 at 3:35pm, Mr. A.R. was brought to the Male Surgical ward of Sunyani Regional Hospital, through the Out-Patient department in a wheel chair accompanied by a relative. He had history of coughing, fever, painful inguino-scrotal swelling, headache and straining during urination. His admission was ordered by Dr. Marshall with a diagnosis of right inguino scrotal hernia. His admission was confirmed by calling his name written on the folder handed to me and

he responded. I also read through his folder and his admission was stated clearly there by the doctor. On arrival, patient was conscious and alert. He was made comfortable in an already prepared bed. His particulars were recorded into the admission and discharge book as well as the daily census sheet. I introduced myself as a final year student of the Holy Family Nursing and Midwifery Training College, Berekum and the nurses around were also introduced. Mr. A.R. was reassured that he would recover soon with the quality of care which will be rendered. I also assured him of confidentiality of information about his health and personal life.

His vital signs were checked and recorded as:

- Temperature -36.8°C
- Pulse -80bpm
- Respiration -20cpm
- Blood Pressure -130/80 mmHg

His weight also checked and recorded as 71kilograms. The laboratory investigations that were ordered on arrival included Full blood count (Hemoglobin level, white blood cell count and differentials), Blood for grouping and cross matching.

In addition to that, the following treatment was prescribed by the doctor to prepare the patient for surgery (Herniorrhaphy).

- Intravenous Normal Saline 2000mls for 48 hours
- Intravenous Ringers Lactate 1000mls for 24 hours
- Intravenous Dextrose Saline 1000mls for 24 hours
- Intravenous Amoxiclav 1.2g tid for 24 hours
- Intravenous Flagyl 500mg tds for 48 hours
- Intramuscular Pethidine 50mg 8 tid for 24 hours

His prescribed drugs were collected from the pharmacy and stat doses were given.

Intravenous infusions were given to rehydrate him and to provide nutrients to him while he was on no oral feed.

I recorded her history in the nurse's continuation sheet as well as the care rendered. All other forms such as the vital signs sheet and medication sheet were filled and kept in the patient's folder.

Daily routines such as visiting hours, time for medications and vital signs of the hospital were explained to Mr. A.R. and his relatives. His relatives were orientated to the ward and areas such as toilet and bathroom and the nurses' post. Mr. A.R. was introduced to other patients on the ward. Their belongings were packed in a bed side locker. Mr. A.R. and her family were assured of a speedy recovery which would lead to their discharge when she fully recovers. I then introduced myself again and sought for her consent to take her in writing my care study. I further explained that the care study was a requirement by the Nursing and Midwifery Council of Ghana in order to be awarded a license. He agreed and gave me his consent. An intravenous cannular was passed in the dorsum of his palm. Due medications were served at the right time and a comprehensive care plan was drawn for MR. A.R. Patient was educated on the condition to relieve anxiety.

1.10 Patient's Concept of His Illness

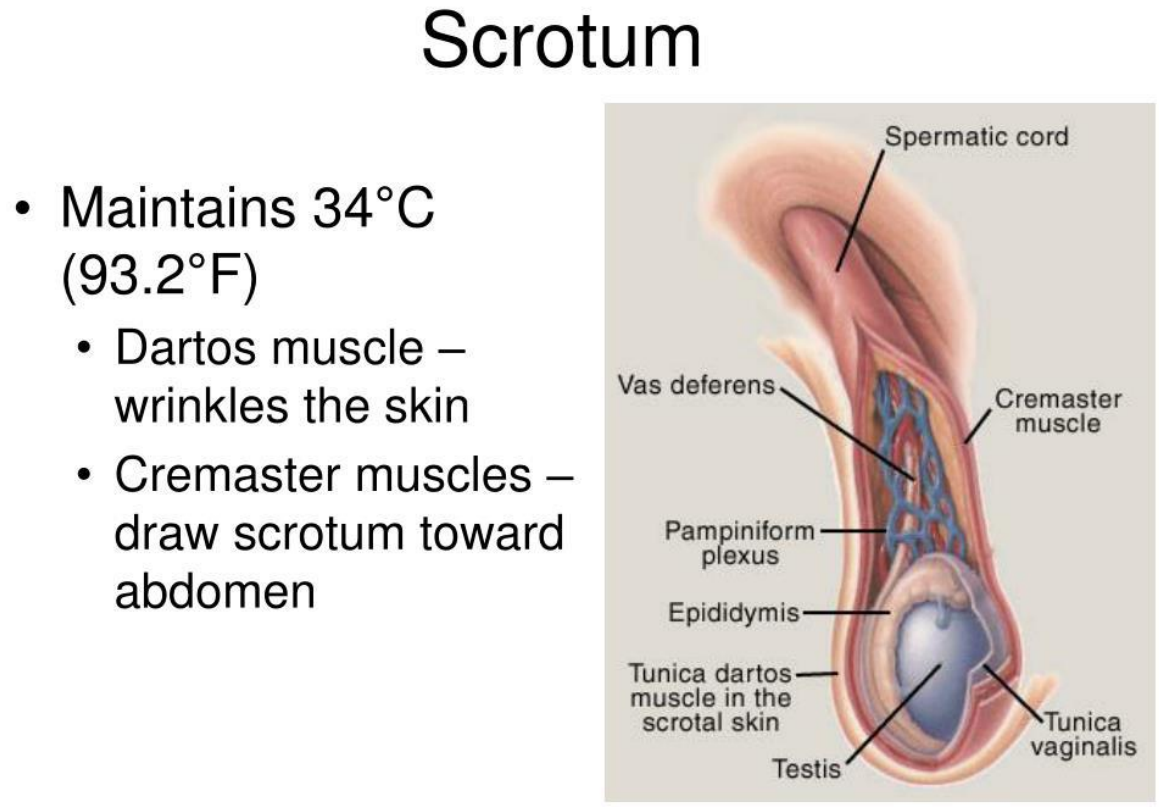
Mr. A.R is of the view that his illness is as a result of the tedious work he did on the day before the illness. Though patient and his relatives were very anxious of condition, they did not attribute illness to any spiritual beliefs. They were looking forward to speedy recovery once he was receiving treatment. I took this opportunity to educate them on the causes, signs and symptoms, treatment, prevention and the need for the admission of Mr. A. R.

1.11 LITERATURE REVIEW ON HERNIA

ANATOMY OF THE SCROTUM

According to Hammoud & Gerken (2021), the scrotum is a sac of skin that hangs from the body at the front of the pelvis, between the legs. It sits next to the upper thighs, just below the penis. The scrotum contains the testicles. These are two oval-shaped glands responsible for producing and storing sperm. They also produce several hormones, the main one being testosterone. They also produce several hormones, the main one being testosterone. The scrotum hangs outside the body because it needs to maintain a slightly lower temperature than the rest of the body. This lower temperature helps to maintain sperm production. Scrotal tissues help protect the structures inside the testicles, where sperm and important hormones are produced.

In addition, the scrotum protects the testicles and major blood vessels, as well as tubes that release sperm from the testicles into the penis for ejaculation.



Anatomy and function of the scrotum

The scrotum is a sack of skin divided in two parts by the perineal raphe, which looks like a line down the middle of the scrotum.

The raphe joins the internal septum with the scrotum. The septum splits the scrotal sac into two parts with similar anatomy.

Each side of the scrotum usually consists of a:

- **Testicle.** Each testicle produces hormones, the main one being testosterone, with the help of parts of the brain like the hypothalamus and pituitary gland. They also contain tubules and cells that produce sperm, or spermatozoa. Sperm are transferred from the testicle to the epididymis.
- **Epididymis.** An epididymis is located on the top of each testicle. Each epididymis is a tightly coiled tube. They store sperm created in each testicle until they're mature, usually for about 60 to 80 days. The epididymis also absorbs extra fluid secreted by the testicle to help move sperm through the reproductive tract.
- **Spermatic cord.** Each spermatic cord contains blood vessels, nerves, lymph vessels, and a tube called the vas deferens. This tube moves sperm out of the epididymis into ejaculatory ducts. The blood vessels maintain the blood supply for the testicle, vas deferens, and cremaster muscle. The nerves transport information from the spinal cord to and from the scrotum, testicles, and cremaster muscle.
- **Cremaster muscle.** Each cremaster muscle surrounds one of the testicles and its spermatic cord. The muscle helps to move the testicle toward and away from the body to maintain the ideal temperature for sperm production. This is why the scrotum hangs lower in warm conditions and closer to the body in cold weather.

All of these structures are surrounded by the scrotal wall. This wall is lined with smooth muscle called the dartos fascia muscle. This muscle, along with the cremaster muscles, help to expand or tighten the skin of the scrotum as it moves up and down.

DEFINITION

A hernia is the abnormal protrusion of an internal organ or part of an organ through an aperture (opening) or a weakness in the walls of the cavity in which the organ is contained into another cavity. (Cahil, 2015).

PARTS OF AN ABDOMINAL HERNIA

THE SAC:

According to Hammoud & Gerken (2021), it is an out pouch of the peritoneum. The neck of the sac may be broad allowing internal organs to slip in and out of the sac. It may also be narrow and surrounded by a dense fibrous tissue.

THE CONTENT:

This is what is in the hernia sac. It could be a loop of intestine, omentum, caecum, ovary or occasionally the bladder.

THE RING:

The hernia ring is a ring of muscular or fibrous tissue that forms an opening into the sac through which the viscus protrudes.

PATHOLOGICAL VARIETIES OF HERNIAS

Hammoud & Gerken (2021), outlined the pathological varieties of hernias according to the severity of the protrusion.

These include;

1. REDUCIBLE HERNIA

A reducible hernia is one that can easily return into the abdomen by mechanical when the patient is placed in supine position or can be manually replaced by gently pushing the mass back into its original cavity

2. IRREDUCIBLE HERNIA

An irreducible hernia is one that cannot be reduced by itself or by any manual method. This occurs when adhesions form between the sac and its content, so that it cannot be pushed back and in which intestinal flow may be obstructed completely.

3. STRANGULATED OR INCARCERATED HERNIA

An incarcerated hernia is one in which the protruding viscus is both irreducible and obstructed. This condition eventually leads to obstructed blood flow to or from the strangulated incarcerated hernias are considered to be surgical emergency. Immediate surgery is necessary to prevent necrosis and gangrene formation of the viscus.

Inguinal, umbilical and femoral hernias are more likely to become strangulate than other hernia because their sacs have smaller necks and tend to be surrounded by rigid rings of tissues. Also over time, adhesions may develop between a hernia sac and its contents and result in an irreducible or incarcerated.

TYPES OF HERNIA

1. INDIRECT INGUINAL HERNIA:

These herniations occur through the inguinal ring and follow the spermatic cord through the inguinal canal. It is far more common in males because of the space allowed for the descent of the testes. These hernias have a high incidence among infants and young persons after which the incidence drops, then rises again among persons in their 50’s and then tapers off. These hernias con become extremely large and they frequently descend into scrotum.

2. DIRECT INGUINAL HERNIA

These hernias pass through the abdominal wall in an area of muscular weakness and not through a canal as the indirect inguinal and femoral hernias. It is more common in the elderly and is the

result of a gradually developed weakness in an area that is congenitally deficient in the number of fibres present.

3. FEMORAL HERNIA

This occurs through the femoral ring and more common in females than in males. It begins as a plug of fat in the femoral canal that enlarges and gradually pulls the peritoneum and almost inevitably the urinary bladder, into the sac. There is a high incidence of incarcerated and strangulation in this type.

4. UMBILICAL HERNIA

There are two types; congenital umbilical hernia and acquired umbilical hernia. Congenital umbilical hernia is due to an abnormality of the muscular structure of the cord. Acquired umbilical hernia is due to increased abdominal pressure which occurs in obesed persons and woman who have had several pregnancies. It is due to defect of the umbilicus that has persisted from birth.

5. INCISION HERNIA

This type of hernia occurs at the site of a previous surgical incision. It is the result of inadequate healing of the incision because of a post-operative problem such as infection, inadequate nutrition, extreme distension, obesity or other factors. The incidence of this type of hernia is increasing probably because of the higher number of surgical procedures being performed.

6. DIAPHRAGMATIC HERNIA

This occurs when the abdominal organs herniated through the diaphragm into thoracic cavity.

7. EPIGASTRIC HERNIA

Also called ventral hernia which occurs in the epigastric region due to weakness of the muscles of the epigastric region.

8. HIATAL HERNIA (HIATUS HERNIA)

Hiatal hernia occurs when a portion of the stomach protrudes into the thoracic cavity through a defect in the diaphragm wall at the point where the esophagus passes through the diaphragm.

INCIDENCE

Inguinal hernia mostly affects men whiles femoral and umbilical hernia is more prevalent among women (Cahil, 2015).

CAUSES

Abdominal hernias are caused by a combination or co-existence of factors such as:

1. a weak or defect in the muscle wall. The muscular wall defect may arise from congenital factors including impairment of the collagen tissue and musculature integrity. Acquired muscular weakness may develop as a result of trauma or with the ageing process.

2. Increase intra-abdominal pressures. This increase occurs under a number of circumstances and with certain pathological states. These include;

- Pregnancy.
- Obesity.
- Bearing down as with chronic constipation.
- Straining associated with the use of incorrect techniques when lifting weights or other heavy objects.
- Pushing or pulling.
- Ascites.
- Chronic cough.
- Enlargement tumor or lesion.

PATHOPHYSIOLOGY

Abdominal hernia develops by a combination of two factors; a weakness or defect in the muscle wall. The muscular wall defect may arise from congenital factors including impairment of collagen tissue and musculature integrity. Acquired muscular weakness may develop as a result of trauma or with the aging process.

Also, increase intra-abdominal pressure under a number of circumstances such as straining to lift heavy object, straining on defecation and during forceful coughing or sneezing. A segment of the intestine or abdominal organ moves into a weak area of the abdominal cavity. At first, the defect in the abdominal wall is small as the hernia persists and the organs continue to protrude, the defect grows larger.

Eventually the protruding organ may become trapped within the weakened pouch and adhesion may develop between the hernia sac and it content resulting in an incarceration hernia.

If blood flows to or from the protrusion is obstructed the hernia is referred to as strangulation. Immediate surgery is usually involved when there is a strangulation or incarceration so as to prevent necrosis and gangrene.

SIGNS AND SYMPTOMS

1. Pain at site of strangulation.

2. Vomiting.

3. Swelling of the hernia sac which is tense.

4. Tenderness

5. Fever and chills

6. Pulse rate may be increased.

7. Anxious facial expression.

8. Constipation

9. If gangrene has developed there will be less pain

COMPLICATIONS

1. Irreducibility: this is when the hernia contents cannot be pushed back into the abdomen which may be due to swelling or congestion of the protruded organ.

2. Intertrigo of the skin: abrasion due to two folds of skin rubbing each other.

3. Strangulation: here the blood supply to the content becomes obstructed by constriction at the neck of the sac so that the blood supply to the content is impaired. If the constriction is not relieved urgently, the bowel becomes gangrenous and perforate. About 30% of femoral hernia and 5% of inguinal hernia get strangulated.

4. Fistula formation: if part of the circumference of the bowel is in the sac become strangulated and left untreated, it may lead to gangrene and perforate. As abscess form in the sac which later raptures on the skin to form an enterocutaneous fistula

5. Reoccurrence of hernia.

6. Damage of spermatic cord in males.

7. Infections after surgery.

8. Oedema of the scrotum.

9. Retention of urine.

10. Bowel obstruction.

11. Hemorrhage.

12. Shock.

DIAGNOSTIC INVESTIGATIONS

1. Physical examination reveals the presence of a swelling which appears on coughing or straining and disappears when the patient is supine.

2. Abdominal or pelvic x-ray reveals the protrusion of the viscus outside its normal cavity.

3. Laboratory studies which includes complete blood count, electrolytes, white blood cells count will be elevated.

4. Computed tomography scan.

TREATMENT OR MANAGEMENT OF HERNIA

(A) NON-OPERATIVE TREATMENT

MECHANICAL REDUCTION

This is carried out on reducible hernia; it involves manipulating the content back into place to bring about temporary relief.

After that the patient may wear a truss to keep the abdominal content from protruding into the hernia sac.

A truss is a firm pad, with a belt attached that is placed over the hernia to keep it from protruding.

Non-operative treatment does not cure the patient.

MEDICAL TREATMENT

There is no medical treatment for hernia. Until surgery is performed antibiotics and Intravenous fluids are administered to prevent infections, fluid and electrolyte imbalance and dehydration.

Some of the drugs administered include;

1. Intravenous fluids such as normal saline, ringers' lactate and dextrose saline.
2. Analgesic such as pethidine for pain.
3. Antibiotics such as metronidazole (flagyl) and ciprofloxacin

(B) SURGICAL TREATMENT

Surgery results in radical cure:

Procedures that may be use are:

HERNIOTOMY

This operation involves opening the hernia sac and reducing its content into the abdominal cavity.

HERNIORRHAPHY

It involves removal of the hernia sac after it has been dissected and free from the surrounding structures and the content have been replaced in the abdominal cavity and the neck has been ligated.

HERNIOPLASTY

In hernioplasty, the weaken areas is reinforce with synthetic sutures such as steel mesh, fascia, a wire. It is an attempt to prevent reoccurrence.

SPECIFIC PRE-OPERATIVE CARE

OBSERVATIONS

(A) Assess the patient for upper respiratory tract infection, chronic cough, and sneezing or constipation, it may be necessary to postpone the operation, because coughing or sneezing could weaken the post-operative wound.

(B) Closely monitor vital signs and intravenous fluid administration.

(C) In emergency conditions of strangulated or incarcerated hernia, the nurse prepares the patient as in any other acute surgical condition, the following points should however be taken into consideration:

1. The patient is nursed in a recumbent position with the foot end of bed elevated.

2. Insert nasogastric tube promptly to empty the stomach and relieve pressure on the hernia sac.

3. Temperature, pulse, respiration and blood pressure are monitored half hourly.

4. Apply cold compresses to the site of the hernia to relax the muscles.

5. An intravenous line should be maintained to correct fluid and electrolyte imbalance.

6. The supra-pubic area should be shaved up to the anterior surface area of the thigh.

7. Specimen or samples should be obtained for laboratory investigations example, obtain urine to test for sugar and albumin and also samples for analysis and grouping and cross-matching.

8. Reassure patient and his relatives by explaining procedure to them.

PATIENT EDUCATION

Reinforce the surgeon's explanation of the surgery and its possible complications. An emphasis is place on deep breathing exercise and leg movement.

Encourage early ambulation, but warm the patient against bending and lifting or other strenuous activities.

SPECIFIC POST-OPERATIVE CARE

1. If general anesthesia is used oral fluid and food are restricted until peristalsis occurs.

2. For more extensive hernia repair, nasogastric suction may be use to prevent distension, vomiting, and straining.

3. Check for retention of urine, the patient may face difficulty in voiding following spinal anesthesia. Catheterization may be necessary to relief or avoid retention of urine.

4. Swelling of the scrotum on a rolled towel and apply ice-bags intermittently. A bandage or a scrotal support may be applied for support and comfort.

5. The sutures are removed on the 7^{th} and 9^{th} day post operatively. Clips are removed on the 5^{th} day after operation. If a drain is in place, it is removed on the 2^{nd} or 3^{rd} day post-operatively.

6. Any elevation of temperature should be reported to the surgeon.

7. If the patient develops coughs, or sneeze, instruct him to splint the incision site with his hands to lesser pain and protect the incision.

8. The nurse must encourage early ambulation but warn the patient against lifting.

NUTRITION

Intravenous fluids are administered as prescribed and monitor to ensure that drip is according to prescribed rate by the surgeon to prevent dehydration pre-operatively and post operatively. Patient is given nothing by mouth in the abdominal surgery until it is directed by the surgeon after the certifying the presence of bowel sound or peristaltic movement, patient is then started with sips of

water and then patient is introduced to fluid diet e.g. plain tea then followed by light nourishing diet e.g. light soup and eventually to normal diet.

Plan diet with patient taking into consideration her like and dislike, serve meal attractively, remove unsightly scenes from the ward and providing snacks in between meals.

MEDICATION

Patient prescribed drugs are served both pre-operatively and post operatively. When serving drugs, the nurse should take into consideration the following, the right of patient, the right of drug, the right of dosage, the right of patient to refuse medication, the right route of drug administration. Observe for the desirable effects and side effects of the drug and record should be encouraged to take the full course of the drug.

WOUND CARE

Patient's wound is observed for signs of bleeding and infection, any offensive odour, discharges of pus or signs of wound gapping. Wound is dress aseptically from inside out to prevent wound contamination. Also, alternative stitches are removed aseptically as directed by the surgeon.

The patient is educated to keep the wound dry and not to be touching it with the hand to prevent wound infection. Also, the patient is encouraged to take in high protein diet with vitamin to promote wound healing and repair worn-out tissues.

PERSONAL HYGIENE

Depending on the patient's condition he is either assisted to bath when he can do so or given bed bath. This help to remove dirt from the skin, improves circulation and muscles tone. It also refreshes patient and enhances patient's comfort. During bathing care must be taken to wash the perineum. Also, during bathing, pressure areas such as the occipital, scapular, and sacrum should be treated to stimulate circulation and prevent bed sores. The patient's finger and toe nails are soaked in water respectively to soften and trimmed them in order to prevent accumulation of dirt

and also causing injury to patient. Patient mouth is cared for by using tooth brush and paste or chewing stick if the patient is conscious. Mouth care help to prevent oral infections e.g. halitosis, gingivitis sores etc. it also enhances Patient appetite.

ELIMINATION

Serve Patient with bedpan on request and encourage patient to take more fluid and roughages to prevent constipation. If the patient is unable to pass urine, the following measures are carried out; open nearby taps to stimulate urination or apply warmth over the bladder and the perineum. If these measures fail to induce micturition, pass catheter under aseptic technique. The amount, colour, odour and any abnormalities found is documented in the nurse's notes.

REST AND SLEEP

It is important the patient has a calm peaceful rest. Bed rest is provided to converse energy. This can be ensured by providing comfortable bed free from creases and crump. There must be less noise on the ward with all procedure organized in such a way to prevent interruption during sleep. Ensure good ventilation and reduce the number of visitors.

POSITION

Patient is placed on the supine position to reduce pain and facilitate breathing after surgery. The patient is allowed to assume a comfortable position which is not contra-indicated to his condition to help prevent complication.

1.12 PATIENT EDUCATION BEFORE DISCHARGE

1. Warn the patient against lifting or straining.

2. Inform him that he will be able to return to work or resume normal duties within four weeks.

3. Remind him to take surgeon's permission before returning to work or completely resuming his normal activities.

4. Instruct him to watch for signs of wound infection such as oozing, tenderness, warmth and redness of the incisional site or wound.

1.13 Validation of Data

All information provided by patient were compared with standards from literature, data from patient's folder as data obtained from patient's relatives through series of interventions which aided in arrival of the diagnosis of right inguino scrotal hernia.it is therefore considered valid for the study.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Weller (2014), defined analysis as the critical examination and interpretation of the data collected during the assessment of the patient. This is the second phase of the nursing process where information gathered is interpreted, strength and weakness are identified and possible interventions employed. It helps the nurse to identify the actual and potential health problem as well as arrived at nursing diagnosis. This chapter comprises the following headlines;

1. Comparison of the data with standards
2. Patient/family strengths.
3. Health problems.
4. Nursing diagnosis

2.1 Comparison of The Data with Standards

This involves the comparison of information gathered from the patient with that of the standards in the literature to help in gathering an empirical basis of the disease condition. These covers;

1. Diagnostic investigation.
2. Causes.
3. Clinical features.
4. Treatment.
5. Complications

Table 1: **Comparison of the diagnostic tests carried out on Mr. A.R. with literature review.**

Diagnostic Tests Per Literature Review	**Diagnostic Tests Conducted Mr. A.R.**
Physical examination	Physical examination was done.
Abdominal X ray	Abdominal X ray was not done
Full Blood Count	Full Blood Count was tested
White blood Count	White blood count was done
Computed temograhpic scan	Computed temographic scan was not done

TABLE 2: DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATIONS	RESULTS	NORMAL	INTERPRETATION	REMARKS
1/12/21	Blood.	Hemoglobin level estimation	13g/dl	Male =12-18g/dl Female= 11-16g/dl	Within the normal range.	No treatment was given.
1/12/21	Blood.	Sickling	Negative.	Negative.	Normal sickling status	No treatment was given.
1/12/21	Blood.	White blood cell count.	4.50 [10^3/uL]	2.60-8.50 [10^3/uL]	White Blood cell count was within normal range	No treatment was given.
1/12/21	Blood	Red blood cell count	4.51 [10^6/uL]	4.50-5.50 [10^6/uL]	Within normal range	No treatment was given

2.3 COMPARISON OF CAUSES OF PATIENT'S DISEASE CONDITION WITH STANDARDS IN THE LITERATURE

With reference to the literature, hernia (inguino scrotal hernia) is caused by a combination factors, which may include congenital defects, a weakened muscle of the abdominal walls, increased intra-abdominal pressure as in constipation, lifting heavy objects with little precautionary measures and so on.

Mr. A.R has the acquired type, which was brought about by lifting and pulling heavy objects at the farm (work place) and also straining during defecation because of constipation.

TABLE 3: COMPARISON OF SIGNS AND SYMPTOMS OF PATIENT WITH LITERATURE

Signs and symptoms as per literature	**Signs and symptoms presented by patient**
1. Pain at the site of hernia especially at the early stage.	1. There was severe pain at the lower abdominal region of Patient.
2. Vomiting	2. Patient did not vomit.
3. Swelling at the site of hernia.	3. There was swelling at the inguinal region.
4. Tenderness	4. Patient experienced tenderness at the inguinal region.
5. Constipation.	5. Patient complained of constipation.
6. Pulse rate may be increased.	6. Patient had a normal pulse rate.
7. Fever and chills.	7. Patient had fever.
8. Anxiety.	8. Patient was anxious.
9. If gangrene has developed there will be less pain.	9. Patient did not develop gangrene.

According to the table, patient presented with most of the clinical manifestations in the literature review and this shows that my Patient had the condition.

2.4 SPECIFIC MEDICAL TREATMENT GIVEN TO THE PATIENT

The following medications were prescribed for patient;

PRE-OPERATIVE MEDICATION

1. Intravenous normal saline infusion two (2) litres for 48 hours.
2. Intravenous ringers lactate infusion one (1) litre for 24 hours.
3. Intravenous dextrose saline infusion one (1) litre for 24 hours.
4. Intravenous Ciprofloxacin 400mg bd for 72 hours.
5. Intravenous flagyl 500mg tds for 72 hours.
6. Intramuscular pethidine 50mg 8 hourly for 24 h

POST-OPERATIVE MEDICATION

1. Intravenous Ciprofloxacin 400mg bd for 72 hours.
2. Intramuscular pethidine 100mg one (1) litre for 48 hours.
3. Intravenous ringers lactate one (1) litre for 48 hours.
4. Intravenous normal saline infusion 1000mls for 24 hours.
5. Intravenous dextrose saline one (1) litre for 48 hours.
6. Intravenous flagyl 500mg tds for 72 hours.
7. Ciprofloxacin (Tab) 500mg bd x 7 days.
9. Flagyl (Tab) 200mg tds for 7 days.
10. Tablet paracetamol 500mg tds x 7 days.

Patient was given the following medications which do not correspond to those listed in the literature review;

Table 4: Treatment outlined in the literature review compared with that given to the patient.

Treatment outlined in the literature review	**Treatment given to Mr. A. R.**
Antibiotics	IV Ciprofloxacin 400mg bd intravenously x 72 hours IV Flagyl 500mg tds x 72 hours Tab Ciprofloxacin 500mg bd x 7 days Tab Flagyl 200mg tds x 7 days
Analgesics/ Anti-inflammatory	Intramuscular pethidine 100mg 8 hourly x 24 hours Tab paracetamol 500mg tds x 7 days
Intravenous fluids	Intravenous normal saline infusion two (2) litres for 48 hours. Intravenous ringers lactate infusion one (1) litre for 24 hours. Intravenous dextrose saline infusion one (1) litre for 24 hours.

TABLE 5: PHARMACOLOGY OF DRUGS PRESCRIBED FOR PATIENT

DATE	DRUG NAME	DOSAGE/ROUTE OF ADMINISTRATION ACCORDING TO LITERATURE	DOSAGE/ROUTE OF ADMINISTRATION PRESCRIBED FOR PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL EFFECTS	SIDE EFFECTS/REMARKS
01-12-21	Normal saline Infusion.	Adults and children dosage is highly individualized Route: Intravenous	2000mls for 24 hours intravenously.	Intravenous fluid electrolyte expander and isotonic replacement.	To restore sodium, chloride and fluid level.	Patient's sodium and chloride level was maintained.	Large doses may give rise to sodium accumulation, oedema and potassium loss. None was observed.
01-12-21	Ringers lactate Infusion.	Adults and children dosage is highly individualized. Route: Intravenous	1000mls for 24 hours intravenously	Electrolyte solution and isotonic replacement.	To replace fluid and electrolyte balance that might be lost in dehydration.	Patient was rehydrated and electrolyte balance maintained.	Fluid overload, osmotic diuresis and hyperglycaemia. None was seen.

01-12-21	Dextrose saline Infusion.	Adults and children dosage depends on fluids and caloric requirement Route: Intravenous	1000mls for 24 hours intravenously.	Isotonic solution of glucose sodium chloride and water.	Minimize glycogenisis, prevents anabolism in patient's whose oral caloric intake is limited.	Patient was rehydrated and energy was restored	Fluid overload, osmotic dieresis and hyperglycaemia. None was seen.
01-12-21	Injection Pethidine .	Adult dose: 50 – 100 mg Child dose:25-50mg Route: Intramuscular	100mg stat then 8 hourly for 24 hours intramuscularly.	An opoid narcotic analgesic	For analgesic and sedative effect.	Pain was relieved.	Euphoria, dizziness, constipation, vomiting. None was observed.
1-12-21	Ciproflox acin Infusion.	Adult dose: 100-500mg Child dose:10-15mg/kg Route : intravenous	400mg bd for 72 hours intravenously.	Broad spectrum antibiotic Flouroquinolones	Inhibit deoxyribonuclei c acid (DNA) replication in susceptible bacteria preventing cell production.	Patient's condition improved.	Headache, dizziness, vomiting, fatigue. None was observed.

1-12-21	Metronidazole (flagyl) Infusion.	Adult dose: 500 mg – 750 mg Child dose: 30 – 50 mg Route: Intravenous	500mg tds for 72 hours intravenously.	Antibiotic/Antiprotozoa	Destroys bacteria and protozoa.	Infection was controlled.	Confusion, headache, weakness, constipation and vomiting. None was observed

2.5 COMPLICATIONS DEVELOPED BY PATIENT

With reference to the complication stated in the literature review, Patient did not develop any complications. However due to early detection and management he received, he had a successful surgery and recovered well.

2.6 PATIENT /FAMILY STRENGTHS

Strength is a resource and ability that an individual has which can help him cope with the stress of his condition (Weller, 2014). The following were the strengths of Mr. A.R;

1. Patient could describe the characteristics of pain (location and intensity)
2. Patient could verbalize his concerns about the surgery
3. Patient could verbalize the intensity of pain
4. Patient was willing to follow infection prevention measures.
5. Patient was willing to be assisted to attend to his personal hygiene
6. Patient expressed readiness to know more about hernia

2.7 HEALTH PROBLEMS

Health problems are any condition in which the patient requires nursing management to overcome the said problem (Weller, 2014). It could be physical, social or spiritual. The following health problems were identified upon assessing M.R A. R

1.(1/12/2021) Patient complained of pain in the inguinal region.

2.(1/12/2021) Patient complained of anxiety.

3.(2/12/2021) Patient complained of pain in the incision site.

4. (2/12/2021) Patient had an incisional wound.

5. (3/12/2021) Patient could not perform his personal hygiene.

6.(3/12/2021) Patient and family had insufficient knowledge about hernia.

2.8 NURSING DIAGNOSIS

This is based on the patient's complaints and the observation made by the nurse. The following diagnoses were made on patient;

1. (1/12/2021) Impaired comfort (inguinal pain) related to swelling and inflammatory process at the inguinal region.
2. (1/12/2021) Anxiety (patient and family) related to impending surgery.
3. (2/12/2021) Impaired comfort (pain) related surgical incision.
4. (2/12/2021) Risk for infection as evidenced by break in the continuity of skin (surgical incision).
5. (3/12/2021) Self-care deficit (bathing and grooming) related to confinement to bed.
6. (3/12/2021) Deficient knowledge (patient and family) related to the complex nature of information about hernia and its management.

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is third stage of the nursing process in which the nurse and the patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2014). Plans for implementation are based on assessment and diagnosis of the patient health status, strength and concerns. The nursing care plan facilitates achievement of the patient goals. It communicates clearly the nature of the patient's problem and specifies the nursing interventions necessary for the patient.

3.1 Objectives and Outcome Criteria

1. Patient will be relieved of pain within six hours as evidenced by: (1/12/2021).
    a. Patient verbalizing that inguinal pain has subsided.
    b. Nurse observing that patient is relaxed with a cheerful facial expression.
2. Patient will be relieved of anxiety within twelve hours as evidenced by: (1/12/2021).
    a. Patient reporting resolution of anxiety.
    b. Nurse observing relaxed facial expression of patient and eagerness to undergo surgery.
3. Patient will be relieved of incisional site pain within 24 hours as evidenced by: (2/12/2021).
    a. Patient reporting a relief of pain.
    b. Patient rating pain as 2 or below on the numeric pain rating scale.
4. Patient's incisional wound will be healed devoid of infection within the period of hospitalization as evidenced by: (2/12/2021).
    a. Patient participating in wound care and infection prevention measures.

b. Nurse observing that wound is healing by first intention without signs of infection.

5. Patient will be assisted to bath within 24 hours as evidence by; (3/12/2021).
    a. Patient looking well groomed.
    b. Patient/ family gathering bathing supplies.

6. Patient and family will gain adequate knowledge about hernia and its management within 4 hours as evidenced by: (3/12/2021).

a. Patient and family practicing knowledge gained on hernia and its management.
b. Patient and family being able to answer correctly questions asked on the cause, clinical features and management of hernia.

TABLE 6: NURSING CARE PLAN FOR MR. A.R

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
1-12-21 4:00pm	Impaired comfort (inguinal pain) related to swelling and inflammatory process at the inguinal region.	Patient will be relieved of pain within five hours as evidenced by: a. Patient verbalizing that inguinal pain has subsided. b. Nurse observing that patient is relaxed with a cheerful facial expression.	1. Reassure patient and family. 2. Put patient in a comfortable position. 3. Apply cold compress to the inguinal region. 4. Provide scrotal support. 5. Employ diversional therapy. 6. Serve prescribes analgesics to relieve pain.	1. Patient and family were reassured that appropriate nursing care will be instituted to relieve him of the pains. 2. Patient was placed in a recumbent position in order to relieve the pains. 3. A wrapped cold compress was applied on the inguinal region every hour to reduce pain sensation. 4. The scrotum was supported by placing wrapped cold compress under it to prevent vigorous movement and to ease the pain. 5. Diversional therapy such as conversation was used to help put patient's mind off the pain. 6. Injection pethidine 50mg as was administered to patient.	1-12-21 9:00pm	Goals fully met as patient verbalized that inguinal pain had subsided and was relaxed with a cheerful facial expression.	A. G

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
1-12-21 4:20pm	Anxiety (patient and family) related to impending surgery	Patient and family will be relieved of anxiety within 5 hours as evidenced by: a. Patient reporting resolution of anxiety. b. Nurse observing relaxed facial expression of patient and eagerness to undergo surgery.	1. Reassure patient and relatives. 2. Introduce patient and relatives to other patients who have undergone the similar surgery successfully. 3. Educate patient and his relatives on the benefits of the surgery and the complications that can occur if the surgery is not done. 4. Allow patient and his relatives to ask questions and express their fears. 5. Answer their questions promptly in simple terms to their understanding.	1. Patient and relatives were assured that everything possible will be done for him to have a successful surgery. 2. Patient and his relatives were introduced to MR. A.R who had successfully undergone the herniorraphy and was recovering. 3. Patients and his relatives were educated that if the surgery is not done, complications like intestinal obstruction, peritonitis, and urine retention could occur hence the need for surgery. 4. Patient and his relatives were allowed to ask questions bothering their minds and express their fears. 5. Patients and his relatives' questions were duly answered in simple terms to their understanding.	2-12-21 9:20pm	Goal fully met as patient reported resolution of anxiety and on observation patient had a relaxed facial expression of patient and was eager to undergo surgery.	A. G

			6. Provide a noise free environment to reduce stimulation and ensure relaxation.	6. Volumes of ward television were reduced to minimize noise and visitors were restricted to ensure relaxation.			

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
2-12-21 2:00pm	Impaired comfort (pain) related surgical incision.	Patient will be relieved of incisional site pain within 24 hours as evidenced by: a. Patient reporting a relief of pain. b. Patient rating pain as 2 or below on the numeric pain rating scale.	1. Assess patient's level of pain. 2. Put patient in a comfortable position. 3. Monitor vital signs. 4. Plan a diversional therapy for patient. 5. Encourage rest and sleep to reduce pain sensation. 6. Serve prescribed analgesics.	1. Patient level of pain was assessed using the numeric pain rating scale. Patient rated pain as 7 on a scale of 0 to 10. 2. Patient was put in a recumbent position in order to relieve him of the pain. 3. Vital signs such as temperature, pulse, respiration and blood pressure were monitored. 4. Diversional therapy such as engaging patient in conversation and watching television was employed to help divert patient's attention from the pain. 5. Patient's bed linen was straightening and free of creases to enhance rest and sleep in order to reduce pain sensation. 6. Injection pethidine 50mg was administered.	3-12-21 2:00pm	Goal fully met as patient reported a relief of pain. and rated his pain as 2 on the numeric pain rating scale	A. G

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
2-12-21 2:30pm	Risk for infection as evidenced by break in the continuity of skin (surgical incision)	Patient's incisional wound will be healed devoid of infection within the period of hospitalization as evidenced by; Patient participating in wound care and infection prevention measures. Nurse observing that wound is healing by first intention without signs of infection.	1. Observe wound site. 2. Dress patient's wound aseptically. 3. Serve patient with highly nutritious diet to facilitate wound healing. 4. Educate patient on how to promote wound healing and prevent infection. 5. Serve prescribed antibiotics.	1. Patient's wound was observed for swelling, drainage, and hemorrhage to assess for infection and none was seen. 2. A sterile trolley was set to dress patient's wound under strict aseptic technique as ordered to prevent infection. 3. Patient's diet was planned with him to include food rich in protein, vitamins and mineral salts to facilitate wound healing. 4. Patient was educated to keep wound dry and avoid touching it unnecessarily to prevent wound infection. 5. Ciprofloxacin, Amoxiclav and flagyl were administered to prevent infection.	4-12-21 2:30pm	Goal fully met as patient participated in wound care and infection prevention instructions and wound appeared to be healing by first intention on assessment without signs of infection.	A. G

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
3-12-21 6:00am	Self-care deficit (bathing and grooming) related to confinement to bed.	Patient will be assisted to bath within 2 hours as evidence by; Patient looking well-groomed and patient/family gathering bathing supplies.	1. Reassure patient and family 2. Educate patient on the importance of personal hygiene. 3. Protect bed with long mackintosh and assist patient to bath. 4. Change patient's bed linen when soiled. 5. Keep incisional site clean and dry.	1. Patient and family were reassured that patient's bathing needs will be catered for and with time patient will bath himself unaided. 2. Patient was educated on the importance of hygiene and that he will be aided to attend to his personal hygiene needed. 3. Patient's bed was protected with long mackintosh and assisted to bath in bed with warm water. 4. Patient's bed linen was frequently changed to prevent infection and enhance comfort. 5. Patient's surgical incision was kept clean and dry during bathing and the	3-12-21 8:00am	Goal fully met as Patient appeared clean and well groom in bed.	**A. G**

			6. Assist patient with grooming.	importance of some was explained to patient. 6. Patient was assisted to groom.			

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
3-12-21 9:00am	Deficient knowledge (patient and family) related to the complex nature of information about hernia and its management	Patient and family will have adequate knowledge about hernia and its management within 24 hours as evidenced by: a. Patient and family practicing knowledge gained on hernia and its management. b. Patient and family being able to answer questions asked on the causes, clinical features and management of hernia.	1. Provide a conducive environment to enhance learning 2. Assess patient and his family level of knowledge on hernia. 3. Educate Patient and his family on hernia and its management. 4. Allow Patient and his family to ask questions.	1. A conducive environment with less noise was created to enhance learning. Radio and televisions were put off. 2. Patient and his family level of knowledge on hernia were assessed by questioning and misconception about hernia was clarified in simple term. 3. Patient and his family were educated on the definition, causes, signs and symptoms, treatment, prevention and complications of hernia. 4. Patient and his family were allowed to ask questions	4/12/21 9:00am	Goals fully met as; a. Patient and family were seen practicing knowledge gained on hernia and its management. b. Patient and family were able to answer questions asked on the causes, clinical features and management of hernia.	A. G

			5. Answer questions in simple terms in patient's dialect. 6. Evaluate patient and family's understanding by question.	5. Answer questions in simple terms in patient's dialect to facilitate understanding. 6. Patient and family were asked questions on the causes, clinical features and management of hernia. They able to provide appropriate answers to question posed.			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT / FAMILY CARE PLAN

4.0 Introduction

Implementation of patient / family care plan started from the day of admission of patient and continued till his discharge. It includes the routine nursing care such as checking of vital signs, assisting patient to bath, eat, bed making etc. Its purpose is to provide technical and therapeutic nursing care required to help the patient achieve an optimal level of health.

4.1 Summary of Actual Nursing Care

The nursing care of Mr. A.R started on the 1st of December, 2021 at the Male Surgical Unit Nursing care was aimed at relieving him of his condition, to prevent infection and complete healing of wound as well as maintenance of physiological function so that he could return home as a healthy individual.

First Day of Admission (1st December, 2021)

On 1st December, 2021 at 3:35pm, Mr. A.R. Patient was brought to the Male Surgical ward of Sunyani Regional Hospital through the Out-Patient department in a wheel chair accompanied by a relative. He had history of coughing, fever, painful inguino-scrotal swelling, headache and straining during urination. His admission was ordered by Dr. Marshall with a diagnosis of right inguino scrotal hernia. Vital signs were checked and recorded as:

- Temperature- 36.8°C
- Pulse - 80bpm
- Respiration - 20cpm
- Blood Pressure- 130/80 mmHg

His weight also checked and recorded as 71kilograms. The laboratory investigations that were ordered on arrival included Full blood count (Hemoglobin level, white blood cell count and differentials), Blood for grouping and cross matching.

Blood sample was taken and specimen was labeled and sent to the laboratory to check haemoglobin level to rule out anaemia, sickling to rule out sickle cell disease, grouping and cross matching against one pint of blood and also to know the blood group and rhesus type of patient.

In addition to that, the following treatment was prescribed by the doctor to prepare the patient for surgery (Herniorraphy).

- Intravenous Normal Saline 2000mls for 48 hours
- Intravenous Ringers Lactate 1000mls for 24 hours
- Intravenous Dextrose Saline 1000mls for 24 hours
- Intravenous Amoxiclav1.2g tid for 24 hours
- Intravenous Flagyl 500mg tds for 48 hours
- Intramuscular Pethidine 50mg tid for 24 hours

His prescribed drugs were collected from the pharmacy and stat doses were administered.

At 4:00pm a nursing diagnosis of impaired comfort (inguinal pain) related to swelling and inflammatory process at the inguinal region was made and an objective set to relief patient of pain within five hours. The following nursing actions were carried out: patient and family was reassured that appropriate nursing care will be instituted to relieve him of the pains, patient was placed in a recumbent position in order to relieve the pains, a wrapped cold compress was applied on the inguinal region every hour to reduce pain sensation, the scrotum was supported by placing wrapped cold compress under it to prevent vigorous movement and to ease the pain. Diversional therapy such as conversation was used to help put patient's mind off the pain. Injection pethidine 50mg was administered as prescribed.

At 4:20pm Patient expressed concerns about the upcoming surgery. A nursing diagnosis of Anxiety (patient and family) related to impending surgery was made. An objective was set to help relief patient of anxiety within five hours. Nursing interventions carried executed include: patient and relatives were assured that everything possible will be done for him to have a successful

surgery, patient and his relatives were introduced to MR. A.R who had successfully undergone the herniorraphy and was recovering, patients and his relatives were educated that if the surgery is not done, complications like intestinal obstruction, peritonitis, and urine retention could occur hence the need for surgery, patient and his relatives were allowed to ask questions bothering their minds and express their fears, patients and his relatives' questions were duly answered in simple terms to their understanding, volumes of ward television were reduced to minimize noise and visitors were restricted to ensure relaxation.

His vital signs such as temperature, pulse respiration and blood pressure were taken and recorded as in appendix.

His prescribed drugs were collected from the pharmacy and stat doses were given. Intravenous infusions were given to rehydrate him and to provide nutrients to him.

PRE-OPERATIVE CARE OF PATIENT

Psychological Preparation:

Patient and his relatives were assured of a competent health staff. Procedures were explained to patient and his relatives to reduce fear and anxiety.

It was observed that patient and relatives were anxious about the impending surgery and did not know anything about hernia or herniorrhaphy. They were however assured that patient is in safe hands of competent health staff who will take good care of him.

The disease process including the causes, signs and symptoms and treatment were explained to patient and relatives in simple terms and they were then allowed to express their fears and problems and these were explained in simple terms promptly.

The spiritual needs of the patient were also met by inviting his relatives to pray for him to go through the surgery successfully.

Physical Preparation:

To prevent post-operative complications, patient's skin was assessed for any abnormalities such as rashes, keloids, scars or incision of previous operations of which none was seen. He was

instructed not to take anything by mouth. Food and fluids were withheld orally for about 8hours to prevent vomiting and aspiration during the period of administration of the anaesthetic agents.

Patient operation site was prepared by shaving with particular attention to the perineal area to help prevent wound infection.

Soap and water were used to clean the area after shaving and savlon used to rinse the area and finally, methylated spirit was applied to minimize microorganisms in the area. After which the area was covered with a sterile dressing towel.

Patient was taught how to do deep breathing exercise to prevent hypostatic pneumonia by breathing deeply in and deeply out during the exercise. He was again taught to support his wound with his palms when coughing or sneezing to prevent wound gaping.

Patient and his relatives were given the reasons for signing the consent form. Results for the various laboratory investigations were received. A theatre nurse and anesthetist came to introduce themselves to him and his relatives on the same day around 7pm and also assess him for fitness for the surgery.

At 9:00pm the objective that was set to relief patient of pain was evaluated and goal was fully met as patient as patient verbalized that inguinal pain had subsided and was relaxed with a cheerful facial expression.

At 9:20pm the goal that was set to help relief patient of anxiety was evaluated and goal was fully met as patient reported resolution of anxiety and on observation patient had a relaxed facial expression of patient and was eager to undergo surgery.

Around 10:00pm a low and dim environment was provided for the patient to have adequate sleep. He was then handed over to the night nurse after all procedure has been recorded.

Second Day of Admission (2nd December, 2021)

Immediate Pre-Operative Care

Patient woke up at 5:00am, made his quiet time, said his prayers and at 5:30am took his bath.

After bathing, his vital signs were checked and recorded as in appendix.

At 6:30am, he was encouraged to eliminate his bladder and bowel if he feels the urge to do so. The site of the operation was inspected and was cleaned and disinfected again, the site was then wrapped with a sterile towel. Afterwards, patient was given a theatre gown to wear and then the theatre staffs were alerted that the patient was ready for the surgery.

At 9:00am patient was sent to the theatre on a stretcher with his folder and was handed over to the receiving theatre staff. An operation bed was prepared to receive him. Time and his state of condition were written in the nurses 'note

Immediate Post-Operative Care

The objective of immediate post-surgical nursing care is to assist the patient to recover from anesthetic agent as quickly, safely and comfortable as possible. After recovering from anesthesia, patient was brought to the male surgical ward at 11:35am for observation and continuity of care after he has prescribed the following drugs;

- Intravenous normal saline infusion 1000mls for 24 hours.
- Intravenous dextrose saline 1 litre for 48 hours.
- Intravenous Amoxiclav 1.2g tid for 24 hours.
- Intravenous Paracetamol 1g tid for 24 hours.
- Injection pethidine 50mg tid for 48 hours.

Patient was received into an already prepared operation bed and was placed in a recovery position and incisional site was observed for heamorrhage. His vital signs were checked and recorded as follows;

Temperature	:	36.2 degrees Celsius
Pulse	:	76 beat per minute
Respiration	:	20 cycles per minute
Blood pressure	:	100/70 millimeter of mercury.

The subsequent vital signs were strictly monitored quarter hourly for an hour, half hourly for an hour, hourly for four hour and four hourly for 24 hours.

At 2:00 pm Patient complained of pain at the incisional site hence a nursing diagnosis of impaired comfort (pain) related surgical incision was formulated and a goal was set to relief patient of incisional site pain within 24 hours. Nursing interventions include: Patient's level of pain was assessed using the numeric pain rating scale. patient rated pain as 7 on a scale of 0 to 10. Patient was put in a recumbent position in order to relieve him of the pain. Vital signs such as temperature, pulse, respiration and blood pressure were monitored. Diversional therapy such as engaging patient in conversation and watching television was employed to help divert patient's attention from the pain. Patient's bed linen was straightening and free of creases to enhance rest and sleep in order to reduce pain sensation. Injection pethidine 50mg was administered

At 2:30pm, Due to the presence of surgical incision a nursing diagnosis of Risk for infection as evidenced by break in the continuity of skin (surgical incision) was made. An objective was set to ensure patient's incisional wound heal devoid of infection within period of hospitalization. The following nursing interventions were carried out: Patient was reassured of the available measures to help prevent wound infection, Patient's wound was observed for swelling, drainage, and hemorrhage to assess for infection and none was seen, Patient's diet was planned with him to include food rich in protein, vitamins and mineral salts to facilitate wound healing, Patient was educated to keep wound dry and avoid touching it unnecessarily to prevent wound infection, Prescribed Ciprofloxacin, Amoxiclav and Flagyl were administered to prevent infection

At 9:00pm, patient was made comfortable in bed and handed over to night staff.

Third Day of Admission (1st Day Post-Operatively) (3rd December, 2021)

Patient woke up around 6:00am. His vital signs were checked and recorded as in appendix.

At 6:30am A nursing diagnosis of self-care deficit (bathing and grooming) related to confinement to bed was formulated. A goal was set to assist patient to bath within 2 hours. The following nursing interventions were executed: Patient and family were reassured that patient's bathing needs will be catered for and with time patient will bath himself unaided, patient was educated on the importance of hygiene and that he will be aided to attend to his personal hygiene

needed. patient's bed was protected with long mackintosh and assisted to bath in bed with warm water, patient's bed linen was frequently changed to prevent infection and enhance comfort, patient's surgical incision was kept clean and dry during bathing and the importance of some was explained to patient, patient was assisted to groom.

A sterile trolley was set to dress patient's wound under strict aseptic technique as ordered to prevent infection.

At 8:00am the objective that was set to assist patient to bath within 2 hours was evaluated and goal fully met as patient was looking clean and well groom in bed.

At 9:00am upon interaction with patient and relatives, it was noticed that they had insufficient knowledge on Hernia. Therefore, a nursing diagnosis of Deficient knowledge (patient and family) related to the complex nature of information about hernia and its management was formulated and a goal was set to help patient and family will gain adequate knowledge about hernia and its management within 24 hours. Nursing actions include the following: A conducive environment with less noise was created to enhance learning. Radio and televisions were put off, Patient and his family level of knowledge on hernia were assessed by questioning and misconception about hernia was clarified in simple term, Patient and his family were educated on the definition, causes, signs and symptoms, treatment, prevention and complications of hernia, Patient and his family were allowed to ask questions, Answer questions in simple terms in patient's dialect to facilitate understanding, Patient and family were asked questions on the causes, clinical features and management of hernia. They able to provide appropriate answers to question posed.

At 2:00pm the objective set to relief patient of incisional site pain was evaluated and goal was fully achieved as patient reported a relief of pain and rated his pain as 2 on the numeric pain rating scale

Fourth Day of admission (Day of discharge) (4th December, 2021)

Mr. A. R's condition was very good on this day. He spent the night perfectly and woke up well relaxed. He was assisted to maintain his personal hygiene and he took his breakfast. His vital signs were checked and recorded as in appendix.

Patient's wound was observed for swelling, drainage and haemorrhage to assess for infection and none was seen. His wound was found to be clean and was healing by first intention.

Mr. A.R and family were to be discharged as written by physician during ward rounds. Patient and family were happy to go home without complications and in a very good condition.

At 9:00am, the objective that was set to help patient and family gain adequate knowledge about hernia and its management within 24 hours was evaluated and goal was fully met as patient and family was seen practicing knowledge gained on hernia and its management on observation and they were able to answer questions asked on the causes, clinical features and management of hernia.

At 2:30pm the goal that was set to ensure patient's wound heal within period of hospitalization was evaluated and goal was fully met as patient participated in wound care and infection prevention instructions and wound appeared to be healing by first intention on assessment without signs of infection.

His folder was sent to the accounts office for assessment and payment of his bills. Patient and his family were educated on how to take his prescribed drugs. They were asked to report for review on 10th December, 2021. Mr. A.R general condition at the time of discharge showed an immense improvement. They were seen off and bid goodbye at the taxi rank at 4:25pm. I returned to the ward, stripped off the bed linen, disinfected the items and remade the bed for the next admission.

PREPARATION OF PATIENT / FAMILY FOR DISCHARGE AND REHABILITATION

Preparation of Mr. A.R and family for discharge and rehabilitation started on the day of admission and continued until the day of discharge. A cordial and therapeutic relationship was established with patient and family members, who were encouraged to cope with the admission since it was only a temporary measure after which patient would be discharged home to continue life independently. Patient was assisted to have his bath with warm water as he preferred. Afterwards, his mouth was cared for using a tooth paste and tooth brush. These were done twice daily throughout his hospitalization to maintain his personal hygiene and promote circulation as well as relax him and improve his personal image.

His vital signs were checked and recorded as in appendix.

All other treatments were ordered to be continued as prescribed by patient's doctor. They were educated on the causes, clinical features, management and prevention of the condition. The need for a well-balanced diet and proper personal and environmental hygiene were stressed to them as the best way to live a healthy life. Home visits were also discussed with them; this was to ensure continuity of care and to make the necessary changes where applicable.

4.2 FOLLOW UP / HOME VISITS / CONTINUITY OF CARE

First Home Visit (3rd December, 2021):

When patient was on admission, a visit was paid to his house with his wife madam A.B on 3rd December, 2021. It was a planned visit with the aim of assessing patient's home environmental condition upon which health education was given. Their house is a compound house, well ventilated with two (2) windows in a room. Built with cement blocks and roofed with aluminum roofing sheets. There are four (4) rooms, two bath rooms and toilet (water closet) facility. They had good sources of electricity and water supply from national grid and number of community boreholes.

The community also enjoys the services of Sunyani Regional Hospital. Waste being produced in the house was disposed at the community waste disposal area. The opportunity was taken to educate the family on the need to observed strict personal and environmental hygiene. They were also educated on some of the possible dangers of their method of disposal and the preventive measures they can employ to safeguard possible disease outbreaks. There was no venerable person in the house. Time was allowed for questions and they were promised of a visit again after the discharge of Mr. A.R.

Second Home Visit (10th December, 2021)

On the second visit, patient and family were doing well with no complications and complain. The wound was almost healed. The family and patient were encouraged to maintain their personal and environmental hygiene. It was also emphasized that patient should not lift heavy objects. Patient and family were eventually reminded that should any complication arise, they should not hesitate to come to the hospital for early treatment. Periodic medical checkups were also encouraged.

The family members and the patient expressed their gratitude for the care given and wished me all the best in life. I left the house around 5: 30 pm.

Day of Review (12th December, 2021)

On the day of review, patient was assisted to collect his folder and accompanied to the consulting room. The doctor examined him and encouraged him to continue taking his prescribed drugs. Patient had no complains on examination. He was advised not to lift heavy objects and also practice good lifting techniques. Again, he was advised to report to the hospital if he is not feeling well. His vitals were checked and recorded as;

- Temperature -$36.3^{0\,C}$
- Pulse -78bpm
- Respiration -20cpm
- Blood Pressure -120/80mmhg

Third Home Visit (15th December, 2021)

This was on Wednesday 15th December, 2021 at 4.30pm. When I arrived at the house, I was warmly welcomed by the family and was given a seat. They were all very happy to see me again in their house and were very happy about MR. A. R condition. He did not complain of any ill health. His wound was completely healed with stitches been removed. I explained to the family that MR.A. R condition was good but he can report to the Hospital if any problem arises.
I told them that I will not be visiting them frequently since our interaction had come to an end but promised to pass by anytime, I am in their vicinity.
I thanked them for their support and co-operation throughout the interaction, asked permission and took leave of them.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 INTRODUCTION

Evaluation determines the progress made by patient with comparison to the specific goals and objectives. It helps to judge the effectiveness of the nursing process.

5.1 STATEMENT OF EVALUATION

Patient was relieved of pain

On 1/12/2021 at 4:00pm based on patient's complaints a nursing diagnosis of impaired comfort (inguinal pain) related to swelling and inflammatory process at the inguinal region was made and an objective set to relief patient of pain within five hours. The following nursing actions were carried out: patient and family was reassured that appropriate nursing care will be instituted to relieve him of the pains, patient was placed in a recumbent position in order to relieve the pains, a wrapped cold compress was applied on the inguinal region every hour to reduce pain sensation, the scrotum was supported by placing wrapped cold compress under it to prevent vigorous movement and to ease the pain. Diversional therapy such as conversation was used to help put patient's mind off the pain. Injection pethidine 50mg was administered as prescribed.

At 9:00pm on the same day, the objective that was set to relief patient of pain was evaluated and goal was fully met as patient as patient verbalized that inguinal pain had subsided and was relaxed with a cheerful facial expression.

Patient and family were relieved of anxiety

On 1/12/2021 at 4:20pm Patient expressed concerns about the upcoming surgery. A nursing diagnosis of Anxiety (patient and family) related to impending surgery was made. An objective was set to help relief patient of anxiety within five hours. Nursing interventions carried executed include: patient and relatives were assured that everything possible will be done for him to have a successful surgery, patient and his relatives were introduced to MR. A.R who had successfully undergone the herniorraphy and was recovering, patients and his relatives were educated that if the surgery is not done, complications like intestinal obstruction, peritonitis, and urine retention could occur hence the need for surgery, patient and his relatives were allowed to ask questions bothering their minds and express their fears, patients and his relatives' questions were duly answered in simple terms to their understanding, volumes of ward television were reduced to minimize noise and visitors were restricted to ensure relaxation.

On 1/12/2021 at 9:20pm the goal that was set to help relief patient of anxiety was evaluated and goal was fully met as patient reported resolution of anxiety and on observation patient had a relaxed facial expression of patient and was eager to undergo surgery.

Patient was relieved of incisional site pain

On 2/12/2021 at 2:00 pm Patient complained of pain at the incisional site hence a nursing diagnosis of impaired comfort (pain) related surgical incision was formulated and a goal was set to relief patient of incisional site pain within 24 hours. Nursing interventions include: Patient's level of pain was assessed using the numeric pain rating scale. patient rated pain as 7 on a scale of 0 to 10. Patient was put in a recumbent position in order to relieve him of the pain. Vital signs such as temperature, pulse, respiration and blood pressure were monitored. Diversional therapy such as engaging patient in conversation and watching television was employed to help divert patient's attention from the pain. Patient's bed linen was straightening and free of creases to

enhance rest and sleep in order to reduce pain sensation. Injection pethidine 50mg was administered

On 3/12/2021 at 2:00 pm, the objective set to relief patient of incisional site pain was evaluated and goal was fully achieved as patient reported a relief of pain and rated his pain as 2 on the numeric pain rating scale.

Patient's incisional wound healed devoid of infection

On 2/12/2021 at 2:30pm, Due to the presence of surgical incision a nursing diagnosis of Risk for infection as evidenced by break in the continuity of skin (surgical incision) was made. An objective was set to ensure patient's incisional wound heal devoid of infection within period of hospitalization. The following nursing interventions were carried out: Patient was reassured of the available measures to help prevent wound infection, Patient's wound was observed for swelling, drainage, and hemorrhage to assess for infection and none was seen, Patient's diet was planned with him to include food rich in protein, vitamins and mineral salts to facilitate wound healing, Patient was educated to keep wound dry and avoid touching it unnecessarily to prevent wound infection, Prescribed Ciprofloxacin, Amoxiclav and Flagyl were administered to prevent infection

On 4/12/2021 at 2:30pm the goal that was set to ensure patient's wound heal within period of hospitalization was evaluated and goal was fully met as patient participated in wound care and infection prevention instructions and wound appeared to be healing by first intention on assessment without signs of infection.

Patient was assisted with self-care activities (bathing and grooming)

On 3/12/2021 at 6:00am A nursing diagnosis of self-care deficit (bathing and grooming) related to confinement to bed was formulated. A goal was set to assist patient to bath within 2 hours. The following nursing interventions were executed: Patient and family were reassured that patient's bathing needs will be catered for and with time patient will bath himself unaided, patient was educated on the importance of hygiene and that he will be aided to attend to his personal hygiene needed. patient's bed was protected with long mackintosh and assisted to bath in bed with warm water, patient's bed linen was frequently changed to prevent infection and

enhance comfort, patient's surgical incision was kept clean and dry during bathing and the importance of some was explained to patient, patient was assisted to groom.

On 3/12/2021 at 8:00am the objective that was set to assist patient to bath within 2 hours was evaluated and goal fully met as patient was looking clean and well groom in bed.

Patient and family gained adequate knowledge about hernia and its management

On 3/12/2021 at 9:00am upon interaction with patient and relatives, it was noticed that they had insufficient knowledge on Hernia. Therefore, a nursing diagnosis of Deficient knowledge (patient and family) related to the complex nature of information about hernia and its management was formulated and a goal was set to help patient and family will gain adequate knowledge about hernia and its management within 24 hours. Nursing actions include the following: A conducive environment with less noise was created to enhance learning. Radio and televisions were put off, Patient and his family level of knowledge on hernia were assessed by questioning and misconception about hernia was clarified in simple term, Patient and his family were educated on the definition, causes, signs and symptoms, treatment, prevention and complications of hernia, Patient and his family were allowed to ask questions, Answer questions in simple terms in patient's dialect to facilitate understanding, Patient and family were asked questions on the causes, clinical features and management of hernia. They able to provide appropriate answers to question posed.

On 4/12/2021 at 9:00am, the objective that was set to help patient and family adequate knowledge about hernia and its management within 24 hours was evaluated and goal was fully met as patient and family practiced knowledge gained on hernia and its management on observation and they were able to answer questions asked on the causes, clinical features and management of hernia.

5.2 AMENDMENTS OF NURSING CARE PLAN

Upon careful analysis of evaluation of nursing care given to MR. A. R all goals were fully met. This can be attributed to the expert nursing and medical care rendered to him during his stay on the ward and the cooperation from the patient and his family.

5.3 TERMINATION OF CARE

Termination of care is a therapeutic process that helps patient and the nurse to end their relationship. It is gradual process which started from the day of admission to the last home visit

Throughout hospitalization M.R. A.R and family were made aware that the care is for a period of time after which the nurse- patient relationship will eventually be terminated; patient and family were educated on their personal and environmental hygiene, exercise, eating of a well-balanced diet and was advised not lift heavy objects.

The patient and his family showed appreciation for the services I rendered and asked for continuation of the relationship. The termination left no ill effect on the patient and family, since they were educated from the beginning. The actual termination of the interaction occurred on the last home visit thus, 15th December, 2021. Since there was no health facility patient was handed over to his daughter (a student nurse) to continue with care at home.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 SUMMARY

Mr. A.R a sixty-five-year-old man of 4 children and a residence of Odumasi, a suburb of Sunyani in the Bono Region was admitted through the Out-Patient unit of Sunyani Regional Hospital to the male surgical unit on the 1st of December, 2021 with a diagnosis of right inguino-scrotal hernia. He underwent herniorrhaphy the following day and was transferred to male surgical ward B1 for continuity of care.

Some of the nursing problems identified on patient were pain at the inguinal region, anxiety, pain at the incisional site, and knowledge deficit.

The following drugs were prescribed for patient and were served accordingly; intravenous normal saline, dextrose saline, ringers' lactate, injection pethidine, intravenous ciprofloxacin, intravenous flagyl, paracetamol. Nursing diagnoses were employed to achieve the objectives and goals.

Patient and family were educated on the disease, its possible causes, treatment and preventive measures.

M.R A. R was finally discharged on 4th December 2021 and came for review on 10th December 2021.

Home visits were made to his home whilst he was still on admission and also after discharge to assess and insure a therapeutic home environment.

6.1 CONCLUSION

In conclusion, the patient and family care study has not only broadened my knowledge in hernia disease but also helped me put the knowledge I have acquired for the three-year nursing course into practice. It has also helped me to understand comprehensive nursing care that has to be given to individual patient and also improved my interpersonal relationship with patients.

I suggest that if possible, all patients who come on admission should be given such specialized and individualized nursing care so as to promote recovery and positive self-image of patients.

APPENDIX

TABLE FIVE: FLUID INTAKE AND OUTPUT CHART

DATE/ TIME	FLUID INTAKE	AMOUNT	DATE/ TIME	FLUID OUTPUT	AMOUNT
1/12/21 4:00pm	Intravenous Normal Saline	500mls	1/12/21 8:30pm	Urine	1000mls
1/12/21 6:05pm	Intravenous Ringers Lactate	500mls			
1/12/21 8:45pm	Intravenous Dextrose Saline	500mls	1/12/21 10:00pm	Urine	800mls
1/12/21 10:50pm	Intravenous Normal Saline	500mls			
1/12/21 3:45pm	Intravenous Ringers Lactate	500mls	1/12/21 3:10pm	Urine	700mls
1/12/21 5:55pm	Intravenous Dextrose Saline	500mls			
1/12/21 8:30pm	Intravenous Normal Saline	500mls	1/12/21 6:15pm	Urine	700mls

TOTAL INTAKE=3500mls

TOTAL OUTPUT=3200mls

BALANCE=300mls

DATE/ TIME	FLUID INTAKE	AMOUNT	DATE/ TIME	FLUID OUTPUT	AMOUNT
2/12/21 5:45am	Intravenous Normal Saline	500mls	2/12/21 5:00am	Urine	1000mls
2/12/21 7:05am	Intravenous Ringers Lactate	500mls			
2/12/21 9:45am	Intravenous Dextrose Saline	500mls	2/12/21 9:00am	Urine	800mls
2/12/21 12:00pm	Intravenous Normal Saline	500mls			
2/12/21 2:45pm	Intravenous Ringers Lactate	500mls	2/12/21 1:10pm	Urine	800mls
2/12/21 4:50pm	Intravenous Dextrose Saline	500mls			
2/12/21 6:30pm	Intravenous Normal Saline	500mls	2/12/21 5:40pm	Urine	1000mls
2/12/21 8:00pm	Intravenous Ringers Lactate	500mls			

TOTAL INTAKE=4000mls

TOTAL OUTPUT=3600mls

BALANCE=400mls

Vital signs of Mr. A.R.

Date	Time	Temperature (^{0}C)	Pulse (bpm)	Respiration (cpm)	Blood pressure (mmHg)
1/12/21	3:35pm	36.8	80	20	130/80
	6:00pm	36.7	83	22	120/80
	10:00pm	36.5	70	21	120/60
2/12/21	6:00am	37.3	92	22	110/70
	11:35am	36.9	86	27	110/80
	2:00pm	36.5	74	25	120/60
	6:00pm	36.3	81	24	120/80
	10:00pm	36.7	70	21	110/70
3/12/21	6:00am	37.5	92	21	120/70
	10:00am	36.7	72	22	120/70
	2:00pm	36.9	89	20	110/80
	6:00pm	37.1	79	23	120/80
	10:00pm	37.2	80	22	110/80
4/12/21	6:00am	37.5	95	23	120/70
	10:00am	37.1	79	21	120/70
	2:00pm	36.9	74	20	110/70

SYMBOLS/ABBREVIATIONS	MEANING
Bds	Twice daily
Tds	Three times daily
Qid	Four times daily
^{O}C	Degrees Celsius
Bpm	Beat per minute
Cpm	Count per minute
Ml	Milliliters’
Mg	Milligram
Kg	Kilogram
Tabs	Tablet
MmHg-	Millimeters of mercury
G/dl	Grams per decimeter in hemoglobin level
T	Temperature
P	Pulse
R	Respiration

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SIGNATORIES

1. **THE STUDENT NURSE**

NAME OF STUDENT: OWUSU MANU ISAAC

SIGNATURE:.....

DATE: 5TH OCTOBER, 2022

2. **THE NURSE-IN-CHARGE OF THE MALE'S WARD (ST. ELIZABETH HOSPITAL HWIDIEM)**

NAME OF WARD IN CHARGE: MRS. DEBORAH ADU-GYAMFI

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