HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/FAMILY CARE STUDY ON DIABETES MELLITUS

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A PATIENT/FAMILY CENTERED CARE STUDY ON PNEUMONIA SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILLMENT FOR THE AWARD OF THE LICENSE TO PRACTICE AS A REGISTERED GENERAL NURSE.

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PREFACE

The patient and family care study is a complete detailed written report of the nursing care to rendered comprehensive service to a patient and his family chosen by the literate student nurse and nursed over a specified period of time.

The patient and family care study assist final year student nurses to get the knowledge acquired in their study areas such as public health, Psychiatry, medicine, obstetrics, surgery, gynaecology, sociology and paediatrics nursing to give effective nursing care to a patient.

The study also assists the student nurse to render holistic care to patients by nursing each and every patient as an individual. It also helps the student nurse to know much and acquire more knowledge into the specific condition, their presentations and how they are treated.

The patient and family care study forms part of the final assessment of the student nurse at the end of the three (3) years training program before the Registered General Nurses Diploma Certificate is awarded to him/her by the Nurses' and Midwifery Council (NMC) of Ghana.

The study utilizes the nursing process, which is a systematic approach to nursing care taken to care for an individual and the steps include Assessment, Diagnosis, Planning, Implementation and Evaluation of all data collected on patient and the family to ensure an effective nursing care.

The patient and family care study also serve as a means to establish an effective nurse/patient relationship and a way of collaborating with other health care team members.

ACKNOWLEDGEMENT

I wish to express my greatest gratitude to the Almighty God for his grace, wisdom and good health given to me to carry out this care study successfully.

Particular thanks also go to the entire tutorial staff of Holy Family Nursing and Midwifery Training College Berekum, especially my supervisor Madam Rita Gyamfi for their immense support and guidance given to me which has enabled me to make this care study a reality.

Again, I would like to express my profound appreciation to Ms. M.E the subject of my study and family for allowing me to carry out this care study on them. Their maximum cooperation and the necessary information given me made this piece of writing success.

I cannot forget the staff of Females surgical ward at Sunyani Municipal Hospital for their guidance and support.

Finally, I would like to express my appreciation to all the authors from whose books I used as references for my study.

May God richly bless you all.

INTRODUCTION

The greatest fear of human being is the fear of unexpected pains, diseases and death. We fear the things we do not comprehend much more than we fear the things of which we have for knowledge.

The aim of the care study is to replace fear with knowledge. The comprehensive information gathered and the expert nursing care given will help one understand the concept of individualized patient care.

The patient/family care study is a report of the nursing care rendered to a patient and the family.

This entails a maximum interaction, between the patient, family and community on one hand the health team on the other hand. It also involves the application of the nursing process to attain and maintain high levels of wellness for a patient. This interaction occurs within a specific period of time.

Ms. M. E is the name of the subject of study. She was born on 28th March 2003 and she's about nineteen years old (19yrs). She is dark in complexion, about 160 centimeters tall and has a round looking face. Ms. M. E comes from Chiraa about 19.4 kilometers from Sunyani in the Sunyani West District in Bono Region of Ghana. On 21st November, 2022, at 10:30am, M.E was admitted into the Female Ward of Sunyani Municipal Hospital with diagnosis of Acute Appendicitis. She was accompanied by a nurse from the Out Patient Department (OPD) and a relative into the ward.

A comprehensive nursing care plan was drawn and implemented. This led to the patient's speedy recovery. At the end of hospitalization, terminal evaluation revealed that all goals set

were fully met. Ms. M.E was discharged on 26th November, 2022 in a satisfactory health condition. There were two follow-up visits made to the patient's home at Chiraa which indicated improvement in patient's health.

For that matter the doctor declared her fully fit when she came back for review a week after her discharge. Having achieved all patient's goals, the care was terminated on the day I handed over the patient to the community health nurse for continuity of care.

This care study has been categorized under five (5) chapters:

- Chapter one (1) consists of Assessment of the patient and family
- Chapter two (2) consists of Analysis of data collected
- Chapter three (3) deals with the planning of patient/family care
- Chapter four (4) consists of Implementing patient/family care
- Chapter five (5) deals with Evaluation of care of the patient/family
- Chapter six consist of summary, conclusion and Bibliography.

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY CARE

1.0 Introduction

The nursing process is the systematic process through which the nurse, the patient and patient's family members work together to ensure adequate care. The first step in the nursing process is assessment. Assessment, according to Barbara F.W., (2014), involves gathering of information about health status of a patient, analysis and synthesis of the data and making clinical nursing judgment. Assessment which involves a comprehensive and holistic gathering of data about the health status of the patient, family and the community at large is the first step of the nursing process. Analysing and making a clinical judgment from the data collected is a basic priority in the care of the patient. The data collected reflect the past and present health status of the patient. Assessment is the first component of the nursing process that is used in the patient/family care study. The methods used for assessment include interviews, observation and physical examination through palpation, percussion and auscultation, inspection and other necessary information gathered from the health team members.

Assessment helps the nurse to identify physiological, emotional and intellectual problems of the patient. It also helps the nurse to plan the care for the patient. Basically, it involves the collection of data about the patient's health status, family medical history, socio-economic history, lifestyle and hobbies of patient, his past and present medical history. Proper assessment helps the student nurse to identify the actual and potential health needs and provide a good nursing care to the patient.

1.1 Patient Particulars

Particulars are special indication used to single out an individual member of a specified group or class. Ms. M. E is the name of the subject of study. She was born on 28th March 2003 and she's about nineteen years old (19yrs). She is dark in complexion, about 160 centimeters tall and has a round looking face. Ms. M. E comes from Chiraa about 19.4 kilometers from Sunyani in the Sunyani West District in Bono Region of Ghana. She stays with her Mother and the last born of six children. She's bono by tribe and speaks Twi. She is a Christian and worships at Chiraa Pentecost Church. She was born in Sunyani Municipal Hospital and weighs about forty-one (41) kilograms, she was born to Mr. B. E and Madam A. C all from Chiraa They are Cocoa farmers. Her favorite food is Fufu and palm nut soup. Singing is her hobby and enjoys playing Ludo at her leisure time. She stays in the house with the house number D/10 Chiraa.

She's single and spends more time with peers.

1.2 Family Medical and Socio – Economic History

1.2.1 Patients/Family Medical History

According to Ms. M.E and family, there is no known hereditary disease like asthma, leprosy, diabetes, hypertension, mental illness, epilepsy and any other mental disorder in their family but occasionally they suffer from headache, fever, abdominal pains and common cold which they treat with over-the-counter-drugs they purchase from nearby chemical store. They usually do not go to the hospital unless the illness becomes severe. Ms. M.E explained that she prefers over-the counter drugs due to the long waiting time at the hospital. She was however educated on the need to go to the hospital when sick. According to Ms. M.E and family, there are no known allergies within the family. Patient stated that her parents, siblings and his nuclear

family members are all in good health and also added to it that none of her family members have been hospitalized before aside her who was hospitalized for appendectomy.

1.2.2 Patient/ Family Socio – Economic History

Socio – economically, patient's family fall within the middle-class income category as they are able to provide for all the basic needs of the family such as food, Shelter and clothing. . Ms. M.E is a student and the source of money is from the parents. She however indicated that her parents are farmers. Her father cultivates cocoa and her Mother (Mrs A.C) also cultivates other food crops such as tomato, beans, garden eggs and groundnuts of which she generates extra income in supporting the family. The family depends on the electricity company of Ghana for electricity and their source of water is a pipe-borne water.

Each and every one of the family is an active member of National Health Insurance Scheme (NHIS) and therefore have their medical bills covered by the scheme. The family of the patient is very sociable as it was noticed that they interacted with themselves and others with respect and socially. According to Ms. M.E and family, they are all Christians.

1.3 Patient's Developmental History

Ms. M.E was born on 28th March, 2003. According to her, her mother confirmed that she was successfully delivered at Sunyani Municipal Hospital, through a normal spontaneous vaginal delivery without any congenital deformities such as cleft palate or club foot at birth, she was told that, she had immunization against all the vaccine preventable diseases and scheduled immunization schedules during infancy.

According to Ms. M. E, her mother had confirmed to her that she was not exclusively breastfed but rather had a supplementary feeding. Her mother, Mrs A.C said patient had a normal developmental milestone. According to her mother, at two to three months, she could smile at

family members, could sit and support at five and half months. Ms. M.E stated that she attends School at Chiraa Senior High School in the Bono Region Ghana. She has no learning difficulties.

According to Erik Erikson psychosocial theory, every individual goes through 8 stages of development with its corresponding characteristics.

She is currently in the sixth stage of Erikson's theory of psychosocial development namely intimacy versus isolation (18-35years).

During this stage, the major conflict centres on forming intimate, loving relationships with other people. Erikson believed it was vital that people develop close, committed relationships with other people. These emotionally intimate relationships as people enter adulthood play the critical role in the intimacy versus isolation stage. Such relationships are often romantic in nature, but

Erikson believed that close friendships were also important.

Upon interaction with Ms. M.E she said she has been able to form intimate relationships which she said was characterized by honesty, and love. Erikson believed that, People who are successful in resolving the conflict of the intimacy versus isolation stage are able to develop deep, meaningful relationships with others.

Adults who struggle with this stage experience poor romantic relationships. They might never share deep intimacy with their partners or might even struggle to develop any relationships at all. Ms. M.E have been successful so far as she has been able to form intimate, meaningful and lasting relationships with others. This was achieved since her parents who always exhibit love and patience towards her actions and also guided her. She added to it that she has always wanted to be a Nurse from childhood and my care for her and the family has inspired her more

to perceive the goal. She is a 2nd year student at Chiraa senior high school currently and intend to further towards her goals after completion

1.4 Patient's Lifestyle and Hobbies

Ms. M.E is sociable and easily gets along with others he encounters in life. She is a Pentecostal and tries to attend to church services every time she's back from school on vacation but does go to church when she's in school. She's wakes up around 5:30am in school and prepare for class on working days and games on weekends. She usually closes from school at 3pm every day. She washes her uniform on Saturday sometimes Sunday and sleeps for about 9hours. She also said, she has bowel movement either once or twice daily and passes urine normally depending on her fluid intake.

1.5 Patient's Past Medical/Surgical History

According to M.E she has never had any serious disease and also not experience any of the childhood disease such as measles, whopping cough etc. She has a known allergy to

Artesunate Amodiaquine indicated by skin rashes after few minutes taken. She has not been involved in any accident but has once suffered from malaria and went to Chiraa Community Health Center for treatment. According to patient, she also added that she goes to the pharmacies or over the counter stores for treatment for other minor conditions like diarrhea and headaches. She sometimes takes herbal medicine but not on a regular basis. She barely goes for regular checkup at the hospital.

1.6 Patient's Present Medical History

According to patient he was doing well going about her normal activities until the midnight of 21st September, 2022 when she started experiencing mild abdominal pain. Particularly at the right iliac fossa region of the abdomen in the early hours of the day.

She said, she experienced a rise in her temperature not long after the pain had become severe, she then began vomiting. Her brother then decided to take her to the Out Patient Department (OPD) of Sunyani Municipal Hospital in the morning around 7:00am, where she was examined by the physician. She presented with pain, particularly at the right iliac fossa and tenderness in the right lower abdominal quadrant. M.E also complained of anorexia, nausea and vomiting. On account of all these clinical features, laboratory investigation conducted and physical assessment conducted, the doctor diagnosed her of Acute Appendicitis. She was then asked to be admitted to Female ward at Sunyani Municipal Hospital.

1.7 Admission of the Patient

On 21st November, 2022, at 10:30am, M.E was admitted into the Female Ward of Sunyani Municipal Hospital with diagnosis of Acute Appendicitis. She was accompanied by a nurse from the Out Patient Department (OPD) and a relative into the ward. On reaching the ward, she was cheerfully welcomed and made comfortable at the nurses' station.

The necessary documents were collected and her name was mentioned to identify the patient, her particulars were crosschecked.

Her computer system number was then given to the Nurse-in-Charge who also read through and asked me to admit her into any empty bed in the female's medical ward. She was called by her name and again welcomed to the ward. She was then assisted to her bed and the bed number was 5A.

The vital signs were checked and recorded as follows:

Temperature - 38.7^{o}C

Pulse - 124bpm

Respiration - 24cpm

Blood pressure - 130/68mmHg.

I introduce Ms. M.E to other patients on the ward especially those who have gone through surgery. The subject of study and her family were reassured that they have themselves in the hands of a competent and professional health team and also availability of modern equipment to help go through the surgical procedure successfully. Her brother was oriented to the ward and its annexes.

The immediate medications were obtained and administered. The treatment consisted of;

1. IV Ciprofloxacin 400mg bid x 24 hours
2. IV Metronidazole 500mg tds x 48 hours
3. Injection Diclofenac 75mg bid x 24 hours
4. IVF dextrose saline 1.5L x 24hours
5. Tablet Paracetamol 500mg tds x 48hours

The diagnostic investigations done already includes:

1. Blood film for malaria parasites
2. Full blood count (FBC)
3. Ultrasound scan of the abdomen.

Since the patient was having high body temperature, an objective was set to help reduce the temperature to normal (36.2 ºC - 37.2 ºC) within 24 hours. She was quickly tepid sponged. Ms. M.E was encouraged to take in more ice water and also paracetamol 500mg was served as ordered to help further reduce the temperature to normal. Ms. M.E was educated on the need to

maintain good personal hygiene, balanced diet and little exercises. The cash and carry system as well as the National Health Insurance Scheme was explained to Ms. M.E. She revealed that she was insured thus, it was explained to her that certain drugs and treatment were not covered by the national health insurance scheme.

The patient was made aware that as a final year student, it is a requirement by the Nursing and Midwifery Council of Ghana to take a patient, render individualized nursing care to him/her from admission until discharge and carry out home visits before and after discharge until She recovers fully.

Ms. M.E and relative accepted my proposal and promised to cooperate with me and give all the necessary information to complete the care am rendering to them. Finally, the patients name, age, sex, diagnosis and date of admission were all recorded into the admission and discharge book and the daily ward state.

The preparation for discharge started from the day of admission and would be handed over to a Community Health Nurse for continuity of care. I chose to write on this condition (Acute Appendicitis) because I wanted to gain more insight about it.

1.8 Patient's Concept of His Condition

Patient believed that it is normal to fall sick irrespective of whoever you are. Upon interviewing the patient, he did not attribute his sickness to any spiritual factor but she strongly said that by grace of Almighty God and with the quality care from the hospital staff, she will get better soon.

1.9 Literature Review on Appendicitis

Introduction on Appendix

The appendix is a wormlike extension of the caecum and, for this reason, has been called the vermiform appendix. The average length of the appendix is 8-10 cm (ranging from 2-20 cm). The appendix appears during the fifth month of gestation, and several lymphoid follicles are

scattered in its mucosa. Such follicles increase in number when individuals are aged 8-20 years. Appendicitis is one of the most common surgical emergencies and one of the most common causes of abdominal pains. In the last few of the lumen of the appendix years, though, the incidence and mortality rate of appendicitis has markedly decreased (Hinkle & Cheever 2018).

DIFINITION OF APPENDICITIS

According to Hinkle & Cheever (2018) appendicitis is an inflammation of the vermiform appendix, the appendix is a small, finger like pouch about 8cm (3inches) long attached to the caecum of the colon. Its usual location is the right iliac region, just below the ileocecal valve. The appendix has no function but as part of the caecum, it fills with food and empties on a regular basis.

INCIDENCE

According to World Health Organization (2010) about 7% of the population will have appendicitis at some time in their lives; males are affected more than females and teenagers more than adults. Although it can occur at any age, it occurs most frequently between the ages of 10 and 30 years.

AETIOLOGY

According to Hinkle & Cheever (2018), the most common cause of appendicitis is obstruction of the appendiceal lumen by

(a) Facecolith (a small hard mass of accumulated faeces)

(b) Tumour or foreign body

(c) Barium ingestion

(d) Kinking of the appendix

(e)Strictures of the lumen
(f) Infection

RISK FACTORS

1. Age: Appendicitis can occur in all ages but it is more common between the ages of 6-30
2. Gender: It is more common in males than females
3. Hereditary: Having a family history of appendicitis may increase the risk of infection
4. Seasonal Variation: Min winter month, the appendicitis cases occurs in winter month, the month of October and may.
5. Infections: Gastroenteritis and Mumps can predispose the individual to appendicitis.

PATHOPHYSIOLOGY

According to Hinkle & Cheever (2018) appendicitis is initiated by obstruction of the lumen caused by impacted faeces or facecloth. In the early stages of appendicitis, the mucosa become inflamed first. This inflammation eventually extends through the sub-mucosa to invade the muscular and serosae (peritoneal) layers. A fibrin purulent exudates forms on the serosa surface, and extends to any adjacent peritoneal surface, example bowel or abdominal walls causing a localized peritonitis. By this stage the necrotic glandular sloughs into the lumen, when it becomes distended with pus.

Finally, the end arteries supplying the appendix become thrombosed and infracted. The appendix becomes necrotic or gangrenous. This usually occurs at the distal end and the appendix begins to disintegrate. Perforation soon follows and faecal contaminated appendiceal contents spread into the peritoneal cavity. If the spilled contents are enveloped by the omentum, a localized abscess occurs; otherwise spreading peritonitis develops.

TYPES OF APPENDICITIS

According to Gerrald and Bryan (2016) there are two types of appendicitis, these are

1. Acute appendicitis.
2. Chronic appendicitis

ACUTE APPENDICITIS

Acute appendicitis is the inflammation of the appendix which has a sudden onset and usually characterized by severe pain and reddening of the lower abdominal wall. This is the most severe and dangerous type. The lumen becomes obstructed leading to a severe ischemia, gangrene and perforation. Later on, perforation occurs in nearly 25 percent of patients who report 24hours or more after onset of disease. Localization or spread of the infection depends on whether adjacent organs, especially the greater omentum, loops of ileum, wall off the inflamed organ, before perforation occurs.

CHRONIC APPENDICITIS

This is where the mucosa and sub mucosa are inflamed, the appendix may be swollen and the serosa reddened with increased vascularity. If untreated, resolution occurs but with formation of fibrous adhesions either within the lumen or on the obstruction due to factors mentioned above obstruct the lumen and cause more severe attack later.

CLINICAL MANIFESTATION

According to Hinkle & Cheever (2018), signs and symptoms of acute appendicitis include;

1. Peri umbilical pain which localizes at the right iliac fossa after few hours due to increased inflammation involving the parietal peritoneum.
2. Anorexia due to the abrupt onset of illness.
3. Moderate increase in temperature 37.2^0C to 38.9^0C due to infection.

4. Nausea and vomiting as a result of reflux of duodenal or gastric content.
5. Dysuria (painful or difficult urination).
6. Constipation or diarrhoea.
7. Tenderness or rebound tenderness and guarding when appendiceal inflammation extends to parietal peritoneum and surrounding tissues.
8. Rovsing's sign (this is pain felt in right lower quadrant after the left lower quadrant has been palpated).
9. Physical examination yielding tenderness, rebound tenderness and guarding at McBurney's point at the right lower quadrants
10. Severe Abdominal pain

DIAGNOSTIC MEASURES

According to Hinkle & Cheever (2018), diagnostic investigations for appendicitis includes;

1. Abdominal ultrasonography will show thickening of appendix wall, abscess
2. Urine for routine examination may show urinary tract infection especially in pelvic located acute appendicitis.
3. Full blood count shows increased white blood cells
4. Physical examination and patient history taking

COMPLICATIONS

1. Perforation: It is a hole that develops through the wall of a body organ.
2. Peritonitis: It is the inflammation of the membrane lining the abdominal wall and covering of the abdominal organs. If the appendix inflames and bursts, the linen of the abdomen (peritoneum) will become infected with bacteria which can also damage other internal organs.

3. Abscess: It is a confined pocket of pus that collects in tissues, organs or spaces inside the body. Patents with ruptured appendicitis spill stool from the appendix into the belly causing an infection resulting in a collection of pus or an abscess.
4. Pyelonephritis: It is an inflammation of the kidney due to specific type of urinary tract infection which begins in the urethra or bladder and travels to the kidneys. The development of acute renal failure after appendectomy is usually related to either a ureteral injury caused during appendectomy.
5. Gangrene formation: Gangrene occurs when tissues in the body die after a loss of blood caused by illness, injury, or infection the cause of appendicitis relates to blockage of the inside of the appendix leading to increased pressure, impaired blood flow and inflammation. If the blockage is not treated, gangrene and rupture (breaking or tearing) of the appendix can result.

MEDICAL MANAGEMENT

According to Williams and Hopper, (2019) medical treatment includes:

- Administer antibiotics to prevent sepsis.
- Intravenous fluids are administered to correct dehydration, fluid and electrolyte imbalance.
- Opioid analgesics such as morphine are administered to manage the pains.

SURGICAL/SURGICAL TREATMENT

For effective treatment, it will depend on the severity of symptoms, the size and location of the tumour, patient age and parity .and general health. Treatment option includes non- surgical as well as surgical procedure.

SURGICAL TREATMENT (APPENDICECTOMY / APPENDECTOMY)

Surgical intervention involves removal of the appendix. In most cases the surgery is done immediately diagnosis is established except in situations that perforation is suspected.

The procedure is carried out through a land incision at the McBurney`s point, into the abdominal wall (laparotomy), or by insertion of a laparoscope into the abdomen through a small abdominal incision to cauterize the appendix (laparoscopy). The fascia muscle layers and peritoneum are all incised transversely. Appendiceal blood vessels are clamped and ligated at the base which is located distal to the caecum. It is then excised distal to the ligated portion. The peritoneum and layers of incision are closed by suturing. The peritoneal cavity is drained if there is pus around the appendix due to gangrene or perforation. The drainage tube is being inserted through a stab wound below the incision.

NURSING MANAGEMENT / CARE

PRE-OPERATIVE NURSING CARE

PSYCHOLOGICAL CARE

To enhance psychological care, the following measures are to be put in place

1. The patient and family are reassured that all effort would be put in place to assist her undergo a successful surgery.
2. Patient is oriented to her new environment to relax her.
3. Patient is allowed to express her fears and concerns for appropriate nursing interventions
4. Patient and family are allowed to ask question for clarification or explanation.
5. All questions are answered in simple terms and correctly to the patient and family's understands.

6. It was ensures that the surgeon explains the procedure, nature of the operation as well as activities and outcome of the surgery to the patient to enhance cooperation
7. Consent form, a legal document indicating the patient's acceptance to undergo an operation is given to the patient and family to sign after the benefits and potential complications of the surgery has been duly explained to her.

PHYSIOLOGICAL CARE

1. Blood sample is taking to the laboratory for grouping and cross matching and haemoglobin level estimation for possible transfusion.
2. Gastric content is aspirated through nasogastric tube if fluids or a meal have been taken recently to prevent aspiration during surgery.
3. Tray is set for catheterization to empty the bladder to prevent accidental incision of the bladder during surgery.
4. Vital signs such as temperature, pulse, respiration and blood pressure are monitored and recorded to detect any abnormalities for the appropriate nursing intervention to be carried out.
5. Prescribed intravenous infusions such as dextrose saline 500mls 4 hourly x 2daysis administered to provide patient with fluid and electrolyte.

OBSERVATION

1. Vital signs such as temperature, pulse, respiration and blood pressure are monitored to detect abnormalities for the appropriate nursing care to be rendered.
2. The side effects of pre-medications served such as dry mouth, urticarial rash are observed for immediate nursing intervention.
3. Patient's level of pain is assessed to know the intensity of the pain.

4. Cyanosis and pallor are assessed for possible transfusion.
5. Intake and output are monitored, recorded and balanced in the intake and output chart to know the fluid and electrolyte status.

RELIEVING OF PAIN

1. Patient's pain level, including location, intensity and pattern is assessed to ascertain the level of pain.
2. Patient is assisted to assume a comfortable position, such as semi-Fowler's and knee up positions to relieve pain and to promote comfort.
3. Restriction of activities that may aggravate pain, such as noise to ensure rest.
4. Ice packs are applied to the abdomen to relief pain and provide comfort.
5. Prescribed analgesic such as Diclofenac 75mg bid for 5days is served to help relieve the pain.

PERSONAL HYGIENE

1. Depending on the patient's condition, He is assisted to take her bath. This helps to remove dirt from the skin, stimulate circulation, improve muscle tone and enhance comfort of the patient.
2. The perineum is also washed and vulva toileting is done to prevent infection.
3. Patient is assisted to clean the mouth using tooth paste. This is done to maintain oral hygiene and to prevent oral infection example gingivitis and halitosis.
4. The hair is cared for to prevent hair infestation (example pediculosis, dandruff) by washing it with hair shampoo, water and drying it. It is then combed or braided to prevent hair infestation.

PHYSICAL PREPARATION

1. The skin area is observed for lesion, scars or infection and report for appropriate nursing intervention.
2. The area is washed with soup and water to remove dirt.
3. The operative site is shaved so that it will not interfere with the surgical procedure.
4. The surgical site is clean with an antiseptic solution to help prevent infection.
5. All contra-surgical items are removed from the patient before taking her to the theatre to prevent infection and possible electrical shock.
6. The patient is encouraged or induced to have adequate rest the night before the surgery to relax the patient and reduce anxiety.

NUTRITION

1. Patient is hydrated with intravenous fluid and monitored carefully.
2. The surgeon is assisted to set up a sterile tray for intravenous infusions example ringer's lactase 500mls for 24hours.
3. Food and liquids are with- held for 6 to 8 hours before general anaesthesia to empty stomach. It helps prevent aspiration of vomit (nil per os).

ELIMINATION

1. Patient is encouraged to empty her bowel in the morning before the surgery to help empty the intestines.
2. Urethral catheter is passed to empty the bladder to prevent accidental incision into the bladder during

PRE-OPERATIVE PATIENT TEACHING

1. The patient is informed that She will experience pain after the surgery but medications will be prescribed by the surgeon to reduce the pain. Also patient is taught how to use relaxation and distraction technique to relieve the pain.
2. Patient is educated on how to do deep breathing and cough exercise after her surgery.
3. Patient will assume activities gradually
4. Need passive exercise which will help in blood circulation in the system
5. The patient is discouraged from straining during elimination, heavy lifting and driving to prevent fatigue.

IMMEDIATE PRE-OPERATION CARE

1. Vital signs such as temperature, pulse, respiration and blood pressure are monitored to detect abnormalities and to serve as a baseline.
2. All contra-surgical items such as ear rings, dentures and bracelets are removed from patient to prevent infection.
3. Identity name tag is put on the patient arm to know the identity of the patient.
4. Patient case notes, x-ray and the other requirement with the signed consent form are made ready to accompany the patient to the theatre for the commencement of the surgery.
5. Patient is helped to put on theatre gown to prevent infection in the theatre.

POST-OPERATIVE NURSING CARE

IMMEDIATE POST-OPERATIVE CARE

1. Quick observation of patient is made by watching for chest movement, feeling the pulse to make sure patient is alive.

2. Receive patient gently and put her in a supine position and the head is turned to one side to keep the airway patent and facilitate breathing.
3. Patient is observed for signs of airway obstructions such cough for immediate nursing interventions.
4. The operation site is observed for any bleeding and reinforcement of dressing is done if bleeding occurs.
5. Patient is observed for signs of dehydration such as poor skin turgor for good nursing measures to be employed.
6. The pulse oximetry is used to check the oxygen concentration in the blood to know whether to administer oxygen if the oxygen saturation level is low.
7. Patient's temperature, pulse, respiration and blood pressure are monitored quarter hourly, half hourly, respiration and blood pressure are monitored quarter hourly, half hourly, 1 hourly, 2 hourly and gradually to 4 hourly as patient's condition improves. These are done to detect any deviation for proper nursing interventions.

OBSERVATION

1. Observe the patient's level of consciousness.
2. Quick observation of patient is made by looking for chest movement and feeling the pulse to make sure patient is alive.
3. The wound site is observed for possible bleeding.
4. The elimination pattern of the patient is observed to ensure proper emptying of the bladder.
5. The level of pain of the patient is assessed to know the intensity of the pain.
6. Cyanosis and pallor are assessed for possible transfusion.

7. The patency of the airway is checked for any obstruction for the appropriate nursing interventions to be carried out if it occurs.

WOUND CARE

1. Patient's wound is observed for signs of bleeding and infection, offensive odour, discharge of pus or signs of wound gaping for reinforcement.
2. Wound is dressed aseptically from inside out to prevent wound contamination to prevent infection. Also alternative stitches are removed aseptically on the 7th day as directed by the surgeon.
3. The patient is educated to keep the wound dry and not be touching it with the hand to prevent wound infection.
4. Also the patient is encouraged to take in high protein diet with vitamin to promote wound healing and repair worn-out tissues.

POSITION

1. Patient is placed in a comfortable position to reduce pain and facilities breathing after surgery.
2. The patient is allowed to assume a comfortable position which is not contra-indicated to her condition to help prevent complication.
3. The patient is place in a supine position without pillow with the head turned to one side to keep the airway patent and facilitate breathing.

MAINTENANCE OF FLUID AND ELECTROLYTE

1. Intravenous infusion in situ, example dextrose saline is observed to ensure that, it is regulated to drop according to the prescribed rate of flow.

2. Intake and output chart is maintained to assess the fluid and electrolyte status of the patient.
3. The patient is observed for signs of fluid overload, example dyspnoea, cough, restlessness etc., for immediate nursing intervention.

AMBULATION

- Early ambulation of the patient is encouraged. The patient is assisted to walk, She may be provided with a walking aid like sticks and wheel chair to help prevent deep vein thrombosis.

EXERCISE

- Patients are encouraged to do moderate to active exercises. This improves circulation, muscle wasting and relieve anxiety on the ward. Exercises also help peristalsis and flush out toxins from the body system.

PERSONAL HYGIENE

1. Depending on the patient's condition She is assisted to bath. This help to remove dirt from the skin, improves circulation and muscles tone. It also refreshes patient and enhance patient's comfort. During bathing, care must be taken to wash the perineum.
2. Also during bathing, pressure areas such as the occipital, scapular, and sacrum should be treated to stimulate circulation and prevent bed sores.
3. The patient's finger and toe nails are soaked in water respectively to soften and trimmed them in order to improve hygiene. 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.

NUTRITION

1. Intravenous fluids are administered as prescribed and monitored to ensure that drip is according to prescribed rate by the surgeon to prevent dehydration pre-operatively and post operatively.
2. Patient is given nothing by mouth after surgery until it is directed by the surgeon after certifying the presence of bowel sound or peristaltic movement.
3. Normal diet rich in protein, vitamin c, zinc, iron, calorie and vegetables are introduced later to promote healing and recovery.
4. Diet is planned with the patient taking into consideration her likes and dislikes and meal is served attractively to promote appetite.

ELIMINATION

1. Patient is served with bedpan on request and was also encourage to take more fluid and roughages to prevent constipation.
2. Nearby taps are opened to stimulate patient to urinate.
3. Intake of fluids is encouraged to prevent dehydration
4. Intake and output is monitored and balanced to assess the hydration level of the patient.
5. Catheter is passed under aseptic technique to empty the bladder.
6. The amount, colour, odour and any abnormalities found in the urine and vomitus are documented in the nurse's notes to detect for to serve as reference.

REST AND SLEEP

The nurse ensures that patient rest and has enough sleep to conserve energy, promote relaxation and helps in the recovering process. Patient is given a warm bath and put in a well-ventilated room to promote bed rest. Noise on the ward and the number of visitors to the ward are

minimized to enable patient have enough sleep. Bright lights are put off and dim lights are put on to induce sleep and prevent misinterpretation of objects

MEDICATION

Patient prescribed drugs (Suppository Diclofenac 100mg 12hourly for 48hours) for pain and antibiotic (intravenous ceftriaxone 1 gram daily for 48 hours) for infection are served both preoperatively and post operatively. When serving drugs, the following were taken into consideration, the right of patient, the right of drugs, the right of dosage, and the right of patient to refuse medication, the right route of drugs administration.

PATIENT EDUCATION BEFORE DISCHARGE

1. Patient is warned against lifting or straining to prevent complications.
2. Patient is educated that He will be able to return to work or resume normal duties within four weeks to enhance complete recovery.
3. Patient is educated on good personal hygiene to prevent infection.
4. Patient is informed that sexual intercourse can be done after complete healing of wound.

1.10 Validation of Data

According to Mcintosh (2013) it refers to the process of establishing the suitability of mechanism or system to performing a particular task.

The information for this study was collected from multiple sources including the patient, his relatives, the medical team findings and reports, results from laboratory investigation and reviewed literature on the condition. Data collected were compared with standard literature and there were no discrepancies. It can therefore be concluded that all data collected from Ms. M.E was true and devoid of any misinterpretation, error, distortions and the data should be considered accurate, dependable, out of bias and valid.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is the detailed study or examination of something in order to understand more about it, Hornby (2006). Analysis of data is the second phase of the nursing process. It involves categorizing information and comparing with scientific standards in order to identify actual or potential alteration in health status of the patient.

This includes identifying the patient and family health problems and strength to enable the nurse draw an effective care plan for the patient and family. The data that was analysed includes those from laboratory reports, vital signs checked and physical examination results.

This chapter contains the following:

- Comparison of data with standard.
- Patient health problems.
- Patient/ family strength.
- Patient's strength according to the identified problems.
- Nursing diagnosis

2.1 Comparison of Data with Standards

A comparison is hereby being made between actual experiences of the patient and standard documented evidences to identify deviations.

This includes the investigations requested by physicians for medical diagnosis; causes of the patient's illness, clinical manifestations of the patient's condition, pharmacological management as well as complications.

2.1.1 Diagnostic Investigation/Test

These are the investigations requested and carried on M.E

- History taking
- Physical examination
- Blood film for malaria parasites
- Full blood count (FBC)
- Ultrasound scan of the abdomen

TABLE 1: COMPARISON OF INVESTIGATIONS ORDERED FOR PATIENT WITH LITERATURE REVIEW

Diagnostic Investigations According To Literature	**Diagnostic Investigations Requested For the Patient**
Abdominal ultrasonography	Abdominal ultrasound scan was requested for the patient.
Urine for routine examination	Urine for routine examination was not conducted
Full blood count	Full blood count was conducted.
Physical examination and patient history taking	Physical examination was conducted and

	patient history was taken.

The table above indicate that most of the diagnostic tests in literature was conducted on patient. Blood film for malaria parasites was conducted for patient but was not part of the diagnostic test listed in literature review.

The above investigations were carried out on the day of admission for Ms. M.E

The table below shows detailed results of the laboratory investigations carried on Ms. M.E

TABLE 2: COMPARISON OF INVESTIGTIONS ORDERED FOR PATIENT WITH LITERATURE REVIEW

Date	Specimen	Investigations	Results	Normal Range	Interpretation	Remarks
21st November, 2022	Blood	Blood film for malaria parasite	Negative	Negative	Patient had no malaria	No treatment was given
21st November, 2022	Blood	Differential white blood cell count; Neutrophils: Lymphocyte: Monocyte: Eosinophils: Basophils:	 9700 x 10^6L 1000 X 10^6/ L 169 X 10^6 /L 120 X 10^6/L 20 X 10^6/L	 3000-5800 X 10^6 /L 1500-3000 X10^6 /L 300-500 X 10^6/L 50- 250 X 10^6/L 15-150 X 10^6/L	Patient had infection	Antibiotics were prescribed for patient.

21st November, 2022	Blood	Platelet count Mean corpuscular volume (MCV) Haemoglobin estimation	5.21 X 10^9/L 350 X 10^9/L 12.7g/dL	Males: 4.6-6.2 x 10^6/L 150-400 X 10^9/L Male: 12.0 -18.0g/dL Female: 11.0 -16.0g/dL	Results were normal with no abnormalities seen	No treatment was given
21st November 2022	Lower abdomen of the body	Abdominal Scan	Enlarged than its normal	Uninflamed appendix	Inflamed appendix	Appendectomy done for the patient

2.1.2 Causes of Patient Condition

From the interview with Ms. M.E and reference to the literature, signs and symptoms exhibited by patient and laboratory investigations carried out, I was proved that patient condition was as a result of predisposing factor such as obstruction of the appendicular lumen by a fecoliath, worms and possible infection from pyogenic organisms.

2.1.3 Clinical Features

Details of the manifestation of acute appendicitis exhibited by M.E are compared with those from literature review in the table below.

TABLE THREE; CLINICAL FEATURES MANIFESTED AS COMPERED TO THAT OF THE LITERTURE REVIEW.

Clinical Features according to literature review	**Clinical Features Presented By** **The Patient**
Peri umbilical pain	Peri umbilical was experienced by patient
Anorexia	Patient did not experience anorexia
Moderate increase in temperature	Patient experienced increased in body temperature
Nausea and vomiting	Patient didn't experience nausea and vomiting.
Dysuria (painful or difficult urination).	Patient did not complain of dysuria
Constipation or diarrhoea.	Patient complained of mild constipation
Tenderness or rebound tenderness and guarding	On palpation there was tenderness and rigidity at right iliac fossa of the patient
Rovsing's sign	Patient exhibited Rovsing's sign
Severe Abdominal pain	Patient complained of severe abdominal pain

Physical examination yielding tenderness, rebound tenderness and guarding at McBurney's point at the right lower quadrant	Patient experienced tenderness, rebound tenderness and guarding at McBurney's point

Patient experienced most of the signs and symptoms illustrated in the literature review, this truly shows that patient was rightly diagnosed with appendicitis.

2.1.4 Specific Medical Treatment

Treatment is the provision, coordination or management of health care and related services by one or more health care providers.

With regard to the medical treatment in the literature review, M.E was managed on the following treatment.

Preoperative Medications

1. IV Ciprofloxacin 400mg bid x 24 hours
2. IV Metronidazole 500mg tds x 48 hours
3. Injection Diclofenac 75mg bid x 24 hours
4. IVF dextrose saline 1.5L x 24hours
5. Tablet Paracetamol 500mg tds x 48hours

Intra-Operative Medications

1. Intravenous Dextrose saline 500mls
2. Intravenous Normal saline 500mls
3. Ketamine 2mg/kg stat intravenously
4. Maintenance doses of Halothane 0.6% through inhalation
5. Atropine sulphate 1mg start intravenously
6. Suxamethonium chloride 1mg intravenously

Post-Operative Medications

1. Intramuscular Tramadol 100mg bid x 24hours
2. Intravenous Metronidazole 500mg tds x 24hours
3. Suppository Diclofenac 100mg x 5/7
4. Tablet Metronidazole 400mg tds x 5/7
5. Tablet Multivitamin tds for 30days.

TABLE 3: MEDICATION TABLE IN LITERATURE REVIEW COMPARED WITH THOSE GIVEN TO MS. M.E

Medication According To Literature Review	**Medication Given Patient**
Antibiotics	IV Ciprofloxacin, and, IV Metronidazole were given
Analgesic	Injection Diclofenac was given
Sedatives may also be administered as a start dose to lower anxiety and calm patient. Example: Intravenous Diazepam 10mg as a start	The patient was not given any sedatives
Intravenous fluids example: dextrose saline and or Ringers lactate	IVF dextrose saline was given

From the literature review most of the medications were prescribed for the patient to help minimize the infections, relieve pain and to replace lost fluids.

TABLE 4: PHARMACOLOGY OF DRUGS ORDERED

Date	Drug	Dosage and route of administration according to literature	Dosage and route of administration given to patient	Classification	Desired effect	Actual effect	Side effects/Remarks
21/11/2022 and 22/11/2022	Dextrose saline	**Dose:** Adult/children: dosage depends on the fluid and electrolyte requirement of the patient **Route:** intravenous	**21/11/2022** 1.5 liter for 24hours intravenously **22/11/2022** Dextrose saline 500mls Intravenous	Sterile Isotonic solution of glucose and sodium	To maintain hydration	Maintained fluid and electrolyte imbalance	Cardiac overload, cardiac failure and over hydration. None observed
21/11/2022	Ciprofloxacin	Adult: 100-500mg intravenously and orally. Children: 15mg/kg **Route:** oral and intravenous	**Dose:** 400mg bid x 24 hours **Route:** Intravenously	Antibiotic (Quinolone)	They are bactericidal agent and act by interfering bacterial cell synthesis.	Infection resolved as patient's condition improved	Headache, dizziness, fatigue, insomnia

TABLE 4: PHARMACOLOGY OF DRUGS ORDERED

Date	Drug	Dosage and route of administration according to literature	Dosage and route of administration given to patient	Classification	Desired effect	Actual effect	Side effects/Remarks
22/11/2022	Normal saline	**Dose:** Adult/children: dosage depends on the fluid and electrolyte requirement of the patient **Route:** intravenous	0.5 litre for 24hours intravenously	Sterile isotonic sodium chloride	To maintain fluid and electrolyte balance	Helped to maintain fluid and electrolyte imbalance	Oedema, acidosis and sodium accumulation None observed
22/11/2022	Paracetamol	**Dose:** 0.5- 1g every 4-5 hours; maximum 4g per day **Route** Orally, Rectal and Intravenously.	**Dosage:** 500mg tds x 48hours **Route:** Oral	Anti-pyretic and analgesics	It relieves pain and reduces fever	It relieved pain and reduced fever	Patient was relieved of the signs and symptoms such as pyrexia and pain

TABLE 4: PHARMACOLOGY OF DRUGS ORDERED

Date	Drug	Dosage and route of administration according to literature	Dosage and route of administration given to patient	Classification	Desired effect	Actual effect	Side effects/Remarks
21/11/2022 and 22/11/2022	Metronidazole	**Dose:** 400-500mg tid for 72 hours Child: 7.5mg/kg **Route:** oral, intravenously	**21/11/2022** 500mg tds x 48 hours intravenously **22/11/2022** 500mg tds x 24hours Intravenous	Antibiotics	A direct acting trichomonacide and amebicide that bind to DNA and inhibit	Patient was free from infection.	Headache, depression and drowsiness. None observed
21/11/2022 and 22/11/2022	Diclofenac	**Dose:** Adult dose: 75mg – 150mg 12 hourly. Children: 1 – 3 mg/kg **Route** Orally, Rectal and	**21/11/2022** 75mg bid x 24 hours Intravenously **22/11/2022** 100mg x 5/7. Rectal	NSAID	Relieve of mild pain, fever and also reduce inflammation.	Helped reduce pain, fever and inflammation	Drowsiness, insomnia and constipation None observed.

		Intravenously.					

TABLE 4: PHARMACOLOGY OF DRUGS ORDERED

Date	Drug	Dosage and route of administration according to literature	Dosage and route of administration given to patient	Classification	Desired effect	Actual effect	Side effects/Remarks
22/11/2022	Ketamine	**Dose:** 1-4.5mg/kg via slow injection over 60 seconds and maintenance dose of 0.5-2mg/kg via infusion. **Route:** intravenously, intramuscularly.	2mg/kg intravenously	General anaesthetic agent (N-methyl-D-aspartate receptor antagonist).	Produces a cataleptic like state wherein the patient is withdrawn from the surrounding environment.	Helped withdrawn patient from her surrounding	Confusion, respiratory distress, nystagmus, lachrymation, diplopia etc. None was observed
22/11/2022	Halothane	**Dose:** adult and children dose depends on the duration of surgery **Route:** inhalation	**Dose:** 0.6% was given. **Route:** Inhalation.	Inhalation Anaesthetic Agent.	Prevent vomiting and induces muscle relation	Patient had relaxed muscles during the surgery.	Bradycardia, hypertoxicity and cardiac arrest. None was

							observed in the patient.

TABLE 4: PHARMACOLOGY OF DRUGS ORDERED

Date	Drug	Dosage and route of administration according to literature	Dosage and route of administration given to patient	Classification	Desired effect	Actual effect	Side effects/Remarks
22/11/2022	Atropine	**Dose:** Adult: 300-600mcg 30-60 minutes before anaesthesia. Child: >20kg: 300600mcg, 12-16kg: 300mcg, 7-9kg: 200mcg, >3 kg: 100mcg **Route:** intravenously, intramuscularly and	1mg stat intravenously	Mydriatic and cycloplegic agent, Anticholinergic/ antispasmodic	Prevent vomiting and induces muscle relaxation.	Patient had relaxed muscle during surgery.	Dry mouth, dysphagia, constipation, flushing and dryness of skin, tachycardia, palpitations etc. None was observed.

		subcutaneously.					

TABLE 4: PHARMACOLOGY OF DRUGS ORDERED

Date	Drug	Dosage and route of administration according to literature	Dosage and route of administration given to patient	Classification	Desired effect	Actual effect	Side effects/Remarks
22/11/2022	Suxamethonium chloride	**Dose:** Adult: 0.5-1mg/kg at 5-10 minutes intervals Child: 1mg/kg Neonate/infant: 2mg/kg **Route:** intravenously, intramuscularly.	1mg intravenously	Depolarizing muscle relaxant resulting in neuromuscular blockage.	It acts by mimicking acetylcholine at the neuromuscular junction; depolarization n is therefore prolonged	Rapid onset of the drug was achieved for a successful tracheal intubation.	Tachycardia, hypotension, bronchospasm, skin flushing and anaphylactic reaction. None was experienced by patient.

TABLE 4: PHARMACOLOGY OF DRUGS ORDERED

Date	Drug	Dosage and route of administration according to literature	Dosage and route of administration given to patient	Classification	Desired effect	Actual effect	Side effects/Remarks
22/11/2022	Intramuscular Tramadol	**Dose:** Adult: 50-100 milligrams 4-6 hours, as needed but not exceed 400 milligrams/day Child: not recommended **Route:** intramuscularly, oral or intravenously	100mg bid x 24hours Intramuscularly	Opioid analgesic	Relieve of mild pain, fever	Reduced patient's pain	Nausea, vomiting, constipation, vertigo None observed
22/11/2022	Tab. Multivitamin	**Dose:** Adult: 1 tablet daily or as directed by physician. Children: below 1 year: 9-10 drops (0.3mls), 1 year and above: 23-25	1 daily for 30days Orally	Vitamin and mineral supplement	For boosting appetite and treating ascorbic acid deficiency For vitamin	Helped boost appetite.	Overdose may cause rough skin and enlarge liver.

		drops (1.0mls) once daily or as directed by physician. Route: oral			A and D deficiency correction		None observed.

2.1.5 Complications

With reference to the complications stated in the literature review, Ms. M.E did not develop any complication throughout his stay in the hospital.

2.2 Patient/ Family Strength

Strength is the quality that allows someone to deal with problems in a determined and effective way (Weller, 2018).

The strength of the patient and the family involves what can be done on their part to facilitate the work of health care providers in providing holistic care to promote recovery. Through interaction with the patient, her strength was observed and also some were revealed by her.

Preoperative Strengths

1. Patient could tolerate analgesics when given.
2. Patient could tolerate tepid sponging.
3. Patient and family could verbalize fears.

Postoperative Strengths

4. Patient could verbalize intensity of incisional pain
5. Patient could tolerate assisted bed bath
6. Patient is ready to learn about her lifestyle modification

2.3 Patient Health Problems

Health problem is defined as a state in which one is unable to function normally and with pain (Weller, 2018).

The patient had the following health problems or challenge which was to be adequately addressed so that the patient could recover and live an independent life as early as possible.

Pre- Operative Health problems

1. Patient complained of abdominal pain. (21st November, 2022)
2. Patient experienced fever (37.8°C). (21st November, 2022)
3. Patient was anxious about the impending surgery. (22nd November, 2022)

Post – Operative Health Problems

4. Patient had pain at the incisional site. (22nd November, 2022)
5. Patient could not maintain his personal hygienic needs. (23rd November, 2022)
6. Deficient knowledge on lifestyle modifications. (26rd November, 2022)

2.5 Prioritized Nursing Diagnoses

According to NANDA International, nursing diagnosis is a clinical judgement about individual, family or community experiences/responses to actual or potential health problems/life process.

A nursing diagnosis is a statement that describes the potential or actual health problems of the patient. The following were the diagnosis established to help in the management of Ms. M.E during the patient/ family assessment and data analysis. They are arranged in order of priority.

1. Acute pain (abdominal) related to inflammation of the vermiform appendix.
2. Hyperthermia (38.7°C) related to infectious process of the appendix.
3. Anxiety (fear) related to impending surgery and its unknown outcome.
4. Acute pain (incisional pain) related to surgical incision on the abdomen.
5. Self-care deficit (partial) related to muscle weakness and fatigue
6. Deficient knowledge related to lifestyle modification associated with surgical intervention.

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

The nursing care plan is written guided information about patient in a meaningful whole. It focuses on the action that nurses should take to address the patient identified nursing problem and set goals, also it is usually modified according to changes in the patient's condition.

This is the third stage of the nursing process. Planning nursing care is a category of nursing behaviours in which patient-cantered goals and expected outcomes are established and nursing interventions are selected.

3.1 Nursing Objectives / Outcome Criteria

These are very important because they aid in rendering good, holistic and comprehensive nursing care to the patient as well as facilitating quick recovery.

1. Patient would be relieved of abdominal pain within 24 hours as evidenced by;
    a. Patient verbalizing that she is no longer experiencing the abdominal pain
    b. Nurse observing patient has cheerful facial expression with no complaints of pain.

2. Patient's body temperature would be restored to normal range within 6 hours (36.2 – 37.2^{0}C) as evidenced by;
    a. Patient verbalizing that he does not feel warm to touch.
    b. Nurse observing patient's temperature restored to normal range (36.2 – 37.2^{0}C)

3. Patient would be relieved of anxiety within 2 hours as evidenced by;
    a. Patient verbalizing the absence of fear and confidence in surgery.

b. Nurse observing that patient has stable vital signs and is ready for surgery

4. Patient would be relieved of incisional pains within 48 hours as evidenced by;

a. Nurse observing that patient is relaxed in bed and has a good facial expression
b. Patient verbalizing that the severity of the incisional pains has reduced to tolerable levels.

5. Patient would be able to meet her personal hygiene needs within 48 hours as evidenced by;

a. Patient verbalizing that her personal hygiene needs (bathing, mouth care and grooming) have being meet
b. Nurse observing patient being assisted to perform self-care activities (bathing, mouth care and grooming)

6. Patient would gain adequate knowledge on postoperative lifestyle modification to prevent recurrence and complication within the next 2 hours as evidenced by;

a. Patient verbalizing lifestyle modifications she is supposed to make
b. Nurse observing patient answering questions asked about his lifestyle modifications correctly

3.2 Nursing Care Plan

The nursing care plan illustrates the plan of care made to address/manage patient's health problems.

TABLE 5: Patients /Family Care Plan

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
21/11/22 At 10:40am	Acute pain (abdominal) related to inflammation of the vermiform appendix.	Patient would be relieved of abdominal pain within 24 hours as evidenced by; a. Patient verbalizing that she is no longer experiencing the abdominal pain b. Nurse observing patient has cheerful facial expression with no complaints of pain.	1. Reassure patient and relatives. 2. Assess the patient's pain level. 3. Provide diversional therapy. 4. Assist patient to assume a position of comfort 5. Administer prescribed pain	1. Patient and relatives were reassured of competent nursing care to allay fear and anxiety. 2. Patient's pain level was assessed to be 7 using the numerical pain rating scale from 0 -10. 3. Patient was allowed to watch her favourite TV program in the ward to divert her attention from the pain. 4. The patient was assisted to assume a position of comfort to relieve her of her abdominal pain	22/11/22 At 10:40am	Goal fully met as patient verbalized that she was no longer experiencing the abdominal pain and nurse observed patient had cheerful facial expression with no complaints of pain.	AV

			medications	5. Prescribed pain medication was administered was administered as IM Diclofenac 75 mg stat to help relieve the patient abdominal pain			

TABLE 5: Patients /Family Care Plan

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
21/11/22 At 10:45 am	Hyperthermia (38.7^{o}C) related to infectious process of the appendix.	Patient's body temperature would be restored to normal range (36.2 – 37.2^{0}C) within 6 hours as evidenced by; a. Patient verbalizing that he does not feel warm to touch. b. Nurse observing patient's temperature restored to normal range (36.2 – 37.2^{0}C)	1. Reassure the patient 2. Check and record patient's vital signs 3. Tepid sponge the patient 4. Serve the patient with cold drinks 5. Encourage the patient to remove extra clothing to help	1. Patient was reassured that her condition will improve since she is in the hands of competent nursing staff. 2. Patient's vital signs were checked especially temperature as a baseline. 3. Patient was tepid sponged to help reduce to normal range (36.2 – 37.2^{0}C) the temperature. 4. Patient was served with cold (Coca Cola) 250mls to help reduce patients' temperature. 5. Patient was encouraged	21/11/22 At 4: 45 pm	Goal fully met as Patient verbalized that she did not feel warm to touch and nurse observed patient's temperature restored to normal range (36.2 – 37.2^{0}C)	AV

			reduce the temperature. 6. Administer the patient with prescribed antipyretics	to remove extra clothing to ensure she is wearing light clothing to help reduce the temperature. 6. Prescribed paracetamol was administered to reduce the temperature.			

TABLE 5: Patients /Family Care Plan

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
22/11/22 At 6:00am	Anxiety (fear) related to impending surgery and its unknown outcome.	Patient would be relieved of anxiety within 2 hours as evidenced by; a. Patient verbalizing the absence of fear and confidence in surgery. b. Nurse observing that patient has stable vital signs and is ready for surgery	1. Reassure patient and relative. 2. Orient patient to the environment and staff. 3. Introduce someone who has gone through laparotomy successfully. 4. Educate patient.	1. Patient and relative were reassured that the surgery has always been successful with positive outcomes. 2. Patient was oriented to the staff, theatre, its equipment's, anaesthetics gadgets and the recovery room. 3. Ms. Christiana who has gone through successful laparotomy was introduced to her. 4. Patient was educated on the need for surgery, drug regimen and postoperative management.	22/11/22 At 8:00am	Goals fully met as; Patient verbalized the absence of fear and nurse observed patient's vital signs and recorded as T-36.7°C, P84bpm, R- 22cbpm and BP-110/80mmHg and observed patient's readiness for surgery.	AV

			5. Teach postoperative techniques. 6. Encourage feedback.	5. Patient was taught on deep breathing exercise, drug regimen and guarding the incision site during coughing. 6. Feedback was assessed as patient verbalized all that she heard and demonstrated when necessary.			

TABLE 5: Patients /Family Care Plan

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
22/11/22 At 2:00 pm	Acute pain (incisional pain) related to surgical incision on the abdomen.	Patient would be relieved of incisional pains within 48 hours as evidenced by; a. Nurse observing that patient is relaxed in bed and has a good facial expression b. Patient verbalizing that the severity of the incisional pains has reduced to tolerable levels.	1. Reassure patient. 2. Put patient in a comfortable position. 3. Teach pain reducing techniques.	1. Patient was reassured that the pain He is feeling is normal but will subside after implementation of nursing and medical procedures. 2. Patient was put in a supine position to enhance easy breathing and minimizing pain. 3. Patient was taught deep breathing and coughing exercise, and to guard incision site whenever coughing, should not stretch for any item but should call for help when	24/11/22 At 02:00pm	Goal fully met as; nurse observed that patient was relaxed in bed and had a good facial expression and patient verbalized that the severity of the abdominal pains had reduced to tolerable levels.	AV

			4. Inspect incision site. 5. Administer prescribed analgesics. 6. Observe for shock	necessary. 4. Incision site was inspected for bleeding, nature of wound and sutures. 5. Prescribed analgesics served. 6. Signs and symptoms of shock were observed but none occurred.			

TABLE 5: Patients /Family Care Plan

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
23/11/22 At 8:00am	Self-care deficit (partial) related to muscle weakness and fatigue.	Patient would be able to meet her personal hygiene needs within 48 hours as evidenced by; a. Patient verbalizing that her personal hygiene needs (bathing, mouth care and grooming) have being meet. b. Nurse observing patient being assisted to perform self-care activities (bathing, mouth care and grooming).	1. Reassure patient. 2. Assist patient to care for mouth. 3. Assist patient to elimination needs. 4. Assist patient to bath	1. Patient was reassured that she will safely performs (to maximum ability) her normal duties as soon as possible. 2. Patient was assisted to clean mouth and teeth with tooth brush and paste twice daily to prevent infections and improve appetite. She was given water to rinse his mouth after each meal. 3. Bed pan was offered to patient whenever needed. 4. Patient was given assisted bed bath with soap, sponge and warm	25/11/22 At 8:00am	Goals fully met as; patient verbalized that her personal hygiene needs (bathing, mouth care and grooming) had being met and nurse observed that patient was assisted to perform self-care activities (bathing, mouth care and grooming).	AV

				water and dried with a towel twice daily.			
			5. Assist patient to change soiled linen.	5. Patient was assisted to dress and change soiled clothes and linen.			
			6. Assist patient to feed.	6. Patient was placed in optimal position for feeding preferably sitting up in chair.			
			7. Encourage early ambulation.	7. Patient was assisted with bed mobility, assisted to walk around his bed at least 4 times daily to prevent infection and oedema of the feet.			

TABLE 5: Patients /Family Care Plan

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
26/11/22 at 7:00 am	Deficient knowledge related to lifestyle modification associated with surgical intervention.	Patient would gain adequate knowledge on postoperative lifestyle modification to prevent recurrence and complication within the next 2 hours as evidenced by; a. Patient verbalizing lifestyle modifications she is supposed to make b. Nurse observing patient answering questions asked about his lifestyle modifications correctly	1. Create a peaceful environment for learning. 2. Explain the purpose of the education. 3. Ask patient questions pertaining to her lifestyle modification associated with surgical interventions 4. Educate patient to avoid lifting of heavy objects to prevent wound dehiscence. 5. Educate patient to take in high	1. A peaceful environment was created for learning as noise around was minimized. 2. The purpose of education was explained. 3. Questions were asked pertaining to his lifestyle modification associated with surgical intervention. 4. Patient was educated to avoid lifting heavy objects to prevent wound dehiscence. 5. Educate patient to take	26/11/22 at 9:00 am	Goal fully met as patient verbalized lifestyle modifications she was supposed to make and nurse observed patient answering questions asked about her lifestyle modifications correctly.	A.V.

			protein and vitamins diet 6. Encourage patient to ask questions and answer in a simple and tactful manner	in high protein and vitamin diet to enhance wound healing 6. Patient was encouraged to ask questions and was answered in a simple and tactful manner			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

This is the fourth stage of the patient/ family care study. It is also a stage where the nursing care plan is implemented effectively. This stage reveals all the nursing care rendered to the patient and family throughout the period of hospitalization. Implementation also covers all the nursing interventions directed towards resolving patient nursing diagnosis and meeting health needs. This stage involves;

1. Summary of actual nursing care rendered to patient and family.

2. Preparation of patient/ family towards discharge and rehabilitation.

3. Follow-up/ home visits/ continuity of care.

4.1 Summary of Care Rendered to Patient/Family

The nursing care of Ms. M.E started from the day of her admission until she was handed over to a public health nurse. She was hospitalized for five (5) days thus from 21st November, 2022 to 26th November, 2022.

The management was based on series of activities that were meant to aim at helping patient regain her health as early as possible. The patient/ family data was subjective analysis leading to identification of actual health problems. The following is a narrative summary of the day-to-day nursing care rendered to my patient throughout her stay in the female Medical at Sunyani Municipal Hospital.

DAY OF ADMISSION (21st November 2022)

On 21st November, 2022, at 10:30am, M.E was admitted into the Female Ward of Sunyani Municipal Hospital with diagnosis of Acute Appendicitis. She was accompanied by a nurse from the Out Patient Department (OPD) and a relative into the ward. On reaching the ward, she was cheerfully welcomed and made comfortable at the nurses' station.

The necessary documents were collected and her name was mentioned to identify the patient, her particulars were crosschecked.

Her computer system number was then given to the Nurse-in-Charge who also read through and asked me to admit her into any empty bed in the female's medical ward. She was called by her name and again welcomed to the ward. She was then assisted to her bed and the bed number was 5A.

The vital signs were checked and recorded as follows:

Temperature - 37.8^{o}C

Pulse - 124bpm

Respiration - 24cpm

Blood pressure - 130/68mmHg.

I introduce Ms. M.E to other patients on the ward especially those who have gone through surgery. The subject of study and her family were reassured that they have themselves in the hands of a competent and professional health team and also availability of modern equipment to help go through the surgical procedure successfully. Her brother was oriented to the ward and its annexes.

The immediate medications were obtained and administered. The treatment consisted of;

1. IV Ciprofloxacin 400mg bid x 24 hours

2. IV Metronidazole 500mg tds x 48 hours
3. Injection Diclofenac 75mg bid x 24 hours
4. IVF dextrose saline 1.5L x 24hours
5. Tablet Paracetamol 500mg tds x 48hours

The diagnostic investigations done already includes:

4. Blood film for malaria parasites
5. Full blood count (FBC)
6. Ultrasound scan of the abdomen.

Since the patient was having high body temperature, an objective was set to help reduce the temperature to normal (36.2 ºC - 37.2 ºC) within 24 hours. She was quickly tepid sponged. Ms. M.E was encouraged to take in more ice water and also paracetamol 500mg was served as ordered to help further reduce the temperature to normal. Ms. M.E was educated on the need to maintain good personal hygiene, balanced diet and little exercises. The cash and carry system as well as the National Health Insurance Scheme was explained to Ms. M.E. She revealed that she was insured thus, it was explained to her that certain drugs and treatment were not covered by the national health insurance scheme.

The patient was made aware that as a final year student, it is a requirement by the Nursing and Midwifery Council of Ghana to take a patient, render individualized nursing care to him/her from admission until discharge and carry out home visits before and after discharge until She recovers fully.

Ms. M.E and relative accepted my proposal and promised to cooperate with me and give all the necessary information to complete the care am rendering to them. Finally, the patients name, age, sex, diagnosis and date of admission were all recorded into the admission and discharge book and the daily ward state.

On admission, at 10:40 am, patient complained of severe abdominal pains. A nursing diagnosis of acute pain (abdominal) related to inflammation of the vermiform appendix.

An objective was set to relieve the patient abdominal pain within 24 hours. The following nursing interventions were implemented to relieve the patient of abdominal pain; patient and relatives were reassured of competent nursing care to allay fear and anxiety. Patient's pain level was assessed to be 7 using the numerical pain rating scale from 0 -10. Patient was allowed to watch her favourite TV program in the ward to divert her attention from the pain. The patient was assisted to assume a position of comfort to relieve her of her abdominal pain. Prescribed pain medication was administered was administered as IM Diclofenac 75 mg stat to help relieve the patient abdominal pain.

On the same day on admission at 10:45 am, patient had increased body temperature (38.7^{o}C)). An objective was set to restore the patient body temperature to normal range (36.2 – 37.2^{0}C) within 6 hours. The following nursing interventions were executed to restore the patient body temperature to normal range (36.2 – 37.2^{0}C); Patient's vital signs were checked especially temperature as a baseline. Patient was tepid sponged to help reduce to normal range (36.2 – 37.2^{0}C) the temperature. Patient was served with cold (Coca Cola) 250mls to help reduce patients' temperature. Prescribed paracetamol was administered to reduce the temperature.

At 4:45pm, evaluation was made for the objective set in the morning to help reduce patient's body temperature to normal. Goal fully met as patient verbalized that she did not feel warm to touch and nurse observed patient's temperature restored to normal range (36.2 – 37.2^{0}C)

All routine care for the rest of the day were done and recorded.

FIRST DAY ON ADMISSION (22th November, 2022)

Patient woke up around 5:30am, she was assisted to perform her personal hygiene.

Through interaction with the Patient and family in the morning around 6am, it was observed that Patient was anxious as a result of unknown outcome of the surgery. A nursing diagnosis of Anxiety (fear) related to impending surgery and its unknown outcome was made. An objective was set to relieve patient of anxiety within the next 2 hours. The following interventions were implemented;

Patient and relative were reassured that the surgery has always been successful with positive outcomes. Patient was oriented to the staff, theatre, its equipment's, anaesthetic's gadgets and the recovery room. Patient who has gone through successful laparotomy was introduced to her.

Patient was educated on the need for surgery, drug regimen and post-operative management. Patient was taught on deep breathing exercise, drug regimen and guarding the incision site during coughing.

Pre-operative nursing management

Patients' preparation for appendectomy was done under the following headings;

Psychological Preparation

Patient and father were reassured that the surgery was going to be successful. They were assured to allay fear or anxiety. The expected outcome of the surgery was also explained to them. The patient was taken through the consent form and made to sign as required by the hospital.

Patient was told about what to expect in the theatre; the staff dressed in theatre gowns, face mask etc. she was also informed that she would be put to sleep prior to the operation by injection.

Physical Preparation

Patient was advised to suspend taking food to prevent vomiting and aspiration during surgery. She was monitored in the morning of the day of the surgery to ensure that she does not take anything by mouth in order not to alter the surgical process. To prevent any postoperative complications, Patient surgical site was observed for lesions, scar or rashes. She was prepared by shaving the operation site to help prevent interference during surgery. Patient was taught how to do deep breathing exercise and coughing technique to prevent wound gaping.

Physiological Preparation

The laboratory examination; haemoglobin level estimation. A urethral catheter was passed and connected to a urine bag. The vital signs were checked and recorded. Intravenous infusion of Ringer's lactate 500ml was given prior to the surgery.

Immediate Pre-Operation Care

Vital signs such as temperature, pulse, respiration and blood pressure are monitored to detect abnormalities and to serve as a baseline. All contra-surgical items such as ear rings, and bracelets are removed from patient to prevent infection. Identity name tag is put on the patient arm to know the identity of the patient. Patient case notes, and other requirement with the signed consent form are made ready to accompany the patient to the theatre for the commencement of the surgery.

Transportation of patient to Theatre

Before patient would be transported to the theatre, at 8:00am, an evaluation was done for the objective set to relieve her of anxiety. Goal was Goals fully met as; Patient verbalized the

absence of fear and nurse observed patient's vital signs and recorded as T- 36.7°C, P84bpm, R-22cbpm and BP- 110/80mmHg and observed patient's readiness for surgery.

Patient was transported to theatre at 9 am on a stretcher with intravenous line in-situ. All needed intravenous infusions such as intravenous normal saline infusion 500mls and intravenous dextrose saline infusion 500mls were sent to the theatre together with the patient.

At 10:40am, evaluation was made for the goal set yesterday to relive patient of abdominal pain within 24 hours. Goal fully met as patient verbalized that she was no longer experiencing the abdominal pain and nurse observed patient had cheerful facial expression with no complaints of pain.

Intra-Operative Care

In the theatre room patient was put on theatre couch in a supine position. She was given intravenous infusion dextrose saline and normal saline alternatively to maintain fluid and electrolyte balance. She was pre- oxygenated and Ketamine 2mg/kg stat was given intravenously when the pulse oximetry recorded 99%. Suxamethonium chloride 1mg was given intravenously to relax the muscles for intubation then maintenance dose of Halothane 0.6%. Atropine 1mg was given as reversal agent. These were given by the anaesthetist,

An incision was made at the right iliac fossa of the abdomen and then appendicectomy was done. Haemostasis was secured with the use of diathermy machine. The abdomen was closed in layers using vicryl 2 continuous to fascia and nylon 3.0 interrupted mattresses to skin. Sterile gauze was used to cover the sutured skin and strips of plaster were applied to secure it in position. Finding was an inflamed appendix.

The drape towel was removed and she was cleaned and covered with counterpane. Continuous suctioning was done to maintain her airway patent. The procedure took about 1 hour and the

patient was moved to the recovery ward around 12:00 pm for observations and continuous care. Post-operative management ordered by the surgeon included nil per os, strict intake and output chart, monitoring of vital signs (temperature, pulse, respiration and blood pressure) ¼ hourly, ½ hourly, 1 hourly till patient's condition stabilized then 4 hourly.

Immediate Post-Operative Care at the theatre

Patient was sent to the recovery ward at 12: 00pm in an unconscious state. She was received into an already prepared operation bed. Quick observation was made by looking at the chest movement, feeling of pulse to ascertain that patient was alive. Patient was placed in the supine position with the head turn to one side to facilitate drainage of secretions and oral care was performed to clear the airway. The incision sites were assessed for any possible bleeding and no bleeding was seen at the incision site and the genital. Equipment such as oxygen apparatus, suction machine and endo-tracheal tube were placed at patient bedside in case of emergency.

Post-Operative Care at the ward.

Patient was brought to the ward after the surgery in a semi-conscious state and it was realized that patient was at risk for aspiration.

Around 2:00 pm, patient complained of intense pain at the surgical site. Therefore, a nursing diagnosis was formulated as acute pain (incisional pain) related to surgical incision on the abdomen. And an objective was set to reduce patient pain within the next 48hours. Nursing interventions which were carried out to solve her problem were; Patient was reassured that she will be relieved of pain. Patient pain level was assessed. Patient was put in the recovery position as requested by patient. Nearby windows were opened and noise level in the ward was minimized. Patient's vital signs were checked and recorded 2hourly. Patient was encouraged to

converse with inmates to take her mind off the pain. Injection Tramadol 100mg was administered intramuscularly. All nursing care rendered was documented in the nurses note.

Post-Operative Day One (23rd November 2022)

On this day, patient woke up around 5:45am. She requested assistance in her personal hygiene. Her bed linen was changed. The bed was laid nicely making sure it was free from creases and cramps. Patient was assisted to bath and had her oral hygiene in the morning. She was served with porridge. Her finger nails were trimmed.

At 8:00am, it was realized that patient could not perform her self-care activities. So, a nursing diagnosis of self-care deficit (partial) related to muscle weakness and fatigue was made. An objective was set to assist patient maintain her personal hygiene needs within 48 hours. The following nursing interventions were rendered to resolve the problem; Patient was reassured that she will safely performs (to maximum ability) her normal duties as soon as possible. Patient was assisted to clean mouth and teeth with tooth brush and paste twice daily to prevent infections and improve appetite. She was given water to rinse his mouth after each meal. Bed pan was offered to patient whenever needed. Patient was given assisted bed bath with soap, sponge and warm water and dried with a towel twice daily. Patient was assisted to dress and change soiled clothes and linen. Patient was placed in optimal position for feeding preferably sitting up in chair. Patient was assisted with bed mobility, assisted to walk around his bed at least 4 times daily to prevent infection and oedema of the feet.

At 10am, vital signs were checked and recorded as shown below;

Temperature - 37.6^{o}C

Pulse - 120bpm

Respiration - 23cpm

Blood pressure - 128/65mmHg.

Due medications were administered and documented.

At 2pm, her vital signs were checked and recorded as shown in the appendix. Intravenous dextrose saline 500mg served and documented. Patient was made comfortable in bed and was reassured speedy recovery.

At 5:50pm, patient was assisted to take her bath.

At 6:00pm, vital signs checked and recorded as indicated in the appendix. Intravenous dextrose saline 500mg and metronidazole 400mg were administered to the patient.

At 10:00pm, patient's vital signs checked and recorded as shown in the appendix.

POST-OPERATIVE DAY TWO (24th November 2022)

Patient woke up around 5:50am. Patient was assisted to maintained her personal hygiene. Her due medications had been served and her vital signs were checked and recorded at 6am as indicated in the appendix. According to patient she had a good night sleep. Her bed linen was changed. Patient took tea and bread as breakfast before taking her medications.

At 10:00am, patient vital signs checked and recorded as indicated in the appendix. Tablet multivitamin (1 tablet) was served to the patient. Patient was then made comfortable in bed and was reassured of competent nursing care.

At 2:00pm, evaluation was made for the objective set on 22nd November, 2022 to relive patient of incisional pain with 48 hours. Goal fully met as nurse observed that patient was relaxed in bed and had a good facial expression and patient verbalized that the severity of the abdominal pains had reduced to tolerable levels. Patient was served with rice and tomatoes stew as lunch. Afterward, patient vital signs checked and recorded as shown below;

Temperature - 36.4°C

Pulse - 118bpm.

Blood pressure - 116/70 mmHg.

Respiration - 22cpm

At 2:15pm, tablet metronidazole was administered to the patient.

At 6:00am, patient's vital signs checked and recorded as indicated in the appendix. Due medications such as suppository diclofenac was administered to the patient.

At 10:00pm, her vital signs were checked and record as shown in the appendix. Patient took no medication at the said time.

POST-OPERATIVE DAY THREE (25th November 2022)

On this day, according to patient's relative, patient woke up around 5:30am, she took her bath and brushed her teeth. At 6:00am, routine vital signs were checked accordingly and recorded. The vital signs were recorded as follows:

Temperature - 36.2°C

Pulse - 78bpm.

Blood pressure - 118/65 mmHg.

Respiration - 22cpm

At 7:00am before ward rounds, patient had ''Hausa'' porridge with bread as her breakfast.

At 8:00am, the goal set on 23rd November 2022 to help patient be able to meet her personal hygiene needs within 48 hours was evaluated. Goal was fully met as patient verbalized that her personal hygiene needs (bathing, mouth care and grooming) had being met and nurse observed that patient was assisted to perform self-care activities (bathing, mouth care and grooming)

At 10:0am, patient vital signs checked and recorded as shown in the appendix. Tablet metronidazole 400mg administered and documented.

At 1:30pm, patient was served with rice and stew as lunch.

At 2:00pm, Patient vital signs checked and recorded as shown in the appendix. At 5:45pm, patient took banku and okro stew as supper. Patient was assisted to take her bath.

At 6:00pm, Patient's vital signs checked and recorded as shown in the appendix. Tablet multivitamin (1 tablet) and tablet metronidazole 400mg administered and documented.

At 10:00pm, patient's vital signs checked and recorded as indicated in the appendix. Due medications such as tablet suppository diclofenac 100mg served and documented. She slept around 10:30pm.

POST-OPERATIVE DAY FOUR (26th November 2022) – Day of Discharge.

According to report, patient woke up around 5am, looking cheerful and enthusiastic hoping to be discharged home today. She performed all her morning personal hygiene without any assistance.

On this day, at 7:00am, it was realized that patient had deficient knowledge with respect to lifestyle modifications associated with the surgical intervention. Deficient knowledge related to lifestyle modification associated with surgical intervention was the nursing diagnosis formulated. An objective was set to assist her gain adequate knowledge on postoperative lifestyle modification to prevent recurrence and complication within the next 2 hours. The following nursing interventions were implemented: A peaceful environment was created for learning as noise around was minimized. The purpose of education was explained. Questions were asked pertaining to his lifestyle modification associated with surgical intervention. Patient was educated to avoid lifting heavy objects to prevent wound dehiscence. Educate patient to take in

high protein and vitamin diet to enhance wound healing. Patient was encouraged to ask questions and was answered in a simple and tactful manner.

At 9:00am, evaluation was done for the said objective and goal was fully met as patient verbalized lifestyle modifications she was supposed to make and nurse observed patient answering questions asked about her lifestyle modifications correctly.

During ward rounds in the morning at 10:20 am, the doctor finally confirmed that patient was fit for discharge after thorough assessment made. Patient was informed about her discharge and all necessary preparation towards discharge was made which included patient re-education on disease condition, medication, settlement of hospital bills and the need to maintain personal hygiene to promote healthy living. The need for continuous and follow up was also made known to the patient. The patient had a valid National Health Insurance Scheme card; therefore, there was small amount of cost incurred.

Patient was officially discharged to continue treatment at home and come back for review in a week's time (2nd December 2022).

The patient and relatives thanked the health team for their care and I also thanked them for their co-operation with the health team during the period of hospitalization. I helped Patient packed her belongings and the relative came to pick her home around 11:25 am.

4.2 Preparation Of Patient/ Family For Discharge And Rehabilitation

Preparation of patient and family is the health education that is given to help maintain and promote good health and prevent possible complications of the disease condition as well as the occurrence of other or similar diseases.

The preparation started from the day of admission through till discharge. On admission Patient and father were reassured and informed that, admission may be a short period as recovery time is

usually not more than a week on the ward. She was made to understand that once the surgery was performed, the disease condition will not occur again. Patient was also advised not to touch the wound with her bare hand since it can lead to infection of the wound.

The need to attend regular check-up to maintain her health status was also explained to patient and father. They were reminded of the regular review after discharge, she was told of the review dates. She was also made to know that although she has been given review dates, she can report to the polyclinic when not well even before the review date.

Since the hospital bills had being settled by the National Health Insurance and receipts issued, collected patient prescribed drugs to be taken home and explained how the drugs should be taken, patient's belongings were packed and handed over to the relative to cross check, they were reminded of the review date which was 2nd December 2022.

4.2.1 Follow-Up / Home Visits / Continuity of Care

Follow up and home visit are important aspect in nursing care as they help to ascertain the health and environmental condition of the patient during admission and after discharge. Home visit is a purposeful visit to the patient and family in their home with the aim of preventing diseases, promoting and maintaining health through health education and counselling. Continuity of care at home ensures a smooth transmission from hospital care to home care of the patient and to reduce anxiety and facilitate wellness.

First Home Visit (22/11/2022)

My first home visit was on the 22nd November, 2022 after patients' surgery. She granted permission to visit her home before discharge. The aim of this home visit was to familiarize myself with the patient's home and surroundings and to assess the facilities in the house so as to give proper health education to the patient and relatives. My visit to the house was by vehicle as

a means of transportation in the company of the patient's relative. On arrival, I was welcomed warmly by Ms. M.E relatives. The environment was surveyed and it was very neat. Patient's house was a compound house as she said. The toilet which was not too far from the house was very neat. Their refuse is collected into a dust bin and sent to the refuse damp for disposal every morning

Second Home Visit (29/11/2022)

This visit was on 29th November, 2022, three days after the discharge of Ms. M.E. On arrival, I was welcomed warmly by the patient and family. Upon interaction with the patient, health education done previously was re – emphasized.

The need for review was also stressed on and she was reminded of the review date (2/12/22). According to Patient, she had no problems and assured me that he would be in the hospital on the day of review. Upon observation, the compound was clean, refuse bin was tightly covered and utensils and items in the kitchen were all well arranged. Patient was asked to take her morning medications and she did. I took permission to leave after scheduling to visit them again on the 5th November, 2022. The family thanked me for the visit and I was seen off by them.

Patient's Review (02/12/22)

Ms. M.E came to the hospital for review on the 2nd November, 2022, as planned. I met her and her brother who accompanied her to the hospital and she was in her optimum best condition.

She was helped to retrieve her folder and to see the physician. Ms. M.E vital signs were checked and recorded as follows: Temperature: 36.8°C, Pulse: 76bpm, Respiration: 22cpm and Blood pressure: 112/78mmHg.

The physician expressed satisfaction and advised the Patient to take good care of herself. The physician then declared her fully fit, hence no medications were prescribed but was advised to

report signs and symptoms of complications such as sudden colicky abdominal pain around the epigastric or umbilicus which becomes localized within few hours in the right lower abdomen.

Patient was advised to desist from the habit of self-medicating. The need for avoidance of over-the-counter medication was also re-emphasized. Lifestyle modification, maintenance of a healthy weight, exercising regularly, having a modest fat intake, eating sufficient fibre, limiting alcohol intake, avoid smoking and protection from injury was stressed on to help Patient manage help condition and prevent and complications. Patient and relative were accompanied to join a car back home and they were bid goodbye.

Third Follow-Up/Home Visit (05/12/2022)

My third home visit was on the 5th December, 2022 after her review, with a community health nurse, Mr. A. B. A from Chiraa health Centre. Ms. M.E was very happy to see me again. We were welcomed; I introduced the community health nurse to the family and told them that he will be visiting them from time to time.

Patient and family were advised on the importance of visiting a hospital whenever sick, avoidance of over-the-counter drugs and taking balanced diet to boost their immune system.

More emphasis was made on discharge teachings that was given to her on the day of discharge.

An opportunity was seized to thank the family for their co-operation. They also expressed their profound gratitude for my assistance during the admission of Ms. M.E till her discharge. I then handed over the continuity of care to the community health care nurse, and bid her good bye and this brought a successful end to a very wonderful interaction with Ms. M.E and her family.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

The evaluation of care is the last phase of the nursing process whereby the effectiveness of the nursing interactions is ascertained. It involves comparing current health status of the patient to predetermined goals. This chapter therefore consists of statement of evaluation, termination of care and summary, conclusion and recommendation.

5.1 Statements of Evaluation

Based on the assessments, analysis and identification of the patient's health problems, goals were set to be achieved at predetermined time frame. To each goal set was outcome criteria to determine goal achievement. Below are statements of evaluation of goals set on the care of the patient.

1. Patient was relieved of abdominal pain within 24 hours

On 21st November, 2022, at 10:40 am, patient complained of severe abdominal pains. A nursing diagnosis of acute pain (abdominal) related to inflammation of the vermiform appendix.

An objective was set to relieve the patient abdominal pain within 24 hours. The following nursing interventions were implemented to relieve the patient of abdominal pain; patient and relatives were reassured of competent nursing care to allay fear and anxiety. Patient's pain level was assessed to be 7 using the numerical pain rating scale from 0 -10. Patient was allowed to watch her favourite TV program in the ward to divert her attention from the pain. The patient was assisted to assume a position of comfort to relieve her of her abdominal pain. Prescribed pain medication was administered was administered as IM Diclofenac 75 mg stat to help relieve the patient abdominal pain.

On 22nd November, 2022 at 10:40am, evaluation was made for the goal set yesterday to relive patient of abdominal pain within 24 hours. Goal fully met as patient verbalized that she was no longer experiencing the abdominal pain and nurse observed patient had cheerful facial expression with no complaints of pain.

2. Patient's body temperature was restored to normal range (36.2 – 37.2^{0}C) within 6 hours.

On 21st November, 2022 at 10:45 am, patient had increased body temperature (38.7^{o}C)). An objective was set to restore the patient body temperature to normal range (36.2 – 37.2^{0}C) within 6 hours. The following nursing interventions were executed to restore the patient body temperature to normal range (36.2 – 37.2^{0}C); Patient's vital signs were checked especially temperature as a baseline. Patient was tepid sponged to help reduce to normal range (36.2 – 37.2^{0}C) the temperature. Patient was served with cold (Coca Cola) 250mls to help reduce patients' temperature. Prescribed paracetamol was administered to reduce the temperature.

On the same day, at 4:45pm, evaluation was made for the objective set in the morning to help reduce patient's body temperature to normal. Goal fully met as patient verbalized that she did not feel warm to touch and nurse observed patient's temperature restored to normal range (36.2 – 37.2^{0}C)

3. Patient was relieved of anxiety within 2 hours

On 22nd November, 2022, through interaction with the Patient and family in the morning around 6am, it was observed that Patient was anxious as a result of unknown outcome of the surgery. A nursing diagnosis of Anxiety (fear) related to impending surgery and its unknown outcome was made. An objective was set to relieve patient of anxiety within the next 2 hours. The following interventions were implemented; Patient and relative were reassured that the surgery has always been successful with positive outcomes. Patient was oriented to the staff, theatre, its equipment's, anaesthetic's gadgets and the recovery room. Patient who has gone through successful laparotomy was introduced to her.

Patient was educated on the need for surgery, drug regimen and post-operative management. Patient was taught on deep breathing exercise, drug regimen and guarding the incision site during coughing.

On the same day (On 22nd November, 2022), before patient would be transported to the theatre, at 8:00am, an evaluation was done for the objective set to relieve her of anxiety. Goal was Goals fully met as; Patient verbalized the absence of fear and nurse observed patient's vital signs and recorded as T- 36.7°C, P84bpm, R- 22cbpm and BP- 110/80mmHg and observed patient's readiness for surgery.

4. Patient was relieved of incisional pains within 48 hours.

On 22nd November, 2022, around 2:00 pm, patient complained of intense pain at the surgical site. Therefore, a nursing diagnosis was formulated as acute pain (incisional pain) related to surgical incision on the abdomen. And an objective was set to reduce patient pain within the next 48hours. Nursing interventions which were carried out to solve her problem were; Patient was reassured that she will be relieved of pain. Patient pain level was assessed. Patient was put in the recovery position as requested by patient. Nearby windows were opened and noise level in the ward was minimized. Patient's vital signs were checked and recorded 2hourly. Patient was encouraged to converse with inmates to take her mind off the pain. Injection Tramadol 100mg was administered intramuscularly.

On 24th November, 2022 at 2:00pm, evaluation was made for the objective set on 22nd November, 2022 to relive patient of incisional pain with 48 hours. Goal fully met as nurse observed that patient was relaxed in bed and had a good facial expression and patient verbalized that the severity of the abdominal pains had reduced to tolerable levels.

5. Patient was able to meet her personal hygiene needs within 48 hours.

On 23rd November, 2022 at 8:00am, it was realized that patient could not perform her self-care activities. So a nursing diagnosis of self-care deficit (partial) related to muscle weakness and fatigue was made. An objective was set to assist patient maintain her personal hygiene needs within 48 hours. The following nursing interventions were rendered to resolve the problem; Patient was reassured that she will safely performs (to maximum ability) her normal duties as soon as possible. Patient was assisted to clean mouth and teeth with tooth brush and paste twice daily to prevent infections and improve appetite. She was given water to rinse his mouth after each meal. Bed pan was offered to patient whenever needed. Patient was given assisted bed bath with soap, sponge and warm water and dried with a towel twice daily. Patient was assisted to

dress and change soiled clothes and linen. Patient was placed in optimal position for feeding preferably sitting up in chair. Patient was assisted with bed mobility, assisted to walk around his bed at least 4 times daily to prevent infection and oedema of the feet.

On 25th November, 2022 at 8:00am, the gaol set on 23rd November 2022 to help patient be able to meet her personal hygiene needs within 48 hours was evaluated. Goal was fully met as patient verbalized that her personal hygiene needs (bathing, mouth care and grooming) had being met and nurse observed that patient was assisted to perform self-care activities (bathing, mouth care and grooming)

6. **Patient gained adequate knowledge on postoperative lifestyle modification to prevent recurrence and complication within the next 2 hours.**

On 26th November, 2022 at at 7:00am, it was realized that patient had deficient knowledge with respect to lifestyle modifications associated with the surgical intervention. Deficient knowledge related to lifestyle modification associated with surgical intervention was the nursing diagnosis formulated. An objective was set to assist her gain adequate knowledge on postoperative lifestyle modification to prevent recurrence and complication within the next 2 hours. The following nursing interventions were implemented: A peaceful environment was created for learning as noise around was minimized. The purpose of education was explained. Questions were asked pertaining to his lifestyle modification associated with surgical intervention. Patient was educated to avoid lifting heavy objects to prevent wound dehiscence. Educate patient to take in high protein and vitamin diet to enhance wound healing. Patient was encouraged to ask questions and was answered in a simple and tactful manner.

At 9:00am, evaluation was done for the said objective and goal was fully met as patient verbalized lifestyle modifications she was supposed to make and nurse observed patient answering questions asked about her lifestyle modifications correctly.

5.2 Amendment of Nursing Care Plan for Partially Met or Unmet Outcome Criteria

The nursing care plan is a systematic and continuous process requiring data collection and evaluation so that when the need arises, amendment can be made. Fortunately, all goals set for solving the identified health problems were fully met. This success could be largely attributed to the quality and timely interventions given to the patient. There was therefore no need for amendment of care.

5.3 Termination of Care

Planning towards termination of the nurse/patient relationship begun on the day of admission to ensure that patient appreciate the reality of the separation without experiencing emotional disturbance. With regards to separation, as the patient's condition improved, hours of contact with her was gradually reduced.

At the same time, she was encouraged to meet all her self-care needs independent of the nurses. It was made clear to the patient that once all goals of care were met; there will be the need to terminate the nurse/patient relationship but, promised to visit them. The care was finally terminated on the 5th December, 2022 during the third home visit and patient and family were handed over to a community health nurse who was to continue the care. It was at this moment that my nursing care for Ms. M.E was terminated.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This is the last step of patient/family care study which entails the students' personal appreciation of the therapeutic relationship with the patient as well as the use of nursing process.

6.1 Summary of Care Rendered to Patient and Family

Ms. M. E is the name of the subject of study. She was born on 28th March 2003 and she's about nineteen years old (19yrs). She is dark in complexion, about 160 centimeters tall and has a round looking face. Ms. M. E comes from Chiraa about 19.4 kilometers from Sunyani in the Sunyani West District in Bono Region of Ghana. On 21st November, 2022, at 10:30am, M.E was admitted into the Female Ward of Sunyani Municipal Hospital with diagnosis of Acute Appendicitis. She was accompanied by a nurse from the Out Patient Department (OPD) and a relative into the ward.

Following the analysis of data gathered and assessment of Ms. M.E and family, health problem identified included:

Pre- Operative Health problems

1. Patient complained of abdominal pain. (21st November, 2022)
2. Patient experienced fever (37.8°C). (21st November, 2022)
3. Patient was anxious about the impending surgery. (22nd November, 2022)

Post – Operative Health Problems

4. Patient had pain at the incisional site. (22nd November, 2022)
5. Patient could not maintain his personal hygienic needs. (23rd November, 2022)
6. Deficient knowledge on lifestyle modifications. (26rd November, 2022)

A comprehensive nursing care plan was drawn and implemented. This led to the patient's speedy recovery. At the end of hospitalization, terminal evaluation revealed that all goals set were fully met. Ms. M.E was discharged on 26th November, 2022 in a satisfactory health condition. There were two follow-up visits made to the patient's home at Chiraa which indicated improvement in patient's health.

For that matter the doctor declared her fully fit when she came back for review a week after her discharge. Having achieved all patient's goals, the care was terminated on the day I handed over the patient to the community health nurse for continuity of care.

6.2 Conclusion and Recommendation

In spite of the numerous challenges encountered during the patient/family care study, it has however made me to acquire practical knowledge on appendicitis. It has enabled me gain knowledge about the causes, clinical manifestations, treatment, complications and management of appendicitis. It has also given me the opportunity to put into practice the knowledge and skills

I have acquired in the classroom to undertake activities such as analysis, planning, implementation and evaluation.

The effectiveness of the care plan depends on the availability of staff and logistics to enable all staffs to care for every patient holistically and individually. Finally, it is my sincere hope and wish that all categories of nurses and student nurses would find it necessary to use the nursing process approach in the care of patient and management of all ailments.

APPENDIX 1

Table 6. OBSERVATIONAL CHART FOR Ms.M.E

DATE AND TIME	**TEMPERATURE (°C)**	**PULSE (BPM)**	**RESPIRATION (CPM)**	**BLOOD PRESSURE (mmHg)**

21/1122				
10:30am	37.8	124	24	130/68
2:00pm	37.8	124	24	130/60
6:00pm	37.5	84	22	130/70
22/11/22				
6:00am	37.7	80	20	130/70
2:00pm	37.3	80	22	130/80
6:00pm	37.2	82	20	130/70
23/11/22				
10:00am	37.6	120	23	128/65
2:00pm	37.2	76	19	129/82
6:00pm	37.0	74	20	116/70

24/11/22 10:00am 2:00pm 6:00pm	 36.4 37.1 37.1	 118 78 74	 22 22 22	 118/70 126/74 120/76
25/11/22 6:00am	 36.2	 78	 22	 118/65

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UnpubliHed article: Patient folder number: 23440/19

SIGNATURIES

THE STUDENT NURSE

NAME:

SIGNATURE:…….

DATE:…….

THE NURSE-IN-CHARGE OF THE FEMALE SURGICAL WARD (SUNYANI MUNICIPAL HOSPITAL)

NAME: MRS. NYAMIKE MIEZAH

SIGNATURE:…….

DATE:……..

THE SUPERVISOR, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

NAME: MRS. RITA GYAMFI

SIGNATURE:…….

DATE:……..

THE PRINCIPAL, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.

NAME: NKRUMAH MONICA

SIGNATURE:…….

DATE:……..

SIGNATURIES

THE STUDENT NURSE

NAME: SDOMASH VICTOR

SIGNATURE:.....

DATE: 12TH JULY 2023

THE NURSE-IN-CHARGE OF THE FEMALE SURGICAL WARD (SUNYANI MUNICIPAL HOSPITAL)

NAME: MRS. NYAMIKE MIEZAH

SIGNATURE:..... (f)

DATE: 13/07/2023

THE SUPERVISOR, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

NAME: RITA GYAMFI

SIGNATURE:..... (for)

DATE: 12-07-2023

THE PRINCIPAL, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.

NAME: MONICA NKRUMAH

SIGNATURE:.....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM

DATE: 17TH JULY, 2023