HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A PATIENT/FAMILY CARE STUDY ON PERITONITIS

GODFRED EFFAH

4120190075

A PATIENT/FAMILY CENTERED CARE STUDY SUBMITTED TO NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT FOR THE AWARD OF LICENCE TO PRACTICE AS A PROFESSIONAL REGISTERED GENERAL NURSE

AUGUST-2022

PREFACE

The unique function of the nurse as defined by Virginia Henderson is to assist the individual whether sick or well in the performance of those activities contributing to health or recovery or to a peaceful death that he would have performed unaided if he had the necessary strength, will and knowledge, and to do so in such a way as to help him gain independence as rapidly as possible.

The patient/family care study is a requirement for the award of the Registered General Nursing Certificate by the Nursing and Midwifery Council for Ghana to students pursuing Diploma in nursing.

The patient/family care study also offers the student nurse the opportunity to put into practice the knowledge acquired at school in giving effective nursing care to patient with reference to the Patient's condition.

In addition to the above, the patient/family care study enables the student to acquire more knowledge about the causes, signs and symptoms, diagnosis and treatment given to patients with specific condition using the nursing process.

ACKNOWLEDGEMENT

I am indebted to all those, whose efforts and contribution have made this study successful. My greatest gratitude goes to the Almighty God for the knowledge, strength and understanding offered me during this study.

Special thanks go to my patient and his family members for their co-operation and provision of information for this study.

My sincere gratitude also goes to my Supervisors, Ms. Rita Adjei Boakye and Mr. Ibrahim Alhassan and all tutors of Holy Family Nursing and Midwifery Training College, Berekum, for their guidance and supervision during the study.

I wish to extend a word of appreciation to the nursing staff and medical doctors at the surgical ward of the Holy Family Hospital, Berekum for their immense contribution and good medical and surgical care given to the patient during her admission.

I would like to express my appreciation to my parents especially my dearest father, Mr. James Ameyaw and my dear friend, Mr. Christian Yeboah who contributed in diverse ways to make the writing of this patient/family care study possible.

Lastly, I am very grateful to all publishers and authors whose books I used as references; I say God bless you.

INTRODUCTION

The patient/family care study is a report of the nursing care rendered to a patient and the family. It includes the interaction between the patient and the health team. Mr. S.A, a Twenty-two-year-old man was the subject in this study. He was admitted on 9th November, 2021 at the surgical ward of the Holy Family Hospital, Berekum with the diagnosis of peritonitis.

My interaction with patient and his family started on the 9th November 2021 when patient was brought to the hospital until eventually, care was terminated on 26th November,2021. Patient was operated upon on the 10th November, 2021 and was managed on the following drugs; intravenous ciprofloxacin 400mg bd x 48 hours, intravenous metronidazole 500mg tds x 48 hours, intravenous ringer's lactate 500mls over 1 hour, suppository paracetamol 1g tds x 48 hours, intravenous normal saline 1.5 litres x 24hours, intravenous ringer's lactate 1.5 litres x 24 hours, intravenous dextrose 500mls over 1hour and syrup astymin 10mls daily x 7 days.

During his stay at the hospital three visits to the patient's home were made. First on the 11th November, 2021 when the patient was still on the ward, the second visit was on the 17th November, 2021 and lastly on the 26th November, 2021 after the patient was discharged.

This care study is in five chapters in accordance with the steps used in nursing process.

Chapter one entails the information on the assessment of patient and his family which includes Patient's particulars, medical and socio-economic history, developmental history, his hobbies and lifestyle and the literature review on the disease condition.

Chapter two identifies patient's strengths and problems as well as the comparison of data collected with standards.

Chapter three illustrates the nursing care plan carried out for the patient.

Chapter four summarizes the details of the care given to the patient. It interprets the illustration of the nursing care plan. It gives account of how patient and family were prepared towards patient's discharge and how the continuity of care was carried out.

Chapter five evaluates the care rendered to the patient and the family.

The final chapter, chapter six presents summary and conclusion of the nursing care rendered to the patient.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the first step in the nursing process. It deals with the collection of data from client and clients relatives on the client's particulars, family medical and socio-economic history, the clients lifestyles and hobbies, past and present medical history, the admission of the patient, concept of his illness, the literature review of the condition and validation of data collected.

1.1 Patient's Particulars

Mr. S. A. is a twenty-two-year-old man. He was born on the 18th November, 1999 and a Ghanaian who hails from Gyaaman-South in the Bono region of Ghana. He stays with the mother and siblings at Berekum, with a plot number 12 Mpatapo in the Berekum municipality in the Bono Region of Ghana. Mr. A. A is the patient's father.

His parents are farmers who normally plant foodstuffs and sell them in the nearby villages. He speaks Asante Twi and English language. He has recently completed Presbyterian senior high school in Berekum in the Bono Region. He is a Christian and worships at Presbyterian Church with his parents and siblings. He is the 3rd born of the five children of his parents.

He weighs 64kg, dark in complexion and height of 2.3 meters. His next of kin is Madam A. E. who is the mother.

1.2 Patient's/Family's Medical history

A patient and a family medical history is a record of health information about a person and his or her relative. A complete record includes information from three generation of relatives, including children, brothers and sisters, parents, nephews and nieces, etc. Together with these factors can give clues to medical conditions that may run in a family (Weller, 2016).

According to him there is no known allergy, chronic disease like hypertension, diabetes, cancer in the family. According to them, they have not experienced any form of communicable disease like tuberculosis, cholera in the family. He stated that his grandfather died out of a road traffic accident. According to him, his parents and his four siblings are all alive and healthy. He said that they sometimes suffer from abdominal pains, headache and fever and they mostly treat it by the use of over-the counter drugs and herbal medicines. Patient also stated that this is his third time he has been hospitalized and it was as a result of abdominal pains and headache. The source of medical treatment for patient are orthodox and herbal medicines.

1.3 The Patient/Family's Socio-Economic History

Mr. S. A.'s family has a very good relationship and cohesion. Client's nuclear family is made up of seven people which include his father, mother and four siblings that are made up of two boys, two girls and himself. Client is the 3rd born of both his parents. His elder brother is twenty-seven years and has completed senior high school but did not further the education because of poor results. The second born is a female who has completed senior high school but has not yet continued the education. The fourth born is also a female who is in junior high school form two. And the last born is also in primary school at Berekum. The family needs are therefore catered for by both parents. Socially the family is not noted for smoking or drinking alcohol. He revealed that family members are not public service persons thus depend solely on their income earned from trading and farming. Family members are always willing to support each other in times of financial hardships. His family members are well known for their enormous participation in religious activities, their kindness and generosity. Patient said they have no taboos in their family; rather they conform to the rules and believes of the Christian religion. He also indicated that the National Health Insurance Scheme cover most of his bills whenever he seeks for treatment at the hospital.

1.4 Patient's Developmental History

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014). Maturation is the process of becoming completely developed mentally or emotionally (Walter, 2013). Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2014).

The developmental history was given by patient himself as told by his mother. Mr. S.A indicated that, his mother went through normal pregnancy of nine months' gestation without any pregnancy associated disorders. Client was born on 18th November, 1999 at Gyaaman-South. He was born without any congenital abnormality such as cleft lip or palate, hydrocephalous and undescended testis (cryptorchidism) and was immunized against the vaccine preventable diseases (VPD) as evidenced by Bacilli Calmet Guerin (BCG) scar on his right shoulder. Mr. S.A was breastfed for a period of six months before he was introduced to supplementary foods like porridge. He went through a normal developmental milestone. This includes sitting up at the 7th month, crawling at the 10th month, walking, talking and running between the ages of one and three years old. Mr. S.A at age fifteen (15), began to experience secondary sexual characteristics such as deepening of voice, broadening of chest and facial hair appearance. He started his basic and junior high education at Boahen Korkor Presbyterian School at Sunyani and went on to Presbyterian Senior High School in Berekum. He was a science student and was in SC2 class. According to the client, he never experienced any difficulties in learning and was always motivated to study by virtue of his aspirations of becoming an electrical engineer.

According to Erik Erikson's psychosocial development theory patient is now in his early adulthood (20-35) where there is conflict between intimacies versus isolation. Erik Erikson stated that once self-identity is established after adolescence, it can be merged with another's in an intimate relationship. The adult seeks love, commitment and intimacy of an intense lasting

relationship. Erikson believed that without a secure personal identity, a person cannot form a love relationship. The result is a person who is isolated. It is convincing that patient is in the intimacy dimension of Erik Erikson's psychosocial development because he stays with the parents and visits his grandparents in his home town and has built a strong relationship to establish his own family.

1.5 Patient's Lifestyles and Hobbies

Lifestyle is the pattern of daily living that an individual develops (Weller, 2016). Hobbies are activities one does for pleasure when he/she is not working. (Hornby, 2017). Client is friendly and make friends easily. He is not quick tempered but he does not like cheating and very humble. Client enjoys watching movies. During his leisure time, he reads and does some calculations and sometimes goes for swimming. His favorite food is rice and light soup and he also likes fruits.

He usually goes to bed at 10:00pm and wakes up by 5:00 am daily especially during school going days. He brushes his teeth once daily with toothbrush and toothpaste and moves his bowel once daily. He takes his bath twice daily with warm water. For breakfast, he normally takes "Hausa koko" or white porridge with bread. As a day student, he leaves for school by 6:15am and closes at 4pm.

1.6 Past Medical History

Past medical history is the total sum of a patient's health status prior to a presenting illness. It is also a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health.

Mr. S.A never experienced any childhood illness like whooping cough, poliomyelitis, measles, tetanus, tuberculosis, and diphtheria and has not identified any allergy to food, drugs, animals or insects. He revealed that he usually suffers from minor ailments such as diarrhea, constipation, headaches and common cold which he usually treats with traditional medicines and sometimes

with over-the-counter medications. When symptoms persist or becomes worse, he visits a nearby hospital or clinic. Mr. S.A. said he had never been involved in an accident. He has no physical disability due to illness. Mr. S.A. also indicated that he never goes for health check-ups unless his ailment becomes difficult to treat with traditional medicine and over the counter medications.

1.7 Present Medical History

Present medical history is the details about the chief complaint. It is also the exact condition that brought the patient to the health facility. (Med-ed. virginia.education, 2016). According to client, he was fine until 6th November 2021, when he began complaining of pain at umbilical region. He took in some analgesics for some days but the clinical manifestations were still persistent.

On 9th November 2021, according to patient he vomited several times in the night and when he woke up in the morning he was very weak.

He then decided to ask his parents to take him to the hospital. They reported to the Emergency unit of Holy Family hospital, Berekum on 9th November, 2021 at 6:10am where vital signs checked and recorded as temperature – 38.9^{O}C, pulse – 100beats per minute, respiration – 24 cycles per minute, blood pressure- 120 /70mmHg. He was quickly tepid sponged with tepid water to bring the temperature to the normal range. According to patient he still vomited twice while at the emergency unit.

On examination by the doctor he was very conscious and alert, there was rebound tenderness at the Mcburney's point, abdominal distension, bowel sound reduced in frequency and pitch. His chest was clinically clear but had fever.

Diagnostic investigations ordered included full blood count, blood urea nitrogen (BUN), creatinine, sickling test, blood electrolytes, liver function test, plain abdominal X-ray after which client was diagnosed of peritonitis. The doctor ordered for Nasogastric tube to be placed and nothing should be given by mouth.

Medications given to him included intravenous ciprofloxacin 400mg, bd x 48 hours, intravenous metronidazole 500mg tds x 48 hours, intravenous Ringer's lactate 500mls over 1 hour, paracetamol suppository 1G bd x 48 hours. The doctor ordered for the patient to be sent to the surgical ward for admission and preparation for surgery.

1.8 Admission of Patient

Admission of a patient is when an illness or injury requires an immediate health care (Hornby, 2017). Admission can de scheduled (planned) or unscheduled (emergency).

Client was admitted to surgical ward of Holy Family Hospital, Berekum on 9th November, 2021 at 11:50 am per wheel chair accompanied by a staff nurse and his parents, through the Emergency Unit with diagnosis of peritonitis. The patient's and his family were welcomed to the ward after I introduced myself and the nursing staff to them. They were given seats and his particulars such as the name, age, sex, religion, address and next of kin were collected and were entered into the computer. The patient was given bed due to the pain and weakness and vital signs checked and recorded as follows;

Temperature - 38.2^0C

Pulse - 115beats per minute

Respiration - 30cycles per minute

Blood pressure – 130/90mmHg

On examination by the surgical team at the surgical ward he was weak and looked dehydrated, there was rebound tenderness, abdominal distension, abdominal tenderness, bowel sound reduced in frequency and pitch, conscious and alert. His chest was clinically clear. Client was tepid sponged with tepid water to bring his body temperature to normal. Client's temperature was checked and recorded to know whether the temperature is reducing to normal, Client was

administered with Paracetamol suppository 1g to help reduce body temperature. Client complained of feeling noxious and with the feeling of wanting to vomit.

Client's particulars such as name, age, sex, address, hometown, next of kin and religion were all entered in the Admission and Discharge book as well as the daily ward state. The relatives were then oriented in and around the ward. I introduced myself as well as other colleagues at the nurses' station and assured them of our competency in helping him to get well.

He was also informed of the hospital's policies. That is the cash and carry system for none insured clients and the National Health Insurance Scheme benefit for those with insurance.

Patient and relatives were made aware of the hospital's protocol and routines such as time of visiting, feeding, time of giving medications, type of cloth he is supposed to wear, the daily routine nursing care and ward rounds. He was also told to provide items which will be needed for client's hospitalization such as sponge, soap, towel, pomade and powder to help maintain client's hygiene.

Patient was also advised to keep valuable items such as mobile phone and money safely. The following medications were prescribed;

1. Intravenous ciprofloxacin 400mg bd x 48 hours
2. Intravenous Metronidazole 500mg tds x 48 hours
3. Intravenous Ringer's lactate 500mls over 1 hour.
4. Suppository Paracetamol 1g tds x 48 hours.
5. Intravenous normal saline1.5 litres x 24hours
6. Intravenous ringer's lactate 1.5 litres x 24hours
7. Intravenous dextrose 500mls over 1hour
8. Syrup Astymin 10mls daily x 7 days

The patient and relatives were reassured that, they will have the best of care from health professionals to relieve them from anxiety and fear. The patient was later examined by the medical officer and a nasogastric tube was passed to drained fluid from his stomach. He was advised together with his parents not to take or give anything by mouth because of nasogastric tube in situ and the impending surgery. The patient and family were made aware of surgical intervention and assurance given to them. He was booked for surgical operation (laparotomy) on the following day which was on the 10th November, 2021. The family were psychologically prepared.

His parents were reassured of the competent of staff that will ensure speedy recovery of their son to allay their fears and anxiety.

I reintroduced myself to patient as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my care study. Mr. S. A. was informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of Diploma in Registered General Nursing. I explained to the patient the concept of the patient/family care study and assured them of privacy and confidentiality.

It was added that a report will be written after the entire process. Mr. S. A. agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the relatives; thus, they will continue the care at home once he is well.

1.9 Patient's Concept of Illness

Mr. S.A. did not accredit his illness to any spiritual cause in spite of his spiritual believes as a Christian. He was of the view that some conditions like epilepsy and other mental disorders can have spiritual implications. He did not know the exact cause of his condition. Patient believes that the treatment planned for him, in the hospital, will help cure his illness and prevent any complications.

Literature Review on Peritonitis

Peritonitis is inflammation of the peritoneum which is a serous membrane lining the abdominal cavity and covering the viscera (Hornby, 2017). The peritoneal cavity, is the space between the parietal and visceral layers and contains a film of sterile fluid which envelopes most of the abdominal organs (Weller, 2016).

Causes/Aetiology

According to Kathleen (2017), the causes of peritonitis are:

1. Blunt abdominal injury, penetrating the peritoneal cavity causing the leakage of content into the peritoneum to cause inflammation.
2. Inflammation of an organ leading to localized or generalized peritonitis for example ruptured appendicitis, ruptured diverticulitis.
3. Closed abdominal injury causing ruptures of an organ for example spleen, liver.
4. Escape of gastrointestinal content or content of another organ leading to generalized peritonitis eg perforated peptic ulcer, ruptured gall-bladder. That is if a portion of these organs becomes diseased and their walls infected, these infections may spread to the serous covering coat which becomes inflamed.

5. Bacterial invasion for example *E.coli*, *Staphylocuccus aureus*, *Streptocuccus* causing inflammation of the peritoneum.

6. Chemical reaction caused by bile, pancreatic juice, gastric or intestinal secretions.

7. Procedures such as paracentesis abdominis.

Pathophysiology

Peritonitis is caused by leakage of content from the abdominal organs into the abdominal cavity usually as a result of inflammation, infection and ischemia. Bacteria proliferation occurs and then oedema of the tissues results. Exudation of fluid develops in a short time. Fluid in the peritoneal cavity becomes turbid with increasing amount of proteins, white blood cells, debris and blood (Med-ed. virginia.education, 2016). The immediate response of the intestinal tract is hypermotility soon followed by paralytic ileus with an accumulation of air and fluid in the bowel.

Clinical Features

According to Adznam (2019), the clinical features of peritonitis include:

- The patient may be febrile as the symptoms become more severe and the general condition of the client deteriorates from lack of sleep, toxaemia and fluid and electrolyte disturbances.
- Diffuse type of abdominal discomfort because the portion behind the muscles of the anterior abdominal wall and in front of those on the posterior abdominal wall is richly endowed with nerve endings. Irritation of this portion gives rise to pain at the site at which it is stimulated.
- Nausea and vomiting as a result of disturbance of the chemoreceptor trigger zone.
- Abdominal tenderness and rebound pain when abdomen is touched because of accumulation of fluid in the peritoneum.
- The patient may experience shock due to excessive fluid loss which is mainly plasma, water and electrolyte.eg there may be signs and symptoms of shock such as restlessness, cold clammy skin, hypotension etc.

- Increased pulse rate, the pulse is usually rapid, irregular and of poor value and shallow respiration as a result of the reduction in the blood volume.
- Abdominal muscular rigidity. The pain and the rigidity will give way to painless distension of the abdomen.
- Fever and chills due to the infection.
- Abdominal resonance and tympani on percussion due to the accumulation of fluid in the peritoneal cavity.
- Anorexia due to general malaise and vomiting.
- Altered bowel movement due to decreased peristalsis or absence of bowel sound. The client may have constipation or diarrhoea.

Diagnostic Investigations

According to Regnault (2018), the diagnostic investigations of peritonitis include:

- ✓ Radiography of the chest and abdomen for the presence of free gas in the peritoneal cavity, dilated loose of bowel, urinary calculi and perforated ulcer.
- ✓ Laboratory investigation of urine for the presence of red blood cells and pus
- ✓ Electrocardiography to exclude coronary infarction as a cause of abdominal pain.
- ✓ Peritoneal aspiration may reveal the presence of bile, pus or blood
- ✓ Plain x-ray of the abdomen to show the perforated organ.
- ✓ Computerized tomography scans of the abdomen to visualize the peritoneum.
- ✓ Haemoglobin level estimation to rule out anaemia

- ✓ White blood cells count will be elevated to confirm the presence of infection.
- ✓ Grouping and cross matching to know client's blood group and rhesus in case of emergency.
- ✓ Serum amylase will rise in acute pancreatitis.
- ✓ Culture and sensitivity test to isolate the organism and the correct antibiotic they are sensitive to
- ✓ Full blood count for leukocytosis and haemo concentration.
- ✓ Serum electrolyte which are particularly to be disturbed in vomiting.
- ✓ History from client and signs and symptoms to aid in diagnosis.

Specific Medical Management

According to Adznam (2019), specific medical management of peritonitis include:

1. Nil per-os to rest the bowel.
2. Rehydration by the use of intravenous fluid such as ringers lactate, normal saline, dextrose saline to correct fluid and electrolyte imbalances and treat shock
3. Medication such as;

a. Antibiotics example, intravenous ciprofloxacin to counteract the infection

b. Antibacterial example, metronidazole, gentamycin to reduce infection.

c. Analgesics such as diclofenac and paracetamol to control pain and reduce body temperature.

d. Haematinics are also given to correct anaemia such as multivitamin and vitamin B complex to boost client's appetite and in severe cases blood transfusion may be given to counteract shock and replace protein loss in the inflammatory exudates.

4. Gastric decompression by nasogastric tube suctioning to rest the gastrointestinal tract. Food and purgatives are forbidden and aspiration of the stomach content is undertaken.

Surgical Intervention

A surgical intervention (laparotomy) is performed when complication such as intestinal perforation or haemorrhage into the bowel sets in. The perforated bowel is sutured (simple closure of the perforation with a nylon and vicryl sutures) and intraperitonial lavage is done with saline water and all pus and faecal material and fibrin suctioned. The operation is done under general anaesthesia (Guigernsh, 2017).

Nursing Management

The goals of nursing management are to minimize complication and to give supportive care.

PREOPERATIVE MANAGEMENT

Psychological Preparation or Care;

Client and family are reassured to gain their cooperation and to allay their fears and anxiety. This also makes them comfortable and relaxed. This also in turns makes the patient comfortable and relaxed. The surgical procedure should be explained to client and the purpose of the surgery. The client and parents should be encouraged to ask any questions bordering them and express their fears. The client should make known that, following surgery he will be able to live a normal life without restrictions.

Introduce other clients with successful surgery done to the client and explain surgical procedures to them.

Client's Education

Client should be given a thorough education on the need for post-operative exercises eg deep breathing and coughing exercises. Client was taught to perform these exercises as it enhanced early recovery improves muscle tone and improve the physical well-being of the client. Answers should be provided in simple language without the use of technical terms.

Fluid and Electrolyte Needs

An intravenous line should be instituted to correct any fluid and electrolyte imbalances if present. Intake and output chart should be monitored to prevent any complication.

Cleaning and emptying of the; gastrointestinal tract

Nasogastric suction is required to empty the stomach and to rest the bowel. It should be inserted before the operation to decompress the abdomen and left in place for intra operative and post-operative use.

Nutrition

The client's oral food intake is limited during the first 24 hours before surgery. Discuss how surgery will affect client's diet; explain to him that, after the operation he will be on nil per os for some days before resuming oral feeding. And when oral feeding occurs, he may start from fluid diet to light diet and progressively normal diet as his condition improves.

Medications

Antibiotics may be prescribed as a microbial cover and should be administered accordingly. The effects and side effects of medications should be observed and report any findings for immediate solution.

Personal Hygiene

Client should be assisted and encouraged to take care of the body (bathing, toe and finger nails, the hair and his clothing as well as oral toileting) should be maintained so as to prevent infections and improve a sense of well-being. The bed linen should be clean and attend to client's elimination needs, offer bed pans or urinals each time the client asked for or assist the client to the sluice room for him to void. The day before the operation, let the client use antimicrobial soap to bath so as to remove some microbes from the body.

The supra-pubic area and the abdominal wall is prepared according to the hospitals policy. However, in cases of a very ill client in severe pain, skin preparation is left until the client has been anaesthetized.

Post-Operative Management

Position

Immediately client recovers from anaesthesia, he is place in the semi fowler's position to ease breathing and to prevent aspiration of secretions and vomitus or the client is placed in a position prescribed in the post-operative notes. Patient's safety must be maintained by the use of side rails, the bed in a lowered position and other soft restrains if necessary. Client is assigned to a bed closer to the nurses' station for close monitoring and observation.

Observations/Monitoring

Vital signs which include temperature, pulse, respiration and blood pressure are carefully monitored every 30 minutes for the first hour, and hourly for the next 2 hours and then 2 hourly until the client's condition stabilized. Signs of respiratory distress which may signal haemorrhage, obstruction and/or shock are also monitored. The incision site is also monitored for bleeding. Client should be weigh daily to find out if condition is improving and also measure abdominal girth. Intake and output should be monitored to know the amount taken in and excreted to know if there is imbalance and fluid overload. Signs of pain should also be observed by looking at the facial expression of the client and also effects and side effects of drugs to prevent any drug toxicity.

Nutrition

Intravenous fluids should be administered as prescribed after which sips of water followed by fluid diet. As condition improves, the diet should be planned with the client, and the dietician to take likes and dislikes, culture and taboos into consideration. Light to normal diet should be served attractively to improve nutritional status. All diet should be well balanced and rich in all nutrients as well as roughages to prevent the incidence of constipation, promote general growth, provide energy and enhance speedy recovery. Assess for adequate hydration such as moist mucous membrane and good skin turgor.

Relief of Pain

The client should be assisted to assume a comfortable position to help reduce pain. Warm compresses should be used on the abdomen to reduce pain. Divertional therapy should be used to divert his mind off the pain example watching of television. Prescribed analgesics such as diclofenac, paracetamol should be administered as ordered to reduce the pain.

Wound Care

The wound should be observed for signs of bleeding. Look out for overt bleeding and signs and symptoms of internal bleeding. Reinforce dressing if there is overt bleeding and report to the surgeon. The wound should be observed for wound infection which is characterized by complains of pain, redness and edematous of the wound edges. Dressing should be change frequently and wound dressing should be carried out aseptically on the 3rd day or as prescribed by the surgeon. Alternate stitches are remove aseptically as ordered by the surgeon. The client should be educated to keep the wound dry and not to be touching it with the hands in order to prevent wound infection.

Client is encouraged to take in high protein diet with enough vitamins especially vitamin C to promote wound healing and repair of worn-out tissues.

Client's Education

The client is educated to support the abdomen during coughing, deep breath and change position frequently to help reduce pain. Client is educated on the need to maintained both personal and environmental hygiene to reduce the risk of infection. Teach client to take his prescribed medications and observe any side effects.

COMPLICATIONS OF PERITONITIS

a. Septicaemia: Peritonitis can make fluid fill up in your belly or abdomen. This can cause severe fluid loss or dehydration. If peritonitis isn't treated the infection can quickly spread through your body. This can create an extreme response from your infection-fighting system (immune system) called sepsis.

b. Intestinal obstruction: This part of the intestine enlarges as it fills with food, fluid, digestive secretions, and gas. The intestinal lining becomes swollen and inflamed. If the

condition is not treated, the intestine can rupture, leaking its contents and causing inflammation and infection of the abdominal cavity (peritonitis.

c. Intestinal perforation: Intestinal perforation, defined as a loss of continuity of the bowel wall, is a potentially devastating complication that may result from a variety of disease processes. Common causes of perforation include trauma, instrumentation, inflammation, infection, malignancy, ischemia, and obstruction.

d. Shock: Left untreated, peritonitis can extend beyond your peritoneum, where it may cause: An infection throughout your body (sepsis). Sepsis is a rapidly progressing, life-threatening condition that can cause shock, organ failure and death.

e. Pelvic abscess: Abdominal abscesses are caused by bacteria that usually enter the abdomen as a result of penetrating trauma, rupture of the bowel, or intra-abdominal surgery.

f. Severe toxaemia: Repeated toxic injury of peritoneum: accumulation of toxicity and adaptation to injury.

1.10 Validation of Data

Validation is the extent to which a measure, indicator, or a method of data collection possesses the quality of being sound or true as far as it can be judged (Weller, 2014). All the information gathered from the patient was found to be true after comparing with information obtained from patient's relative through series of interviews. The signs and symptoms exhibited by client were similar to the clinical features of peritonitis in the literature review. The laboratory investigations carried out were also compared to standards of measurement. All these were done to ensure that the data gathered on the client were varied.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis of data is a systematic examination and evaluation of data or information, by breaking it into its component parts to uncover their interrelationship, thus providing basis for problem solving and decision making (Weller, 2014). Analysis of data is the second phase of the nursing process. It contains information on the comparison of data gathered with standards. This helps the nurse to identify the problems of the patient and his family, their strengths and also make his nursing diagnoses, objectives and gives appropriate interventions.

2.1 Comparison of Data with Standards

The following data would be compared with standards;

1. Diagnostic investigation/ Tests
2. Causes/ Risk factors
3. Clinical features/ Sign and Symptoms
4. Medical/ Surgical treatments

Diagnostic investigation/ Tests

Test/ investigations refers to an examination or analysis of the composition of a substance by the use of chemical reagents, and/or to determine the presence or absence of a substance (Weller, 2014). The diagnostic tests below were carried out on patient to aid in the diagnosis and treatment;

- full blood count
- blood urea nitrogen (BUN), creatinine
- sickling test
- blood electrolytes
- liver function test
- plain abdominal X-ray.

Table 1: Diagnostic Investigations/Tests in Literature Review Compared with Those Carried Out On Patient.

Diagnostic Test Outlined In Literature Review	Diagnostic Test Carried Out On The Patient
Laboratory investigation of urine for the presence of red blood cells and pus	Laboratory investigation of urine was not done
Electrocardiography	Electrocardiography was not done.
Peritoneal aspiration	Peritoneal aspiration was not done.
Plain x-ray of the abdomen to show the perforated organ.	Plain x-ray of the abdomen was done.
Computerized tomography scans of the abdomen	Computerized tomography scans of the abdomen were not done.
Full blood count (Hb and WBC)	Blood sample was taken for full blood count.
Serum amylase will rise in acute pancreatitis.	Serum amylase was not done.
Culture and sensitivity test to isolate the organism	Culture and sensitivity test was not done.
Physical anal examination or visualization by external examination	Physical anal examination or visualization by external examination was done.
Grouping and cross matching to know client's blood group	Grouping and cross matching was done.

With reference to the literature review, Laboratory investigation of urine, Electrocardiography, Peritoneal aspiration, Computed tomography scan and Culture and sensitivity test to isolate the

organism were not done because the diagnoses were arrived at and confirmed by history and physical examination conducted and plain abdominal X ray.

Other tests such as blood urea nitrogen (BUN), creatinine, sickling test, and liver function test, were not seen in the literature review but were conducted to determine the kidney function, patient's sickling status and also liver function respectively.

Table 1; Diagnostic Investigations

DATE	SPECIMEN	INVESTIGATION	RESULTS	NORMAL VALUES	REMARKS	TREATMENT
09/11/2021	Blood	Renal function test:	Urea-137mmol/L Nitrogen-12mmol/L Creatinine-13.98mmol/L	8–36 mmol/L 2.1-8.5mmol/L 2.5-8.3mmol/L	Above normal range	Normal saline was given to flush out the body of toxins
09/11/2021	Blood	Sickling test	Negative	SS,AS,AC,SC	Sickling negative means client does not have the trait.	No treatment was given.
09/11/2021	Blood	Liver function test (serum albumin)	22.41g/L	39.70 – 49.50g/L	Below normal	Ringers Lactate was prescribed to provide electrolytes

09/11/2021	Abdominal X-ray	X-ray of the peritoneum	Perforation of the intestine resulting in accumulation of fluid in the peritoneum.	There should not be any perforation.	Result indicate there is a perforation	Client was sent for laparotomy and closure of perforation was done.
10/11/2021	Blood	For electrolyte Sodium (Na^+) Potassium (K^+) Chlorine (Cl^-)	 144mmo/L 4.0mmo/L 110mmol/L	 135-145mmol/L 3.5-5.5mmol/L 90-110mmol/L	Within normal range Within normal range Within normal range	 No treatment was given. No treatment was given. No treatment was given.

10/11/2021	Blood	Full Blood Count: Hb	7.1 g/dl	Male; 12-18g/dL Female;11– 16g/dL	Below normal indicating anaemia	Syrup Astymin a haematinic was given.
		WBC	2.77 IU	2.60 – 8.50Ul	Above the normal range indicating infection	Antibiotics such as IV ciprofloxacin, IV Metronidazole were ordered and administered.
10/11/2021	Blood	Grouping and Cross-matching	blood group ‘O’ with Rhesus ‘Negative	A,B,AB,O	Patient’s blood group is normal O-	Patient was transfused with a pint of blood.

CAUSES

With reference to the causes of peritonitis in the literature review, client's condition was due to the leakage of content from the perforated bowel into the abdominal cavity or the peritoneum.

TABLE 2: Clinical Features

Clinical Features In Literature Review	**Clinical Features Exhibited By Patient**
Diffuse type of abdominal discomfort	Diffuse type of abdominal discomfort was present
Nausea and vomiting	Client had nausea and vomiting
Abdominal distension	Client's abdomen was distended
Abdominal tenderness and rebound pain when abdomen is touched	Abdominal tenderness and rebound pain when abdomen is touched was present.
The patient may experience shock	Patient did not experience signs of shock
Increased pulse rate	Patient had an increased in pulse rate.
Fever and chills	Patient had an increased in temperature (38.2^0C)
Abdominal resonance and tympani on percussion	Abdominal resonance and tympani on percussion was present
Anorexia	Client presented with anorexia
Altered bowel movement	Client's bowel was not altered neither did he experience constipation nor diarrhea

Abdominal tenderness	There was tenderness on palpation
Abdominal muscular rigidity	Abdominal muscular rigidity was present

With reference to the literature review, patient presented most of the clinical manifestations as stated in the literature review.

Treatment

Treatment is defined as the use of an agent, procedure or regimen such as drug, surgery or exercise in an attempt to cure or mitigate a disease, condition or injury.

Treatment for Client

Client underwent surgical treatment, laparotomy, under general anaesthesia and was put on the following medications;

1. Intravenous ciprofloxacin 400mg bd x 48 hours
2. Intravenous Metronidazole 500mg tds x 48 hours
3. Intravenous Ringer's lactate 500mls over 1 hour.
4. Suppository Paracetamol 1g tds x 48 hours.
5. Intravenous normal saline1.5 litres x 24hours
6. Intravenous ringer's lactate 1.5 litres x 24hours
7. Intravenous dextrose 500mls over 1hour
8. Syrup Astymin 10mls daily x 7 days

Table 4: Comparison of treatment outlined in the Literature Review with those given to my Patient.

Treatment Outlined in Literature Review	**Treatment Given to My Patient**
1. The use of Iv fluids a. Dextrose saline b. Ringers lactate c. Normal saline	The following Iv fluids were given a) Intravenous normal saline b) Intravenous Ringers lactate c) Intravenous Dextrose saline
2. Analgesics	Patient was given analgesics; a. Paracetamol
3. The use of antibiotics	Patient was given Metronidazole and Ciprofloxacin

From the above table, the treatments given to patient were in line with the literature. Analgesics like paracetamol was given to patient since patient felt pain due to surgical incision. Antibiotics were also given to prevent infection after surgery.

Table 3: Pharmacology Of Drugs Administered

DATE	DRUG	DOSAGE/ROUTE ADMINISTRATION (LITERATURE)	DOSAGE/ROUTE OF ADMINISTRATION (CLIENT)	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES
09/11/21	Ciprofloxacin	**Adult:** 200 – 400mg of 12hours. **Children:** 20 – 30mg 1kg/day in divided doses of 12hours. Route is by oral and intravenous.	400mg bd x 72hours intravenously	Antibiotic (Fluoroquinolone)	Treatment of susceptible infection due to *E. coli, S. aurous, S. pneumonia.*	Client's infection resolved.	Nauseas and vomiting, constipation, rash, flatulence. Headache, abdominal pain. No side effect was observed on client.
09/11/21	Metronidazole	**Adult/children,** 1kg per day in divided doses of 6hours	500mg tds x 72 hours intravenously.	Antibacterial Antiprotozoal	Destroys anaerobic infections and	Client's infections resolved.	Dizziness, vomiting, constipation, rash, anorexia,

		Dose: oral and intravenously.			prevents complications		dry mouth. None of these side effects was observed on the client.
09/11/21	Normal saline	Adult: Depends on the patient's condition that is fluid and calorie requirement. Children: Depends on the patient's condition	1.5 litres x 24hours intravenously	Fluid and electrolyte replacement therapy. Isotonic solution	Restores normal fluid and electrolyte imbalance	Client's body fluid and electrolyte were maintained.	Pulmonary oedema fluid or dose overload was not observed.

09/11/21	Ringer's lactate	Adult and children doses depend on patient's condition but usually 1.5liters to 3liters over 24hours intravenously	1.5 litres x 24hours intravenously	Fluid and electrolyte replacement therapy. Crystalloid solution.	To restore normal fluid and electrolyte imbalances.	Client's body fluid and electrolyte were restored.	Fluid overload, hypervolemia, pulmonary oedema. No side effect observed on client.

DATE	DRUG	DOSAGE/ROUTE ADMINISTRATION (LITERATURE)	DOSAGE/ROUTE OF ADMINISTRATION (CLIENT)	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES
09/11/21	Dextrose saline	Dosage depends on the fluid and caloric requirement. Intravenously	500mls over 1 hour intravenously.	Correct dehydration and fluid imbalances. Hypertonic solution.	To restore and replenish fluid and electrolyte	Body fluids and electrolyte were restored.	Fluid overload, hyperkalaemia, thrombophlebitis, vomiting and pulmonary oedema. No side effects were observed on client.
09/11/21	paracetamol	Adult; 500mg-1g 3- 4 x daily. Children; 250-500mg 3-4 x daily.	1 gram tds x 48 hours. Rectally	Analgesic, antipyretic	To relieve mild and moderate pains	Client's pain reduced.	Headache, dizziness, nausea, vomiting, No side effect was observed on client.

		Orally, IV and rectally.					

11/11/21	Astymin	Adult (12years and above) 3 teaspoonful (15mls) bd. Children (2- 11 years) 1 teaspoon full (5mls) tds	10mls dailyx7 Orally	Haematenic	To restore the normal haemoglobin level of the client by supplementing amino acids and vitamins	Client's haemoglobin level was restored to normal	No known side effects. No side effect was observed

COMPLICATIONS

With reference to complications listed under the literature review, client exhibited no complications during his time of admission due to good nursing and medical care rendered to him.

2.2 Patient / Family Strengths

This is explained as the ability of the patient and family to help in the achievement of health and goals set for early recovery.

1. Patient could report the extent and exact location of abdominal pain.
2. Patient could take in fluid after vomiting.
3. Patient could take in cold drinks.
4. Patient stated rational for preventing wound infection
5. Patient could sleep for 2 hours at night and an hour during the day
6. Patient could eat 150mls of porridge

2.3 Health Problems

This entails the actual problem the client is facing or the potential problem he is likely to face as a result of his condition.

Pre-Operative Health Problems

1. Patient complained of abdominal pains. (09/11/21)
2. Patient complained of nausea and vomiting. (09/11/21)
3. Patient had high body temperature (38.7°C). (09/11/21)

Post-Operative Health Problems

1. Patient had an incisional wound (10/11/21)
2. Patient complained of finding it difficult to fall asleep. (11/11/21)

3. Patient complained of loss of appetite. (12/11/21)

2.4 Nursing Diagnoses

1. Acute pain (Abdominal pain) related to inflammation of the peritoneum.

2. Risk for fluid volume deficit as evidenced by nausea and vomiting.

3. Pyrexia (38.7°C) related to ongoing inflammatory process.

4. High risk for infection (surgical wound) as evidenced by altered skin integrity.

5. Sleeping pattern disturbance related to pain at the incision site.

6. Altered nutrition (less than body requirement) related to anorexia.

CHAPTER THREE

PLANNING FOR CLIENT / FAMILY CARE

3.0 Introduction

Planning is the third phase in the nursing process which involves setting objectives / outcomes criteria for client and family and outlining nursing care strategies to achieve these objectives.

It incorporates activities such as assigning priorities to nursing diagnosis, establishing goals or expected outcomes derived from the diagnosis, identifying nursing intervention as appropriate for goal attainment and formulating the plan of care.

3.1 Objectives/Outcome Criteria

The following are the objectives set to manage the client's problems

1. Patient's pain would subside within 8 hours as evidenced by;
    a. The patient verbalizing pain has subsided.
    b. The nurse recording 0-3 on the pain rating scale.
2. Client would maintain adequate fluid volume within 48 hours as evidenced by;
    a. Nurse observing patient show no sign of dehydration.
    b. Patient verbalizing cessation of vomiting.
3. Client's temperature would be reduced to normal (36.2°C-37.3°C) within 24 hours as evidenced by;
    a. The nurse recording a temperature within the normal range (36.2°C-37.3°C).
    b. The patient reporting coldness of the skin.
4. Client wound would be prevented from infection within the period of hospitalization as evidenced by:
    a. Nurse observing patient's wound heal by first intention.
    b. Nurse observing patient wound show no signs of infections.
5. Client would sleep continuously for, at least, 6 hours during the night within 48 hours as evidenced by:

a. Patient reporting, he slept well.

b. Nurse observing patient sleep uninterrupted for 6 hours at night.

6. Client would regain and maintain adequate nutritional status within 48 hours as evidenced by:

    a. Nurse observing patient consume $^{2}/_{3}$ spoonful of rice and stew served.

    b. Patient verbalizing regain of appetite.

TABLE 4: Nursing Care Plan

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
09/11/21 At 12:00pm	Acute pain (Abdominal pain) related to inflammation of the peritoneum.	Patient's pain would subside within 8 hours as evidenced by; a. The patient verbalizing pain has subsided. b. The nurse recording 0-3 on the pain rating scale.	1. Assess for pain 2. Help client assume a comfortable position. 3. Provide a diversional therapy 4. Promote adequate rest. 5. Apply warm compresses on the abdomen. 6. Serve prescribed analgesics and antibiotics.	1. Pain assessment was done to know patient's level of pain using the pain rating scale. 2. Client was assisted to assume a supine position to relieve abdominal pain. 3. Television was tunned to his favourite channel. 4. Adequate rest enhanced by making his bed comfortable and linen free from creases and crumps. 5. Warm compresses were applied to the abdomen to help reduce pain. 6. Prescribed analgesics 1g paracetamol suppository and also intravenous ciprofloxacin 400mg were served to relieved pain and also to manage the infection	09/11/21 At 08:00pm	Goal fully met as client stated a reduction in the abdominal pain and rated a pain of 1 on the numeric pain rating scale. `	E.G.

TABLE 4: Nursing Care Plan cont.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
09/11/21 At 2:00pm	Risk for Fluid volume deficit as evidenced by nausea and vomiting.	Client would maintain adequate fluid volume within 48 hours as evidenced by: a. the nurse observing patient show no signs of dehydration. b. Patient verbalizing cessation of vomiting.	1. Reassure client and mother. 2. Provide vomitus bowl with tight fitting cover. 3. Remove all nauseating items from the environment. 4. Give water to rinse the mouth after each vomiting and discard. 5. Monitor intake and output. 6. Administer prescribed IVF to help prevent dehydration.	1. Client and mother were reassured that measures would be put in place for the nausea and vomiting to cease. 2. Vomitus bowl was provided with tight cover to collect the vomitus and also to prevent it from contaminating the linen and the floor. 3. Nauseating items like urinals, bed pans were cleared from the environment to relief him of the nausea. 4. Water was given to rinse the mouth and also to keep the mouth clean. 5. Intake and output were monitored to prevent fluid overload, pulmonary oedema and also to ensure balance. 6. Intravenous normal saline 1L was set up for patient to prevent hydration.	11/11/21 At 2:00pm	Goal fully met as client's skin turgor was normal and he maintain an intact skin.	E. G

DATE /TIME	DIAGNOSIS NURSING	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
09/11/21 At 05:00pm	Altered body temperature (pyrexia) related to inflammation.	Client's temperature would be reduced to normal (36.2°C-37.3°C) within 24 hours as evidenced by; a. The nurse recording a temperature within the normal range (36.2°C-37.3°C). b. The patient reporting coldness of the skin.	1. Reassure client and mother. 2) Open nearby windows and remove extra clothing. (3) Tepid sponge client (4) Check temperature and record (5) Serve cold drink. 6) Administer prescribed antipyretics	(1) Client and mother were reassured to allay their fear and anxiety. 2) Nearby windows were opened and extra clothing were removed to ensure proper ventilation and reduce temperature (3) Client was tepid sponge with tepid water to reduce his body temperature. (4) Client's temperature was checked and recorded to know whether the temperature is reducing to normal (5) Client was not served with cold water because of NPO state. (6) Paracetamol suppository 1g was administered to help reduce body temperature.	10/11/21 at 05:00pm	Goal fully met as client's body temperature was reduced to normal (37.0°C) as per the clinical thermometer.	E.G.

TABLE 4: NURSING CARE PLAN cont.

DATE/ TIME	DIAGNOSIS NURSING	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/21 At 12:35pm	High risk for infection as evidenced by the presence of surgical wound.	Client wound would be prevented from infection within the period of hospitalization as evidenced by: a. Nurse observing patient's wound heal by first intention. b. Nurse observing patient wound show no signs of infections.	1. Reassure client and ensure privacy. 2. Dress wound aseptically. 3. Educate client not to be touching the wound and avoid it from been getting wet. 4. Encourage intake of fruits rich in vitamin C and high protein diet after NPO state is over. 5. Discuss the state of the wound with the client. 6. Serve prescribed antibiotics.	1.Client was reassured that the wound will heal by first intention without any complications and also privacy was ensured by screening 2. The wound was dress aseptically to prevent infection. 3. Client was educated not to touch the wound with his hands or make it wet to avoid microbes from entering the wound. 4. Client was given orange and pineapple and also served with light soup after the surgery to promote healing and repair of won out tissues. 5. The state of the wound was discussed with the client that the wound is healing to gain his confidence. 6. Intravenous ciprofloxacin 400mg and metronidazole 500mg were administered to prevent infection.	14/11/21 At 10:20am	Goal fully met as client's wound was healing by first intention without signs of infection.	E.G.

TABLE 4: Nursing Care Plan

DATE/TIME	DIAGNOSIS NURSING	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
11/11/21 At 7:00am	Sleep pattern disturbance related to pain at the incision site.	Client would sleep continuously for, at least, 6 hours during the night within 48 hours as evidenced by: a. Patient reporting he slept well. b. Nurse observing patient sleep uninterrupted for 6 hours at night.	1. Assess patient's level of pain. 2. Make client's bed comfortable with clean linen free from creases and crumps. 3. Position client in a comfortable position. 4. Ensure a conducive environment. 5. Teach patient some relaxation techniques to help manage pain and induce sleep 6.Serve prescribed analgesics	1. Patient's level of pain was assessed using the numeric pain rating scale of 1-10. 2. A comfortable bed free from creases and crumps was made for the client with clean and dry linen. 3. Client was placed in the supine position as his condition permits for adequate relaxation. 4. Proper ventilation was provided and visitors were restricted in order to help client have enough sleeping. 5. Patient was thought to relax in bed and reminisce some pleasant past experience as it could divert his attention off pain and can also induce sleep. 6. Prescribed analgesics 1g of paracetamol suppository was given to combat the Pain and also intravenous ciprofloxacin 400mg was also given to treat the infection.	13/11/21 At 7:00am	Goal fully met as client's slept for more than 6 hours during the night.	E.G.

TABLE 4: NURSING CARE PLAN cont.

DATE/TIME	DIAGNOSIS NURSING	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/21 At 8:00am	Altered nutrition; less than body requirement related to loss of appetite.	Client would regain and maintain adequate nutritional status within 48 hours as evidenced by: a. Nurse observing patient consume 2/3 of rice and stew served. b. Patient verbalizing regain of appetite.	1. Care for client's mouth twice daily. 2. Plan client's diet with him and the dietician. 3. Provide a pleasant environment before meal is served. 4. Serve meal attractively and in bits. 5. Encourage mother to stay with the client at meal time to enhance enjoyment. 6. Pass Nasogastric tube if client cannot tolerate food orally.	1. Client was assisted in caring for the mouth by using tooth brush and tooth paste to stimulate his appetite. 2. Client's diet was planned with him and the dietician to ensure he took his favorite as well as balance diet by taking likes and dislikes into consideration. 3. All nauseating items like bed pans, urinals, blood on the floor as well as vomitus were removed. 4. Client's meals were served attractively and in small quantities frequently. 5. Client's mother was always with the client at meal times to help him enjoy his meal. 6. Client was able to tolerate food orally to maintained adequate nutritional status.	14/11/21 At 8:00am	Goal fully met as client's nutritional status was improved.	E.G.

CHAPTER FOUR

IMPLEMENTATION OF PATIENT / FAMILY CARE PLAN

4.0 Introduction

This chapter forms the fourth part of the patient/family care study. Implementation is the actualization of the nursing care plan through nursing intervention (Hinkle & Cheever, 2014) .It gives the vivid account of the actual nursing care that was given to the patient /family from the day of admission until discharged based on the patients' health problems identified. This chapter also includes the preparation of the patient and his family towards discharge, home visit and continuity of care.

4.1 Summary of the Actual Nursing Care.

The actual nursing care of Mr. S.A. began right from admission into the surgical ward on the 9th November 2021 and continued until discharged on the 14th November 2021. During his period of admission, daily routine nursing care such as bed making, bathing, mouth care and serving of prescribed medication were carried out. Also, specific care was rendered according to the patient's needs.

Day of Admission, 9th November 2021

Client was admitted to surgical ward of Holy Family Hospital, Berekum on 9th November, 2021 at 11:50 am per wheel chair accompanied by a staff nurse and his parents, through the Emergency Unit with diagnosis of peritonitis. The patient's and his family were welcomed to the ward after I have introduced myself and the nursing staff to them. They were given seats and his particulars such as the name, age, sex, religion, address and next of kin were collected and were entered into the computer. The patient was given bed due to the pain and weakness and vital signs checked and recorded as follows;

Temperature - 38.2^0C

Pulse - 115beats per minute

Respiration - 30cycles per minute

Blood pressure – 130/90mmHg

On examination by the surgical team at the surgical ward he was weak and looked dehydrated, there was rebound tenderness, abdominal distension, abdominal tenderness, bowel sound reduced in frequency and pitch, slightly conscious but alert. His chest was clinically clear. Client was tepid sponged with tepid water to bring his body temperature to normal. Client's temperature was checked and recorded to know whether the temperature is reducing to normal, Client was served with Paracetamol suppository 1g was administered to help reduce body temperature. Client complained of feeling noxious and with the feeling of wanting to vomit.

Client's particulars such as name, age, sex, address, hometown, next of kin and religion were all entered in the Admission and Discharge book as well as the daily ward state. The relatives were then oriented in and around the ward. I introduced myself as well as other colleagues at the nurses' station and assured them of their competency in helping him to get well.

He was also informed of the hospital's policies. That is the cash and carry system for none insured clients and the National Health Insurance Scheme benefit for those with insurance.

Patient and relatives were made aware of the hospital's protocol and routines such as time of visiting, feeding, time of giving medications, type of cloth he is supposed to wear, the daily routine nursing care and ward rounds. He was also told to provide items which will be needed for client's hospitalization such as sponge, soap, towel, pomade and powder to help maintain client's hygiene.

Patient was also advised to keep valuable items such as mobile phone and money safely. The following medications were prescribed;

1. Intravenous ciprofloxacin 400mg bd x 48 hours
2. Intravenous Metronidazole 500mg tds x 48 hours
3. Intravenous Ringer's lactate 500mls over 1 hour.
4. Suppository Paracetamol 1g tds x 48 hours.
5. Intravenous normal saline1.5 litres x 24hours
6. Intravenous ringer's lactate 1.5 litres x 24hours
7. Intravenous dextrose 500mls over 1hour
8. Syrup Astymin 10mls daily x 7 days

The patient and relatives were reassured that, they will have the best of care from health professionals to relieve them from anxiety and fear. The patient was later examined by the medical officer and a nasogastric tube was passed to drained fluid from his stomach. He was advised together with his parents not to take or give anything by mouth because of nasogastric tube in situ. The patient and family were made aware of surgical intervention and assurance given to them. He was booked for surgical operation (laparotomy) on the following day which was on the 10th November, 2021. The family was psychologically prepared. His parents were reassured of the competent of staff that will ensure speedy recovery of their son to allay their fears and anxiety.

I reintroduced myself to patient as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my care study. Mr. S. A. was informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of Diploma in Registered General Nursing. I explained to the patient the concept of the patient/family care study and assured them of privacy and confidentiality.

It was added that a report will be written after the entire process. Mr. S. A. agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the relatives; thus, they will continue the care at home once he is well.

At 12:00pm, Patient complained of abdominal pains. A nursing diagnosis of acute pain (abdominal pain) related to inflammation of the peritoneum was made. A nursing objective was set to help relieve the abdominal pain within 8 hours. The following interventions were carried out: Pain assessment was done to know patient's level of pain using the pain rating scale. Client was assisted to assume a supine position to relieve abdominal pain. Television was tuned to his favorite channel. Adequate rest enhanced by making his bed comfortable and linen free from creases and crumps. Warm compresses were applied to the abdomen to help reduce pain. Prescribed analgesics 1g paracetamol suppository and also intravenous ciprofloxacin 400mg were served to relieved pain and also to manage the infection

At 2:00pm Patient complained of nausea and vomiting. A nursing diagnosis of risk for fluid volume deficit as evidenced by nausea and vomiting was made. An objective was set to enable patient maintain adequate fluid volume within 48hours. Client and mother were reassured that measures would be put in place for the nausea and vomiting to cease. Vomitus bowl was provided with tight cover to collect the vomitus and also to prevent it from contaminating the linen and the floor. Nauseating items like urinals, bed pans were cleared from the environment to relief him of the nausea. Water was given to rinse the mouth and also to keep the mouth clean. Intake and output were monitored to prevent fluid overload, pulmonary oedema and also to ensure balance. Intravenous normal saline 1L was set up for patient to prevent hydration.

At 5pm, patient's temperature checked was high (38.6^{o}C). An objective was therefore set to help bring temperature to normal within 24hours. The following nursing interventions were carried

out. Client and mother were reassured to allay their fear and anxiety. Nearby windows were opened and extra clothing were removed to ensure proper ventilation and reduce temperature. Client was tepid sponge with tepid water to reduce his body temperature. Client's temperature was checked and recorded to know whether the temperature is reducing to normal. Client was not served with cold water because of NPO state. Paracetamol suppository 1g was administered to help reduce body temperature.

His vital signs checked and recorded at 6:00 pm as Temperature - 38.3^{o}c, pulse - 70bpm, Respiration - 18cpm Blood pressure- 110/60mmHg.

Preoperative education regarding the surgery and relevant information was mentioned to the patient. After the surgeon explained everything related to the surgery to the patient, I witnessed him sign the consent form voluntarily.

At 8:00pm, the goal set in the afternoon to help relieve patient's abdominal pain was evaluated. Goal fully met as client's stated a reduction in the abdominal pain and rated a pain of 1 on the numeric pain rating scale. Patient was reassured that antibiotics given will help curb the infection and after the surgery tomorrow, the problem will be resolved.

At 10pm due, medications were administered and vital signs checked and recorded as Temperature - 37.5^{o}c, pulse - 62bpm, Respiration - 17cpm Blood pressure- 120/80mmHg. At 10:30pm patient was observed to be on the bed.

Day of Surgery: 10th November, 2021.

Mr. S.A. woke up from bed around 5:30am since he could not sleep well and patient also complained of intermittently waking up due to change of environment and physical discomfort. Patient was assisted by to carry out his personal hygiene needs such as brushing of the teeth, bathing and grooming. At 6:00am, Patient vital signs was checked and recorded as'

Temperature - 36.2ºC

Pulse - 87bpm

Respiration - 21cpm

SP02 - 96%

BP = 120/60mmHg.

Patient and relatives were reassured of competent health care and was still encourage not to be anxious. Check list was done and incisional site prepared.

Final preoperative preparation for the surgery.

A hair to toe examination was conducted on patient to assess the physical health of the patient. Baseline vital signs before surgery was checked and recorded as Temperature –36.0^0C, Pulse – 72bpm, Respiration – 21cpm, Blood pressure – 110/80 mmHg. Patient had been put on nil per os since yesterday and was on IV fluids which were continuously administered and monitored due to the anticipated surgery. Patient was encouraged to empty the bladder and bowel before surgery to help minimize risk of injury and complications during and after surgery. Patient was educated on deep breathing and coughing exercises to prevent chest complications after surgery as well as active and passive exercises of limbs to prevent postoperative deep vein thrombosis. He was then assisted to change into hospital gown. Surgical site was assessed again for any skin abnormalities such as rash, keloid, scar or incision of a previous operation. He was neatly prepared and draped. Patient was educated to remove all jewelries. Patient's wrist band was labelled with his name, diagnosis and type of surgery. Patient was taken to the theatre at 9:25am. Operation bed was prepared to receive patient from theatre after the surgery is done.

After a successful surgery patient was taken to the theater recovery ward. Patient's immediate postoperative care was to be monitored and managed before transferring to surgical ward.

Immediate post-operative care at the ward

Before the return of patient from the theatre, the following items were assembled: operation bed, anesthetic tray (swab- holding forceps, dissecting forceps and a tongue spatula), oxygen cylinder and a suction machine, pulse oximeter, vomiting bowl, mouth care tray, vital signs tray screen, infusion stand, sphygmomanometer.

Patient was received from the theatre successfully at the surgical ward at 12:10pm on a stretcher. He was received in a semi- conscious state as he was sedated during the surgery with an intravenous infusion (normal saline) running. He was put to bed in a supine position with head turned to the side and the infusion hanged on the infusion stand. The amount of infusion running was noted and then the flow rate was adjusted as ordered. His vital signs (Temperature, Pulse, Respiration and blood pressure) were checked every 15minute for one hour, 30 minutes for other hours till condition is stable. Vital signs were recorded in appendix. On assessment, client had clean wound dressing indicating no sign of bleeding.

At 12:35pm since patient had an incisional wound, he was at risk for infection. Therefore a nursing diagnosis of high risk for infection as evidenced by the presence of surgical wound was made. An objective was set to help prevent patient's wound from been infected within the period of hospitalization. The following nursing interventions were carried out: Client was reassured that the wound will heal by first intention without any complications and also privacy was ensured by screening. Client was educated not to touch the wound with his hands or make it wet to avoid microbes from entering the wound. Client was given orange and pineapple and also served with light soup the day after the surgery to promote healing and repair of won out tissues. The state of the wound was discussed with the client that the wound is healing to gain his confidence. Intravenous ciprofloxacin 400mg and metronidazole 500mg were administered to prevent infection.

At 5:00pm, an evaluation was made for the objective set to help reduce patient's body temperature to normal. Goal was fully met as client's body temperature was reduced to normal (37.0°C) as per the clinical thermometer.

Vital signs were checked and recorded at 6pm as; Temperature - 36.3^{o}c, pulse - 82bpm, Respiration - 22cpm Blood pressure- 120/80mmHg.

Due medications were served and the necessary documentations were observed.

At 10:00pm vital signs were recorded as follows;

Temperature – 37.3^{0}C

Pulse – 66bpm

Respiration – 22cpm

Blood pressure - 120/90mmHg

Patient went to bed at 10:22pm after vital signs were checked.

First Day Post-Operative (11th November, 2021)

Reports from the night nurses indicated that, patient woke up as early as 4:30am.

It was noticed that client could not bath on his own because of the pain and lack of endurance. He was given bed bath to remove dirt and promote feeling of well-being. Client was assisted in brushing his teeth to prevent oral infection.

Bed linens were changed and straightened. Client's wound was assessed for any sign of bleeding which was absent.

The client was advised to avoid touching the wound with bare hands and also keep the site of the operation clean to prevent micro-organisms entering the wound. Client was encouraged to sit-up in bed to promote wound healing and prevent complications. At 6 am, vital signs were checked

and recorded as; temperature: 36.1^{o}C pulse: 100bpm respiration: 25cpm blood pressure: 110/90 mmHg.

According to the night nurse and from the nurse's notes, patient complained of pain at the incision site and insomnia and was given cold compresses at the site to help reduce pain.

At 7:00am, upon interaction with patient he revealed that he finds it difficult having a sound sleep at night as well as during the day. A nursing diagnosis of Sleep pattern disturbance related to pain at the incisional site was made. Client would sleep continuously for at least 6 hours during the night within 48 hours was the objective set to help tackle this problem. The following were the nursing actions executed; Patient's level of pain was assessed using the numeric pain rating scale of 1-10. A comfortable bed free from creases and crumps was made for the client with clean and dry linen. Client was placed in the supine position as his condition permits for adequate relaxation. Proper ventilation was provided and visitors were restricted in order to help client have enough sleeping. Patient was thought to relax in bed and reminisce some pleasant past experience as it could divert his attention off pain and can also induce sleep. Prescribed analgesics 1g of paracetamol suppository was given to combat the Pain and also intravenous ciprofloxacin 400mg was also given to treat the infection.

At 8:40am, routine ward rounds was carried out and the medical doctor ordered to continue with current plan for patient. He ordered for patient to start sips and to resume light diet in the evening. Luke warm Lipton tea was prepared for patient.

At 10:00am vital signs were recorded as follows;

Temperature – 37.1^{o}c

Pulse – 96bpm

Respiration – 28cpm

Blood pressure - 130/90mmHg

Patient was informed that I will be visiting their home this very day while he is still on admission; my purpose of going was communicated to them and was asked to go with his mother.

At 2:00pm, the goal set on the 9th of November, 2021 to help patient maintain adequate fluid volume within 48 hours was evaluated. Goal was fully met as client's skin turgor was normal and he verbalized a cessation of nausea and vomiting.

In the evening, patient was served with 200mls white corn porridge with a very light consistency.

At 6:00pm, vital signs were checked and recorded as; temperature: 36.5^{o}C respiration: 23cpm pulse: 90bpm blood pressure: 120/70 mmHg. Due medications were served and the necessary documentations were done. Patient went to bed at 9:20pm. During the 10pm vital signs patient was not woken up. As this could disturb his sleep, this was done to enable him sleep well since he had a difficulty falling asleep

Second Day Post-Operative (12th November, 2021)

Patient slept soundly during the night according to night staff and woke up at 6am. His vital signs checked and recorded as; Temperature - 36.1^{o}c, pulse - 81bpm, Respiration - 20cpm Blood pressure- 110/70mmHg. He was assisted by his mother to free his bowel, take his bath and care for his mouth. He received IV ciprofloxacin 400mg and IV Metronidazole 500mg.

He was later reviewed by the surgical team and orders were to continue treatment and take normal diet. Patient was given feedback on the home visit I embarked on yesterday.

At 8:00am, patient was served with porridge. He could not consume much of the porridge, according to him he had lost appetite for food. Therefore, a nursing diagnosis of altered nutrition;

(less than body requirement) related to loss of appetite was made. An objective was set to enable patient regain and maintain adequate nutritional status within 48 hours. Nursing interventions carried out included; Client was assisted in caring for the mouth by using tooth brush and tooth paste to stimulate his appetite. Client's diet was planned with him and the dietician to ensure he took his favorite as well as balance diet by taking likes and dislikes into consideration. All nauseating items like bed pans, urinals, blood on the floor as well as vomitus were removed. Client's meals were served attractively and in small quantities frequently. Client's mother was always with the client at meal times to help him enjoy his meal. Client was able to tolerate food orally to maintained adequate nutritional status.

At 10am vital signs were checked and recorded as Temperature - 36.9^{o}c, pulse - 85bpm, Respiration - 20cpm Blood pressure- 120/80mmHg.

At 1:30 pm, Mr. S.A. consumed about 5 spoonsful of rice and soup as lunch. Due medications were served and the necessary documentations were observed.

Mr. S. A. consumed Tuo Zaafi which was made to be very light that it can be digested at 6:00pm with water melon as supper. Vital signs were checked and recorded at 10pm as; Temperature - 36.6^{o}c, pulse - 72bpm, Respiration - 20cpm Blood pressure- 110/80mmHg. Afterwards patient went to bed.

Third Day Post-Operative; 13th November, 2021.

Patient's condition had improved and patient was doing well, and the family members were calm and cheerful and they were grateful to the Almighty God.

Patient slept soundly during the night according to night staff and woke up at 6am. His vital signs checked and recorded as; Temperature - 36.9^{o}c, pulse - 91bpm, Respiration - 22cpm Blood pressure- 120/80mmHg. He was assisted to free his bowel, take his bath and care for his mouth.

At 7:00am, the objective set on the 11th November to help patient be able to sleep continuously for, at least, 6 hours during the night within 48 hours was evaluated. Goal was fully met as client's slept for more than 6 hours during the night.

He was later reviewed by the medical officer at 9am and we were to continue treatment. The medical officer also hinted of a possible discharge the next day which was communicated to the patient and his family. They were very happy. At 10am vital signs were checked and recorded as Temperature - 36.9^{o}c, pulse - 94bpm, Respiration - 19cpm Blood pressure- 120/80mmHg.

Vital signs were checked and recorded at 6pm as; Temperature - 36.4^{0}C, pulse - 85bpm, Respiration - 19cpm Blood pressure- 120/70mmHg.

Mr. S.A. consumed rice and Kontomire stew at 6:30pm with an orange as supper. Due medications were served and the necessary documentations were observed. Patient went to bed at 9:30pm.

Day of discharge: 14th November, 2021

I went to continue the nursing care rendered to my patient at 7:35am. Patient woke up feeling strong and better. His personal hygiene was maintained. The vital signs checked and recorded at 6:00am reads as follows:

Temperature - 36.2^{o}c,

Pulse - 72bpm,

Respiration - 24cpm

Blood pressure- 100/70mmHg.

At 8:00am, the objective set on 12th November, 2021 to help patient regain and maintain adequate nutritional status within 48 hours was evaluated. Goal was fully met as client's nutritional status had improved.

Patient took porridge with koose for breakfast and his medications were served as ordered.

During routine ward rounds at 9:10am, patient was discharged since his condition was stable and he had no complains. His mother was informed and the bills were assessed to be paid. Patient was educated on his drugs, the need to eat food containing high fibre like whole grains, the entire essential food nutrients, for example protein, vitamins and irons, as well as maintaining good personal hygiene as well as the need for follow ups and regular check-ups. No new medications were prescribed. Patient was informed to come for review on the 19th November, 2021. The need to continue with medications and review date were emphasized.

An evaluation of the objective set to ensure patient shows no signs of surgical site infection within the period of hospitalization was done at 10:00am and goal was fully met as client's wound was healing by first intention without signs of infection.

They were helped to pack their belongings after settling the bills and showing the receipts. Patient and the family bade the ward inmates and staff goodbye. I accompanied patient to the hospital taxi rank. The discharge procedure was documented in the admission and discharge book and in the daily ward state as well as in the nurse's notes. Bed linens were sent to the laundry, the mattress and pillow were as well disinfected.

4.2 The Preparation of Patient/Family for Discharge and Rehabilitation

Preparation of patient/family for discharge started on the day of admission when they were told that the hospital is a temporal place for them and that they will be discharged if patient health is restored. The aim was to make them comfortable and understand that the hospital was a temporary place for health care and patient would be discharged home to continue treatment when his condition improves. Patient and his parents were once again educated on the risk factors, signs and symptoms, treatment, possible complications and prevention of disease condition (Peritonitis). They were educated on the need for good personal hygiene and good

nutrition. Patient and his relatives were advised on the importance of review and to keep to the said date (19/11/2021) and also to report promptly to the hospital for proper management if any change occurred in the condition before the review date. Through out the home visits, patient and the relatives were continuously given education necessary for the maintenance of their health. On my last home visit, when patient's condition had considerably improved, he was finally handed over to the community health nurse for the care to be continued in my absence.

4.3 Follow Up/Home Visit/Continuity of Care

A home visit is a visit to the home of the patient with the aim of promoting health through education and assessment of health status. It is carried out before and after discharge. The reasons for this visit are to help assess the nature of patient and family's home/community and the people in the home/community to determine people at risk (vulnerable) to diseases. It also helps client's family to be educated on any unhealthy living and factors that will be identified. State of patient and family's health are assessed and documented.

First Home Visit (11th November, 2021).

On the occasion of my first home visit, Mr. S. A's mother decided that she will go with me to their house. We left Berekum Holy family hospital gate around 12:30pm and alighted at Mpatapo around 12:50pm. The purpose of this visit was to know my patient's residence and the environment in which he lives, verify the information given to me as well as to identify the risk factors such as familial tendency and stresses that can lead to his condition. It was also to enable me know patient's nearest health facility for possible referral and validation of patient data.

The road from hospital gate to Mpatapo was tarred. The client's house had no fence wall. There were very tall Nim trees which was also very close or adjacent to their house. The house is a self-contained building with a toilet and bath attached to the room, hall and a kitchen. Their house is built with blocks but had not been painted and is wired correctly with electricity power and

almost all windows were opened to allow proper ventilation. They had a dustbin with a well-fitting lid in which they dump their waste materials and it is emptied every morning to the community refuse disposal site. Their means of accessing portable water is a bore hole and a tap opposite their house. Observation made in the room revealed a well-furnished room with a television and a ceiling fan, a bed and a center table.

I also entered the toilet and saw that it was a water closet. The place was clean, with the container for toilet papers emptied. Mr. S. A's mother was educated on the need to practice good environmental and personal health and also encouraged them to continue to keep their home and surroundings clean. I reassured Mr. S. A's mother of competent nursing care and that he will be well very soon. She thanked me and assured me that she will ensure that all what I said will be done before I come for my next home visit. We left Mpatapo at 2:10pm and got to the hospital at 2:30pm. Comments made on the condition of the house, education and recommendations were repeated to Mr. S.A. and he also promised to do everything in his power to ensure that all the recommendations are done.

Second Home Visit (17th November, 2021)

My second home visit took place on 17th November, 2021, three days after my patient was discharged. The purpose of the second home visit was to find out how patient's condition is improving in the house with regard to the environment and the medications been taken and to remind them of review date.

I boarded a car to Mpatapo. When I got to the town, I went straight to his house. On arrival at client's house, he warmly welcomed me and was offered a seat by client after exchange of pleasantries with patient and family. Enquiry was made of any new complaint and general health of Mr. S.A. and the family. There were no complaints as he looked very active and cheerful. Patient was asked about his medications and was told he was taking them. He was encouraged to

continue taking his medications and also to report to the hospital if he noticed anything unusual. I further stressed on the importance of good nutrition, the need to eat more fruits and vegetables and also the importance of maintaining environmental and personal hygiene.

They were reminded of the review date which was 19th November, 2021. After having some chats on Mr. S. A's condition, permission was sought to leave. Patient escorted me to the roadside where I bordered Okada from Mpatapo.

Review Day (19th November, 2021).

Mr. S.A. came to the Holy Family Hospital, Berekum for review on 19th November, 2021 around 9am. I went with him to activate his hospital card from the records. Upon my interaction with patient, it was observed that his condition had really improved. His vital signs were checked and were within normal range thus, Temperature: 36.4^{o}C, Respiration: 19cpm, Pulse: 74bpm and BP:110/70.

Patient was escorted to the consulting room for surgical out-patients department and upon assessment by the doctor he confirmed the condition had improved and the stitches could be removed. Some analgesics and antibiotics were prescribed. The drugs were collected from the hospital pharmacy for them. He thanked me, I bade him goodbye and he took Okada home at around 1:00pm.

Third Home Visit (26th November, 2021)

The main reason for conducting the third home visit were to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care.

On the said date, I set off early Friday afternoon around 12:00pm with Okada. I got to Mpatapo at around 12:15pm. Patient and family were doing well as they looked cheerful and had no complains. The environment was tidy as there were no rubbish nor stagnant water around. I

however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication. I asked about patient's drugs and it was found that he had been taking his medications and the recommended foods had also been adhered to.

I sought permission to use the toilet, however my intention was to assess the state of it as well as the washroom and I was highly impressed that there was a change in behavior through the education that was given to my patient and his family I asked questions about the health education I gave them on the day of discharge. They answered me correctly as expected. During my interaction with Mr. S.A. and his family, I had communication with the community health nurse at Mpatapo clinic to continue the care for Mr. S.A. I introduced the community health nurse according to custom as tradition demands. I told Mr. S.A. and family members that, she is the one who is going to take care of him and continue the care and they should give her the maximum support as they always gave to me.

I therefore told Mr. S.A. and his family that because I am a student nurse and I will have to go back to campus to continue my education, I cannot stay with them forever. But promised to pay them unofficial visits from time to time or speak with them on phone. I encouraged them to give her the same co-operation they gave me. Since it happened to be my last day of therapeutic relationship with patient and family, I terminated my care handed over officially to the community health nurse. I thanked them for their cooperation which made my study a success. Again patient and his family expressed their gratitude by showing how grateful they were to me for the support and care given to them. I sought for permission to leave and it was granted. They escorted me the roadside where I got an Okada and came back home.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Smeltzer et al., 2010). The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to my patient and family.

5.1 Statement of Evaluation.

Throughout the period of admission, six health problems were recorded and objectives were set to solve them. Below is the summary of the interventions carried out and to what extent the goals were met.

1. **Mr. S.A. was relieved of abdominal pains (09/11/21).**

On 9th November, 2021 at 12:00pm, Patient complained of abdominal pains. A nursing diagnosis of acute pain (abdominal pain) related to inflammation of the peritoneum was made. A nursing objective was set to help relieve the abdominal pain within 8 hours. The following interventions were carried out: Pain assessment was done to know patient's level of pain using the pain rating scale. Client was assisted to assume a supine position to relieve abdominal pain. Television was tuned to his favorite channel. Adequate rest enhanced by making his bed comfortable and linen free from creases and crumps. Warm compresses were applied to the abdomen to help reduce pain. Prescribed analgesics 1g paracetamol suppository and also intravenous ciprofloxacin 400mg were served to relieved pain and also to manage the infection.

On the same day at 8:00pm, the goal set in the afternoon to help relieve patient's abdominal pain was evaluated. Goal was fully met as client's stated a reduction in the abdominal pain and rated a

pain of 1 on the numeric pain rating scale. Patient was reassured that antibiotics given will help curb the infection and after the surgery tomorrow, the problem will be resolved.

2. **Mr. S.A. maintained adequate fluid volume (11/11/21).**

On the 9th November, 2021, at 2:00pm Patient complained of nausea and vomiting. A nursing diagnosis of risk for Fluid volume deficit as evidenced by nausea and vomiting was made. An objective was set to enable patient maintain adequate fluid volume within 48hours. Client and mother were reassured that measures would be put in place for the nausea and vomiting to cease. Vomitus bowl was provided with tight cover to collect the vomitus and also to prevent it from contaminating the linen and the floor. Nauseating items like urinals, bed pans were cleared from the environment to relief him of the nausea. Water was given to rinse the mouth and also to keep the mouth clean. Intake and output were monitored to prevent fluid overload, pulmonary oedema and also to ensure balance. Intravenous normal saline 1L was set up for patient to prevent hydration.

On 11th November, 2021 at 2:00pm, the goal set on the 9th of November, 2021 to help patient maintain adequate fluid volume within 48 hours was evaluated. Goal fully met as client's skin turgor was normal and he maintain an intact skin.

3. **Mr. S.A. temperature was reduced to normal (36.2°C-37.3°C) (10/11/21).**

It was noted on 9th November, 2021 at 5:00pm, during the routine vital signs checked it was observed that patient had a high body temperature of 38.7°C. Altered body temperature (pyrexia) related to inflammation was the nursing diagnosis made. An objective was set to help client's temperature be reduced to normal (36.2°C-37.3°C) within 24 hours. Interventions carried out included: Client and mother were reassured to allay their fear and anxiety. Nearby windows were opened and extra clothing were removed to ensure proper ventilation and reduce temperature. Client was tepid sponge with tepid water to reduce his body temperature. Client's temperature

was checked and recorded to know whether the temperature is reducing to normal. Client was not served with cold water because of NPO state. Paracetamol suppository 1g was administered to help reduce body temperature.

On 10th November, 2021 at 5:00pm, during after the routine vital signs, an evaluation was made for the objective set on yesterday to help reduce patient's body temperature to normal. Goal fully met as client's body temperature was reduced to normal (37.0°C) as per the clinical thermometer.

4. **Patient's wound was not infected (14/11/21).**

On 10th November, 2021 at 12:35pm, since patient had an incisional wound, he was at risk for infection. Therefore, a nursing diagnosis of high risk for infection as evidenced the presence of surgical wound was made. An objective was set to help prevent patient's wound from been infected within the period of hospitalization. The following nursing interventions were carried out: Client was reassured that the wound will heal by first intention without any complications and also privacy was ensured by screening. The wound was dress aseptically to prevent infection. Client was educated not to touch the wound with his hands or make it wet to avoid microbes from entering the wound. Client was given orange and pineapple and also served with light soup after the surgery to promote healing and repair of won out tissues. The state of the wound was discussed with the client that the wound is healing to gain his confidence. Intravenous ciprofloxacin 400mg and metronidazole 500mg were administered to prevent infection.

On day of discharge (14th November, 2021) evaluation of the objective set to ensure patient shows no signs of surgical site infection within period of hospitalization was done at 10:00am and goal was fully met as client's wound was healing by first intention without signs of infection.

5. **Mr. S.A. slept for 6 hours during the night (13/11/21).**

On 11th November, 2021 at 7:00am, upon interaction with patient he revealed that he finds it difficult having a sound sleep at night as well as during the day. A nursing diagnosis of Sleep

pattern disturbance related to pain at the incision site was made. Client would sleep continuously for at least 6 hours during the night within 48 hours was the objective set to help tackle this problem. The following were the nursing actions executed; Patient's level of pain was assessed using the numeric pain rating scale of 1-10. A comfortable bed free from creases and crumps was made for the client with clean and dry linen. Client was placed in the supine position as his condition permits for adequate relaxation. Proper ventilation was provided and visitors were restricted in order to help client have enough sleeping. Patient was thought to relax in bed and reminisce some pleasant past experience as it could divert his attention off pain and can also induce sleep. Prescribed analgesics 1g of paracetamol suppository was given to combat the Pain and also intravenous ciprofloxacin 400mg was also given to treat the infection.

On 13th November, 2021 at 7:00am, the objective set on the 11th November to help patient be able to sleep continuously for at least, 6 hours during the night within 48 hours was evaluated. Goal was fully met as client's slept for more than 6 hours during the night.

6. **Mr. S.A. nutritional status would be restored (14/11/21).**

On the 12th November, 2021 at 8:00am, patient was served with porridge. He could not consume much of the porridge, according to him he had lost appetite for food. Therefore, a nursing diagnosis of altered nutrition; (less than body requirement) related to loss of appetite was made. An objective was set to enable patient regain and maintain adequate nutritional status within 48 hours. Nursing interventions carried out included; Client was assisted in caring for the mouth by using tooth brush and tooth paste to stimulate his appetite. Client's diet was planned with him and the dietician to ensure he took his favorite as well as balance diet by taking likes and dislikes into consideration. All nauseating items like bed pans, urinals, blood on the floor as well as vomitus were removed. Client's meals were served attractively and in small quantities frequently. Client's mother was always with the client at meal times to help him enjoy his meal. Client was able to tolerate food orally to maintained adequate nutritional status.

On 14th November, 2021 at 8:00am, the objective set on 12th November, 2021 to help patient regain and maintain adequate nutritional status of client within 48 hours was evaluated. Goal fully met as client's nutritional status was improved.

5.2 Amendment of the Nursing Care Plan

With comprehensive individual nursing care rendered to patient, all the goals were fully met. There was no amendment in the care given.

5.3 Termination of care

This forms the last aspect of the interaction with patient and family. Due to psychological effects accompanying separation, it could sometimes lead to anxiety and depression. To avoid this, patient and family were prepared psychologically from the day of admission, during discharge and after discharge.

My third home visit was made on 26th November, 2021.The visit was to ascertain how the patient was doing and whether there was a continuity of those good environmental practice I saw during previous home visits and to also terminate the care. On the said date, I set off early Friday afternoon around 12:00pm with Okada. I got to Mpatapo at around 12:15pm. Patient and family were doing well as they looked cheerful and had no complains. The environment was tidy as there were no rubbish nor stagnant water around. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication. I asked about patient's drugs and it was found that he had been taking his medications and the recommended foods had also been adhered to.

During my interaction with Mr. S.A. and his family, I had communication with the community health nurse at Mpatapo clinic to continue the care for Mr. S.A. I introduced the community health nurse according to custom as tradition demands. I told Mr. S.A. and family members that,

she was the one who was going to take care of him and continue the care and they should give him the maximum support as they always did for me.

I therefore told Mr. S.A. and his family that because I am a student nurse and I will have to go back to campus to continue my education, I cannot stay with them forever. But promised to pay them unofficial visits from time to time or speak with them on phone. I encouraged them to give her the same co-operation they gave me. Since it happened to be my last day of therapeutic relationship with patient and family, I terminated my care and handed over officially to the community health nurse. I thanked them for their cooperation which made my study a success. Again, patient and his family expressed their gratitude by showing how grateful they were to me for the support and care given to them. I sought for permission to leave and it was granted. They escorted me to the roadside where I got an Okada and came back home.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This is the last step of the patient/family care study which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing process in rendering a comprehensive individualized nursing care.

6.1 Summary of care rendered

The subject for the study, Mr. S. A. is a twenty-two-year-old man. He was born on the 18th November, 1999 and a Ghanaian who hails from Gyaaman-South in the Bono region of Ghana.

Client was admitted to the surgical ward of Holy Family Hospital, Berekum on 9th November, 2021 at 11:50 am per wheel chair accompanied by a staff nurse and his parents, through the Emergency Unit with diagnosis of peritonitis.

He was booked for surgical operation (laparotomy) on the following day which was on the 10th November, 2021. The family were psychologically prepared. On 10th November 2021, final preoperative preparation for the surgery was done and patient was sent to the theatre for laparotomy. Patient was received from the theatre successfully at the surgical ward at 12:10pm on a stretcher. He was received in a semi- conscious state as he was sedated during the surgery with an intravenous infusion (normal saline) running. Immediate post-operative management were done for patient until he became stable.

He spent a total of six (6) days at the hospital. During his period of hospitalization, six (6) health problem were identified pre operatively and post – operatively. The health problem identified were as fellows; abdominal pain, fever, insomnia, risk for wound infection, nausea and vomiting

and loss of appetite. Nursing diagnoses were made for each of the problem identified and objective/outcome criteria set to help solve the health problem of Mr. S.A. and his family.

During routine ward rounds on 14th November 2021, patient was discharged since his condition had improved tremendously and he had no complains. Patient was asked to come for review in a week time (19th November 2021). Patient reported on the said date for review as scheduled. Three home visits were embarked on. The first home visit was done while patient was still on admission on 11th November, 2021, second home visit was on the 17th November, 2021. The care of Mr. S.A. and his family were terminated on the 26th November, 2021, during the third home visit when patient had fully recovered.

6.2 Conclusion

In a nutshell, through this care study, I have really gained a lot of knowledge on the condition peritonitis, not only have I gained additional knowledge, it has also widened my practical horizon in the aspect of nursing management of peritonitis since this study offered me the opportunity to practicalized what I studied in class. This study has also enabled me put into practice most of the things that I have learnt during my training as a nursing student. It has also enabled me understand a family's attitudes towards illness and behaviors of individuals when they fall sick.

My recommendation is that, all patients be given individualized, holistic, comprehensive and competent nursing care to help decrease re-occurrences of diseases in our hospitals as well as reducing mortality rate, preventing disease, prolonging life and promoting physical health and efficiency.

I hope and believe that the additional knowledge and experience I have acquired while nursing Mr. S.A. and his family would help me offer expert and comprehensive nursing care to other patients in the health setting and the community as a whole.

Also, it is my recommendation that all student be given the opportunity to embark on the patient and family care study in order to render individualized comprehensive nursing care to patient and families.

APPENDIX

DATE	TIME	TEMPERATURE (^{O}C)	PULSE (bpm)	RESPIRATION (cpm)	BLOOD PRESSURE (mmHg)
09/11/2021	11:50am	38.2	115	30	130/70
	6:00pm	38.3	70	18	110/60
	10:00pm	37.5	62	17	120/80
10/11/2021	6:00am	36.2	87	21	120/90
	10:00am	Patient was at the theatre at this time.			
	2:00pm	38.7	96	24	120/80
	6:00pm	36.3	82	22	120/80
	10:00pm	37.3	66	22	120/90
11/11/2021	6:00am	36.1	100	25	110/90
	10:00am	37.1	96	28	130/90
	2:00pm	37.0	93	24	110/90
	6:00pm	36.5	90	23	120/70
	10:00pm	Not checked.			
12/11/2021	6:00am	36.1	81	20	110/70

	10:00am	36.9	85	20	120/80
	2:00pm	36.8	96	24	120/80
	6:00pm	36.0	84	26	110/90
	10:00pm	36.6	72	20	110/80
13/11/2021	6:00am	36.9	91	22	120/80
	10:00am	36.9	94	19	120/80
	02:00pm	36.1	84	20	120/80
	06:00pm	36.4	85	19	120/70
	10:00pm	36.1	88	21	125/80
14/11/2021	6am	36.2	72	24	100/70

BIBLIOGRAPHY

Charold-L. Baer (1997) *Nurses' Drug Guide*, 9th Edition, Springhouse Corporation Springhouse.

Donna, D, Hausman, K. A. Ignatius, R. O. (2007), *Clinical Companion for Medical-Surgical Nursing* 4th Edition. W. B. Saunders Company. Philadelphia.

Joyce – M. Black (2005) *Medical and Surgical Nursing* 6th Edition, WB Saunders Company.

Skidmore, M. (2005), Mosby's Drug Guide for Nurses, 6th Edition, Elsevier Mosby. St. Louis.

Smeltzer, C. S and Bare BG (1992), Brunner and Saddarth's *Textbook of medical and surgical nursing*, (7th Edition), JB Lippincott company, Philadelphia.

Waugh, A and Grant, A. (2001), Rossand Wilson *Anatomy and physiology in health and illness*,10th Edition, churchil Livingstone Company London.

Weller F. Barbara (2005), Baillière's*Nurses Dictionary*, 24th Edition, Baillière, Tindall London.

Luckmann's (2006). *Core Principle and Practice of Medical-Surgical Nursing.* , 8th Ed. U.S.A W.B Sanders company, pg 1084, 1085, 1006.

Myers, G. (2003). *Mosby's Nursing Care Plan* (5th edition) Philadelphia. Elsevier Mosby Company.

Shafer, Sawyer, McCluskey, Beck Phipps (2004), *Medical -Surgical Nursing*, 6th Ed. Saint Louis. The C.V Mosby Company.

SIGNATORIES

1. **STUDENT NURSE**

NAME: EFFAH GODFRED

SIGNATURE.....

DATE..... 07/10/2022

2. **THE SUPERVISOR, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE**

NAME: MS. RITA AGYEI BOAKYE

SIGNATURE.....

DATE..... 07/10/2022

3. **NURSE-IN-CHARGE OF SURGICAL WARD, HOLY FAMILY HOSPITAL BEREKUM**

NAME: ELIZABETH OBENG POMAA

SIGNATURE.....

DATE..... 07/10/2022

4. **THE PRINCIPAL HOLY FAMILY NURSING ANG MIDWIFERY TRAINING COLLEGE**

NAME: MONICA NKRUMAH

SIGNATURE.....

DATE..... 10/10/2022

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUM