HOLY FAMILY NURSING AND MIDWIFERY TRAINING

COLLEGE, BEREKUM

A PATIENT/FAMILY CARE STUDY ON SCROTAL HERNIA

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

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PREFACE

Modern nursing is a profession that requires knowledge, skills and attitude. The ability to render comprehensive nursing care rests on the nurses' ability to assess the client's condition, analysis, plan, implement and evaluate the effects of management on client health status. Patient/family care study is a report of nursing care rendered to patient and her family. It involves interaction between patient/family, his community and members of the health team. This study is done in partial fulfillment of the award of professional certificate/diploma by Nursing and Midwifery Council of Ghana after a three-year basic nursing training. This study enables the nurse to use scientific advances to provide quality personalized human care base on the holistic care and patient centered approach of nursing care using the nursing process. The student nurse acquires advance knowledge and experience, he/she internalize this thinking process and develops an initiative grasp of patient's situation. This approach forms the basis for learning nursing practice and for making decisions about nursing care. Nursing process is a deliberate and systematic way of identifying and solving client problems meeting the nursing needs of the client, that is, the holistic care of the patient using the nursing process. Patient/family care study forms part of the assessment of every final year nursing student. It is therefore a must for every candidate in order to partially fulfill the award of license to practice as a Professional Registered General Nurse. The patient/ family care study is a comprehensive account of the nursing care rendered to the patient and family from the day of admission through to the day of discharge, review and follow-up visits. Confidentiality is achieved by the use of patient/family initials instead of their full names. The comprehensive care rendered was made possible through the knowledge and skills in disciplines like Psychology, Public Health Nursing, Medical and Surgical Nursing, Pharmacology and Nutrition and Dietetics to meet the patient/family needs and the community at large.

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God richly bless us all.

INTRODUCTION

The patient and family care study is a study conducted on patient/family using the nursing process to nursing the patient and family as an individual, taking into account all the needs of the patient needs to arrive at a desired outcome. It also takes into account of patient's psychological and social needs in planning the care.

This care is about Mr. D.N.N., a 57-year-old man diagnosed of lower Right scrotal hernia. Mr. D.N.N. was admitted into the Male Surgical ward on Tuesday 9th November, 2021 at 4:30pm accompanied by wife in a conscious and ambulatory state, through the Out Patient Department of the Regional Hospital, Sunyani with the diagnosis of lower Right scrotal hernia. Routine care such as maintenance of personal hygiene, monitoring of vital signs, wound dressing, feeding, pain management, education on condition and administration of drugs were carried out successfully.

The following diagnostic investigations were done on the patient; Full Blood Count, Blood for grouping and cross matching and Blood for renal function test and electrolytes

The following drugs were used in the treatment of the condition both preoperatively and postoperatively: Sodium Chloride infusion 0.9% (500ml) 2liters x 48 hours, Dextrose 5% infusion (500ml) 2liters x 48 hours, Ringers lactate solution (500ml) 1.5liters x 48 hours, Injection Amoxiclav 1.2g bd for 48hours, Intravenous Metronidazole 500mg tds × 48hours, Injection Pethidine 50mg qid × 24 hours and Suppository Diclofenac 100mg bid × 48 hours.

The discharge planning started from the day of admission till the actual day of discharge on 14th November, 2021. During discharge the following drugs were given: Tablet Ciprofloxacin 500mg bd x 5 days**,** Tablet Metronidazole 400mg tds x 5days**,** Tablet Zincovit once daily x 30 days and Suppository Diclofenac 100mg bd x 3 days.

Six health problems were identified. Objectives were set, nursing orders were implemented for the identified health problems and some of the nursing interventions carried out were reassurance, monitoring, adequate ventilation, thorough education on the disease condition, introduction of patient and family to patients with similar conditions who were doing well and drugs administration which includes, intravenous fluids, analgesics and antibiotics as prescribed by the physician and goals were fully met. Recovery was satisfactory postoperatively.

Three home visits were conducted. First, second and third home visits were conducted on the 11th November, 2021, 20th November, 2021 and 30th November, 2021 respectively. He came for reviewed on the 22nd November, 2021 at the Out Patient Department of Regional Hospital Sunyani. The interaction with the patient ended on the last day of visit which was 30th November, 2021.

This care study comprises of six chapters as follows:

Chapter one deals with assessment of Mr. D.N.N and family. This involves collection of data about the patient to identify his problems.

Chapter two deals with analysis of data.

Chapter three comprises the planning phase of the nursing process and has the tabulated plan of care for the stated nursing diagnoses spanning the objective criteria, nursing orders, intervention and evaluation.

Chapter four tackles the actual implementation of the care plan giving summary descriptions of activities which were undertaken from the moment of first contact with the patient at the time of admission to the ward till discharge and subsequent follow up with home visit.

In chapter five, evaluation of nursing care given to the patient and his family from encounter till termination of nurse-patient relationship is discussed.

Chapter six focuses on the summary and conclusion of the care study report by reviewing thematic issues that arose in the care study from admission to last home visit after discharge.

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY

1.0 Introduction

Assessment of patient and family is the first step in the nursing process. Nursing assessment is the gathering of information about a patient's physiological, sociological and spiritual status by a licensed registered nurse (Schreiber, 2017). It is the systematic method of collection of vital information from the patient, relatives, health team and medical note on laboratory investigation report, to determine patient health status and identifying the actual or potential health problems. It deals with the collection of data through observation investigations such as laboratory results and x-ray reports, interviewing and physical examination from which analysis can be made to help in planning and implementation of care. This chapter includes patient's particulars, patient and family medical history and surgical history, patient's socioeconomic history, patient's developmental history, past and present obstetric history and patient's lifestyle. All the information about my patient was gathered from the patient and his wife as well as on the computer system.

1.1 Patient's Particulars

Patient refers to a person who is receiving medical treatment in a hospital (Hornby, 2006). Particulars is defined as details or information about a person, especially when officially recorded (McIntosh, 2013). Mr. D.N.N. is a 57-year-old man, born on 20th September, 1964 to Mr. D.N. and Mrs. M.D. He comes from Sunyani in the Bono region and stays at Kotokrom with house number F/63. He is the second born of four children. He is fair in complexion, weighs 75kg and is 1.6m tall. He is married to Mrs. J.D with two sons and a daughter. His next of kin is his son Mr. E.D.N. Mr. D.N.N is the residence pastor of the Assemblies of God Church Ghana, Kotokrom English Assembly. He started his basic and

junior high education at Roman Catholic Primary and Junior Secondary School at Sunyani and went on to Sunyani Senior Secondary School. After his secondary education he continued at University of Ghana, Legon. He speaks English, Twi, Hausa and Dagbani. Mr. D.N.N. is a National Health Insurance beneficiary. He has no physical impairments or disabilities.

1.2 Family's Medical/Surgical History

Health history is a series of questions used to provide an overview of the patient's current health status. Attention is focused on the impact of psychosocial, ethnic, and cultural background on a person's health. Information is obtained on both paternal and maternal sides of the family (Hinkle & Cheever, 2018). Mr. D.N.N. stated clearly that his grandparents are deceased. They died of old age. According to Mr. D.N.N. his parents and three siblings are alive and healthy. There is a history of hypertension in both his paternal and maternal families. His father is a hypertensive patient who is currently taking anti-hypertensive medications. Aside that there is no other hereditary disorder like diabetes mellitus, asthma, sickle cell, epilepsy nor any mental disorders in the family. However, the relatives who were present during his history taking said that, periodically, they do suffer some ailments like headache, fever and abdominal pains which are treated by self-medication (using both over-the-counter drugs and traditional medicines) but if symptoms persist, they report to the hospital. Based on this information I educated the patient and family about the effects of the use of over-the-counter drugs and urged them to seek medical care from any health center when they are suffering from any condition. He has been hospitalized on two occasions of which one these hospitalizations were on account of left inguinal. The source of medical treatment for Mr. D.N.N. and family are both orthodox and herbal medicine. There are no known allergies in the family.

1.3 Family Socio-Economic History

Socio-economic history captures sources of support, coping styles, strengths, and fears (Bickley & Szilagyi, 2009). Mr. D.N.N's family has a very good relationship and cohesion. Socially the family is not noted for smoking or drinking alcohol. He revealed that some family members are in the public service whiles others are into trading. Family members are always willing to support each other in times of financial hardships. Mr. D.N.N doesn't depend much on his extended family for financial support but rather depends on his salary and his wife. 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 developing (Weller, 2014).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 her mother. Mr. D.N.N indicated that, his mother went through normal pregnancy of nine months gestation without any pregnancy associated disorders and had normal delivery with the help of medical staff at the Municipal Hospital, Sunyani. He was born without any congenital abnormality such as cleft lip or palate, hydrocephalous and undescended testis (cryptorchidism). Mr. D.N.N 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. D.N.N at age fifteen (15), begun 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 Roman Catholic Primary and Junior Secondary School at Sunyani and went on to Sunyani Senior Secondary School. After his secondary education he continued at University of Ghana, Legon. According to the patient, he never experienced any difficulties in learning and was always motivated to study by virtue of his aspirations of becoming an engineer. In 2005, he was ordained as a pastor and was given the mandate to head Kotokrom branch of the Assemblies of God Ghana. He got married at age thirty in 1994 and has given birth to two sons and a daughter.

According to Erikson's theory of psychosocial development in 1964 describes the human life cycle as a series of eight ego developmental stage from birth to death. The theory focuses on psychological task that are accomplished throughout the life cycle in which patient falls under Generativity versus Stagnation (35 to 65); this is when middle adult is concerned with guiding the next generation. When a person makes a contribution during this period, perhaps by raising a family or working toward the betterment of society, sense of generativity; a sense of productivity and accomplishment results. In contrast, a person who is self centered and unable or unwilling to help society move forward develops a feeling of stagnation. I am convinced that patient is in the generativity dimension of Erikson's psychosocial development because of his supportive effort towards the success of his children and family.

1.6 Patient's Lifestyle and Hobbies

Lifestyle is defined as the pattern of daily living that an individual develops (Weller, 2014). Mr. D.N.N usually goes to bed around 10:00pm and wakes up at 3.00am. He empties his bowels, maintains his oral hygiene and takes his bath twice daily with warm water. For breakfast, patient mostly takes "Milo" drink and sometimes porridge with bread. Patient has no known allergy to drugs or any food. Mr. D.N.N.'s favorite food is Banku with okro or groundnut soup. He takes three square meals a day with snacks in-between and fruit as well.

However, he does not smoke nor drink alcohol. By virtue of his job as a pastor, he is mostly occupied with ministerial appointments during the week and weekends. He sits for counselling on Mondays from 9am to 3pm depending on the number of attendants and goes for evening services in the evening from 7pm to 9pm. Morning and evening service continues throughout the week with the exception of Wednesdays which he usually spends at home to have some rest, reads the bible and meditate on the word of God, watch television and spends time with his wife and kids in the evening. He usually attends social activities like weddings and funerals on Saturdays. He also goes to church in the evening to supervise choristers and ushers to prepare towards Sunday service. He usually sleeps late on Saturdays because he studies the word of God and prays for direction from the Holy Spirit. On Sundays after church service, he holds meetings with his church elders for about an hour and gets home around 3pm. His hobbies are studying the word of God, watching television and teaching. He has taken keen interest in football and is a very dedicated fan of Chelsea football club in England. He periodically participates in church youth sporting activities and exercises. He described himself as an introvert who has interest in watching television, reading the bible and teaching in spite of his Job as a pastor. Patient usually uses both verbal and non-verbal communication styles such as eye contact and gestures to register his displeasure when his children go wrong. He dislikes dishonesty. He dislikes dishonesty and all sorts of immoralities but likes generosity and hard work. He gives spiritual and financial support to his family and church members. He also gives advices to his nephews, nieces and subordinate pastors. My personal impression about him is that, he is very benevolent and generous.

1.5 Patient's Past Medical History

Past medical history is a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health (MediLexicon, 2009). Mr. D.N.N. never experienced any childhood illness like whooping cough, poliomyelitis, measles, tetanus,

tuberculosis, and diphtheria and has not identified any allergy to drugs, animals or insects. He revealed that he usually suffers from minor ailments such as diarrhoea, 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. D.N.N said he had never been involved in an accident. Mr. D.N.N also indicated that he never goes for health check-ups unless his ailment becomes difficult to treat with traditional medicine and over the counter medication. His first hospitalization occurred during his university days on the account hernia. He was specifically diagnosed of having left inguinal hernia and it was repaired.

1.6 Patient's Present Medical History

According to Bickley & Szilagyi (2009), History of present illness is a complete, clear, and chronologic account of the problems prompting the patient to seek care.

Patient was well until 2nd November 2021 when he started experiencing scrotal swelling and lower abdominal pains. Patient was brought to the emergency unit of Regional Hospital Sunyani by his wife on the 2nd November 2021 at about 11:20am where he was diagnosed of Right Inguino-Scrotal Hernia after assessment. He was given the following treatment; Tablet Paracetamol, Tablet Buscopan and was booked for surgery on the 11th of November 2021. Mr. D.N.N. was ask to go home and come back on Tuesday, 9th November 2021 for admission.

1.7 Admission of the Patient

As specified in Esena (2011) admission is "The initiation of care, usually referring to inpatient care". Mr. D.N.N. was admitted into the Male Surgical ward on Tuesday 9th of November, 2021 at 4:30pm accompanied by wife in a conscious and ambulatory state, through the Out Patient Department of the Regional Hospital, Sunyani with the diagnosis of

lower Right scrotal hernia. Patient had a history of scrotal swelling associated with pain in the abdomen. The patient and his wife were welcomed. It was a planned admission. I personally collected the patient's particulars. The patient's identity was verified by mentioning his name for him to respond. He was then warmly welcomed and immediately made comfortable in an admission bed. His particulars such as name, sex, age, and residential address were entered into the admission and discharge book and the daily ward state. Vital signs were checked and recorded accurately as follows:

1. Temperature 36.0^{o}C
2. Pulse 80bpm
3. Respiration 22cpm
4. Blood Pressure 120/70mm/Hg

It was realised that patient's was anxious because of his impending surgery hence he was reassured to allay all fears and anxiety and was made to relax in bed. Physical examination on the patient was performed from head to toe and patient was observed to have swollen groin.

The following treatment plan were ordered preoperatively:

1. Sodium Chloride infusion 0.9% (500ml) 2liters x 48 hours
2. Dextrose5% infusion (500ml) 2liters x 48 hours
3. Ringers lactate solution (500ml) 1.5liters x 48 hours

Investigations ordered included:

1. Full Blood Count
2. Blood for grouping and cross matching

3. Renal function test

Blood sample was taken, labelled with all requisite information and sent to the laboratory for investigations. The time vital signs will be checked were explained to patient and relatives present. Hospital policies regarding visiting periods and payment of bills were explained to the patient and relatives. Patient relatives were told to visit patient between the hours of 5:30am to 6:30am in the morning and 5:00pm to 6:00pm in the evening. They were made to understand that the NHIS only supports few aspects of the healthcare he was receiving and for that reason majority of the payments will need to be made before drugs can be issued to him. Patient was properly oriented to the ward environment and its annexes. His wife was told to bring Mr. D.N.N. pyjamas and cup for drinking water in addition to his towel, sponge, tooth paste and brush and other toiletries. His property and valuables were kept by his wife since the ward does not have a room for keeping those valuables. Patient was then introduced to the other patients who were on the ward. He was introduced to the staffs present and was assured of competent healthcare team. 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. D.N.N. and his wife were 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 and his wife 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 event. Mr. D.N.N. and his wife 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. I decided to choose this patient for the study because I wanted to know more about the condition and how they become large and cause problems in some individuals.

1.8 Patient's Concepts about His Illness

Mr. D.N.N. did not accredit his illness to any spiritual cause in spite of his spiritual believes as a pastor. He was of the view that some conditions like epilepsy other mental disorders can have spiritual implications. However, he was worried about the possible complications like strangulation but have hope that the treatment regimen been laid down for him by the medical and surgical team will solve his problem just like before. He is expecting to get better and return to his normal duties.

1.9 Literature Review on Hernia

Definition

A hernia is the abnormal protrusion of an organ or tissue outside its normal body cavity or constraining sheath (Kendall, Shiu, & Johnston, 2018).

A hernia is a protrusion of the viscus (internal organ such as the intestine) through an abnormal opening or a weakened area in the wall of the cavity in which it is normally contained. A hernia may occur in any part of the body, but it usually occurs within the abdominal cavity (Lewis, et al., 2014). Hernias that easily return to the abdominal cavity are called reducible (Lewis, et al., 2014).

Types

According to Lewis et al., (2014), the following are types of hernia;

1. Inguinal hernia is the most common type of hernia and occurs at the point of weakness in the abdominal wall where the spermatic cord (in men) or the round ligament (in women) emerges. Inguinal hernias are more common in men (Lewis, et al., 2014).

a. Indirect inguinal hernia: An indirect inguinal hernia is a sac formed from the peritoneum that contains a portion of the intestine. The hernia pushes downward at an angle into the inguinal canal. In males, indirect inguinal hernias can become large and often descend into the scrotum (Ignatavicius & Workman, 2013).
b. Direct inguinal hernia: Direct inguinal hernias, in contrast, pass through a weak point in the abdominal wall (Ignatavicius & Workman, 2013).

2. Femoral hernia occurs when there is a protrusion through the femoral ring into the femoral canal. It appears as a bulge below the inguinal ligament. It easily becomes strangulated. It occurs more often in women (Lewis, et al., 2014).
3. The umbilical hernia occurs when the rectus muscle is weak (as with obesity) or the umbilical opening fails to close after birth (Lewis, et al., 2014).
4. Ventral or incisional hernias are due to weakness of the abdominal wall at the site of a previous incision. They occur most commonly in patients who are obese, have had multiple surgical procedures in the same area, or have had inadequate wound healing because of poor nutrition or infection (Lewis, et al., 2014).
5. Hiatal hernia is a condition in which the lower part of the esophagus and stomach passes through a hiatus (opening in the diaphragm) into the thorax. The most common type is a sliding hiatus in which the stomach slides proximally into the thorax cavity when a client lays supine and then will return into the abdominal cavity once a client stands (White, Duncan, & Baumle, 2013).

Parts Abdominal Hernia

The hernia has three parts: the orifice through which it herniates, the hernia sac, and its contents (Lewis, et al., 2014).

1. The sac: It's an out pouch of the peritoneum; the neck of the sac may be broad, permitting internal organ to slip in and out of the sac. The neck may also be narrow and surrounded by a dense fibrous tissue.
2. The content: An abdominal hernia sac may contain a loop of small intestines, caecum, omentum, appendix, ovary or occasionally the bladder.
3. The ring: The hernia ring is of a muscular or fibrous tissue that forms on opening into the sac.

Classification

Hernia can be classified according to the severity of the protrusion. These include;

1. Irreducible hernia: is one that cannot be reduced by placing back either manipulation or by any manual method; it is by only surgical means. If the hernia cannot be placed back into the abdominal cavity, it is known as irreducible or incarcerated (Lewis, et al., 2014).
2. Incarcerated hernia: is when the hernia becomes both irreducible and obstructed, this condition eventually leads to obstructed blood flow to or from the viscose (Lewis, et al., 2014).
3. Strangulated: When the hernia is irreducible and the intestinal flow and blood supply are obstructed, the hernia is strangulated. The result is an acute intestinal obstruction (Lewis, et al., 2014).

Incidence

Inguinal hernias are more common in men. Femoral hernia occurs more often in women (Lewis, et al., 2014). 85% occur in males, with a lifetime risk of 1 in 4 males, but less than 1 in 20 females. They increase with age (Kendall, et al., 2018).

Aetiology

As mentioned by Kendall et al., (2018), the causes of hernia include the following;

1. Congenital malformation
2. Incisional hernias occur at weakened areas caused by surgical incisions and muscle splitting
3. Femoral hernias are due to a weakness of the femoral sheath
4. Direct inguinal hernias occur as a result of weakness in the floor of the inguinal canal
5. Acquired: Muscular weakness may result as a result of trauma or aging.

Predisposing Factors

According to Hinkle and Cheever (2018), It increase intra-abdominal pressure such as;

1. Persistent or chronic cough
2. Straining associated with the use of incorrect technique when lifting weight or heavy objects
3. Constant blowing of wind instrument e.g. Trumpet flute etc.
4. Pushing or pulling
5. Pregnancy
6. Obesity
7. Chronic constipation
8. Enlarging tumors or lesions

Pathophysiology

Congenital hernias exploit natural openings and weaknesses. They may not become obvious until later in life and may be predisposed to by coughing straining, lifting, trauma or weak musculature. Examples of hernias include inguinal (direct and indirect), femoral, paraumbilical, umbilical and ventral hernias (Kendall, et al., 2018).

Clinical Manifestation

According to (Mayo Clinic, 2021), the following are signs and symptoms of inguinal hernia;

1. A bulge in the area on either side of the pubic pone
2. A burning sensation at the bulge
3. Pain in the groin
4. Heavy sensation in the groin
5. Pressure in the groin
6. Pain and swelling around the testicles

As mentioned by Lewis et al., (2014), If the hernia becomes strangulated, the patient will have severe pain and symptoms of a bowel obstruction such as;

7. Vomiting
8. Cramping abdominal pain and
9. Abdominal distention

Diagnostic Investigations

1. These are rarely necessary to make the diagnosis, although imaging such as ultrasound is sometimes used (Kendall, et al., 2018).
2. Diagnosis is confirmed by x-ray studies (Hinkle & Cheever, 2018).
3. Patient history (Lewis, et al., 2014)
4. Physical examination (Mayo Clinic, 2021).

Specific Medical and Surgical Treatment

Medical Treatment

Lewis et al., (2014), outline the following as medical treatment of hernia. Although hernia is a surgical condition, other treatment can also be carried out if for any reason the surgery cannot be done.

1. Antibiotics are given to prevent or stop any susceptible bacterial infection before or after surgical treatment.
2. Analgesic such as pethidine to relieve pain. Anti-inflammatory analgesics such as acetaminophen, tablet Ibuprofen, diclofenac is given to counter inflammation and help relieve pain.
3. Intravenous fluids are given before and after surgical treatment

Specific Surgical Treatment

Inguinal hernias should be repaired surgically unless there are specific contraindications; both open and laparoscopic approaches are commonly used (Doherty, 2015). Lewis et al., (2014) outline the following surgical treatment;

1. Herniotomy: This is the removal of the hernia sac. This operation involves opening the hernia sac and reducing its content into the abdominal cavity. The sac is then tied off and excised.
2. Herniorrhaphy: This is the removal of the sac and repair of the weakened abdominal wall with a non-absorbable suture. It is the preferred surgical treatment for infants, adult and elderly patient.
3. Hernioplasty: This is plastic repair of the weakened abdominal wall after reducing the hernia using synthetic sutures such as wire, steel mesh etc.

Note: Strangulated hernias are treated immediately with resection of the involved area or a temporary colostomy so that necrosis and gangrene do not occur (Lewis, et al., 2014).

Complications

1. Irreducibility: The hernia contents cannot be completely return to the abdomen. It is often due to adhesion between the sack and the contents. Loops of bowel may also

adhere a mass too bulky to return through the narrowed hernia orifice (Kendall, et al., 2018).

2. Strangulation: blood supply to the hernia sack is obstructed by constriction at the neck of the sack that prevents blood supply to the bowel (Kendall, et al., 2018).
3. Fistula formation: Abscess forms, the sack later ruptures on the skin to form a fistula.
4. Gangrene and perforation: If the constriction is not relieved immediately, the bowel becomes gangrenous and then perforates.
5. Intestinal obstruction: Strangulated internal hernia is the commonest cause of intestinal obstruction.

Nursing Management

Providing Preoperative Care

Psychological preparation

1. The nurse assesses the patient's level of anxiety and reassures her that she was in the hands of competent and well-trained staff that are always ready to offer care and support to ensure good health.
2. She must be introduced to other patients who have similar condition and have recovered.
3. Reassuring relatives that all necessary procedures will be done for her, to speed up her recovery.
4. Explain to patient what happens during anaesthesia
5. Diversional activities such as watching of televisions and the use of slide pictures should be provided to divert patients mind from the impending surgery.

6. Explain to patient on how to get rid of post operatively pain by the use of post-operative analgesics following recovery from anaesthesia.
7. Appropriate information is provided at the patient's level of understanding, all questions are answered, and the patient is encouraged to express fears openly. Explaining diagnostic tests and administering medications on schedule also help to reduce anxiety.
8. The nurse interacts with the patient in a relaxed manner, and relaxation methods, such as biofeedback, hypnosis, or behavior modification.
9. Explain to the patient the possible necessity to be place on hormonal therapy that may extend throughout her life following removal of the thyroid gland (especially if it is total removal).
10. The patient's family is also encouraged to participate in care and to provide emotional support.
11. The nurse also informs the patient about the purpose of preoperative tests, if they are to be performed, and explains what preoperative preparations to expect.

Physical preparation

Position

Patient should be made comfortable on a well-prepared admission bed with enough pillows for comfort. Patient should be encouraged to assume a normal position that was not contrary to her health example supine position. This helps the patient to relax and reduce pain.

Rest and sleep

1. A quiet environment needs to be provided by reducing noise to allow patient to get enough rest.
2. Windows should be opened to allow ventilation.
3. Visitors should be restricted to allow patient gets enough rest and sleep.
4. Bed should be made free from creases and cramps by straighten the bed linen.
5. Warm beverages should be served.
6. Warm bath should be given in order to relax patient and to induce sleep.
7. Teach patient rest and relaxation techniques e.g., guided imagery emphasizes the need to avoid stress.

Personal hygiene

1. Body hygiene is done by giving an assisted bed bath twice daily with warm water, soap, sponge and towel to prevent offensive odour and to remove microorganisms from the skin.
2. Bony prominences, which are prone to be sore, are well cared for by treating the area to prevent bedsore.
3. Soiled and dirty bed linens are also changed when to prevent bad odour and harboring of microorganisms.
4. Oral hygiene is also done twice daily with toothpaste and toothbrush. This help to prevent oral offensive smell and to prevent the harboring of pathogenic microbes.
5. The hair is also cared for by washing it with soap and water and drying it with a towel.

6. Patient’s hands and feet should be cared for by soaking them in water and trimming the nails with nail clippers, washing and filing the nails. This will prevent harboring of microbes or prevent injury from scratching.

Nutrition / Diet

1. As a rule, Patient is not allowed to drink or eat anything the night before the surgery.
2. Patient should be educated on the importance of eating a diet high in carbohydrates, vitamins and proteins.
3. Patient should be reminded to avoid tea, coffee, cola, and other stimulants.
4. Smoking should be avoided.
5. Patient is encouraged to take enough roughage to enhance bowel elimination.
6. Vitamin and minerals such as fruits like orange, banana, pawpaw should be encouraged to boost up the immune system

Observation

1. Vital signs should be checked and recorded which comprises of temperature, pulse, respiration and blood pressure.
2. Intake and output chart should be placed at bedside to help monitor fluids intake and output of patient.
3. The desired effect and side effect of drugs served should be observed and reported.
4. Physical findings of epigastric or abdominal pain, nausea, vomiting, black tarry stool and any form of bleeding from the GIT should be observed.

5. Patient's response to medication therapy, nutritional therapy and emotional rest must be observed.

Prosthesis and jewelry

1. Ask the patient to remove dentures, contact lenses and artificial limbs.
2. Place all items in a container labelled with the patient's name and folder number
3. Place a piece of adhesive strapping around wedding rings if it cannot be removed
4. Jewelry should not be stored in the bedside locker but must be given to a relative on approval by patient.

Exercise

1. Unless in emergency surgery, teach and encouraged patient to carry out various forms of exercises as permitted by their conditions:
    - Passive/active range of motion exercises
    - Early ambulation
    - Deep breathing
    - Coughing exercises

Physiological preparation

1. Conduct head to toe examination
2. Obtain past and present medical history in order to exclude: Bleeding tendencies, Chronic conditions, Drug reaction, Previous operations, etc.
3. Constantly check and record patient's vital signs
4. Carry out basic laboratory investigations
5. Collect other baseline data: Electrocardiogram, scan results, X-ray, etc
6. Arrange for blood donors
7. Continuously administer and monitor prescribed IV fluids

8. Assess for any skin abnormalities.
9. Weigh patient to provide baseline parameters for reference.
10. Monitor intake and output chart if the patient is on IV infusion.
11. Encourage patient to empty the bladder
12. If possible, insert urinary catheter and monitor urine output.
13. Administer prescribed preoperative medication

Postoperative care

1. Prepare post-anaesthetic bed to receive patient after surgery.
2. Position patient in a semi-fowlers position after anaesthesia has worn off
3. Support head and neck with sandbags or small pillows
4. Assemble all necessary equipment needed for resuscitation of the patient at the bedside.
5. Ensure you are receiving a live patient
6. Connect all tubes and ensure that they are functioning properly.
7. Receive patient properly by reading through the postoperative notes for special information
8. A scrotal support with application of an ice bag may help relieve pain and edema. Encourage deep breathing, but not coughing.
9. Teach patients to splint the incision and keep their mouths open when coughing or sneezing are unavoidable.
10. The patient may be restricted from heavy lifting for 6 to 8 weeks.

Maintenance of airway

1. The patient should not be left alone until the cough reflex returns.

2. Put patient in the recumbent position with head turned to one side to avoid the tongue from falling back and obstructing the airway. This position will also avoid aspiration of vomitus.
3. Observe patient closely for secretions and suction as and when necessary.

Post-op observation

1. Check the operation site for bleeding, discharge, etc.
2. Observe for signs and symptoms of internal bleeding such as restlessness, falling blood pressure, cyanosis and thirst.
3. Monitor and record patient's vital sign: Every15 mins for 2hrs, 30 mins for 1hr and then hourly until the patient's condition stabilizes. Remember to report any deviation.
4. Observe the patient for swallowing reflexes. If absent, keep patient in lateral position.
5. Monitor intravenous infusions if any and maintain intake and output chart
6. Observe progress of the patient and report findings.
7. Observe for signs of hypoglycaemia or hyperglycaemia.

Protection from injury

1. Never leave patient alone to prevent injuries from falls.
2. Patients especially those under general anaesthesia should have their beds protected with well-padded side rails.
3. Hot water bottles or heat lamps must be used with care to avoid burns
4. If infusions are being given, secure patient arms by splinting to prevent the cannula from dislodging.
5. Adequate light should be provided at the ward.
6. When the patient gains consciousness, allow him/her to turn in bed, sit up, stand by bed before walking to prevent falls.

Wound care

1. Immediately observe wound for signs of bleeding and infection (any offensive odour, discharge, pus) or signs of wound gaping.
2. Aseptically reinforce dressing if there is bleeding and inform surgical team.
3. Use aseptic technique to change dressing as directed by the surgeon.
4. Dress the wound from inside out to prevent wound contamination.
5. Educate patient to keep the wound dry and not to be touching it to prevent infection.
6. Encourage patient to take in high protein diet with vitamins especially vitamin C to promote wound healing and repair of worn out tissues.
7. Follow surgeon directives as to when alternate stitches are to be removed.

Post-op education

1. Maintenance of personal hygiene
2. Ambulation; restricted as well as permitted activities.
3. Any adjustments to be made in patient's occupation.
4. Drugs; the side effects and precautions.
5. Date to resume active activities.
6. Follow-up care or review schedule.
7. Home care
8. Future treatment needed for the patient e.g. hormonal therapy

Postoperative Complications

Brooks (2020), mentioned the following as the postoperative complications of hernia repair;

1. Hematoma
2. Bladder injury
3. Urinary retention

4. Infection of surgical site
5. Sexual dysfunction or sexual pain
6. Recurrent hernia

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. Also, the patient's folder provided the information to confirm the data collected. With reference to the data collected, signs and symptoms which patient presented are the actual clinical features of inguino-scrotal hernia as confirmed by the literature review of the condition. Data collected from the patient and relatives were cross checked with patient records, laboratory investigation and assessment. After collecting all this information, I realized that the data collected were similar and so considered valid for the study.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is a statistic that measures differences among group means and uses a statistical technique to equate the groups under study in relation to another given variable (Weller, 2014). Analysis of data is the second stage of the nursing process, and it involves grouping the information collected at the assessment phase in simpler components. This allows an individual to come out with a conclusion about the patient health needs. The patient and family strengths are also identified and this forms a guide to arrive at a nursing diagnosis and to give appropriate care to the patient.

2.1 Comparison of Data with Standards

This is where the data collected on the health of the patient is compared with those in the literature review. These include diagnostic investigations, causes, signs and symptoms, treatment and complication

A. Diagnostic Investigation/Tests

Diagnosis is the determination of the nature of a disease and Test is defined as an examination or trial. Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment (Weller, 2014).

The following diagnostic investigations were done on the patient;

1. Full Blood Count
2. Blood for grouping and cross matching
3. Blood for renal function test and electrolytes

Table 2. 1: Diagnostic tests/investigation in literature review compared with those carried out on patient

Diagnostic tests carried out in literature review	Diagnostic tests carried out on patient
1. Ultrasound	1. Ultrasound was not done
2. X-ray studies	2. X-ray studies was not done
3. Patient history	3. History was taken
4. Physical examination	4. Physical examination was done

With reference to the table ultrasound and x-ray studies were not carried out because the diagnoses were arrived at and confirmed by patient history and physical Examination.

Full blood count was done in other to ensure patient had an acceptable level of hemoglobin (Hb) required for him to undergo the surgery. Blood grouping and cross matching was done because patient went into surgery and it is a protocol for all patient going into surgery. Renal function test was done because inguinoscrotal bladder hernias may be associated with severe medical condition such as renal deterioration.

Table 2. 2: Results of Diagnostic investigations carried Out on Patient

Ordered Date	**Specimen**	**Investigations**	**Results**	**Normal values**	**Interpretation**	**Remarks**
09/11/21	Blood	**Full Blood Count** Haemoglobin	13.9g/Dl	**Males:** 14 g/dL -17.5g/dL **Females:** 11.3 g/dL -15.3g/dL	Normal	No treatment given
		Platelet	$351x10^9$/L	$140\ x10^9$/L - $440\ x10^9$/L	Normal	No treatment given
		Red Blood Cell	$5.27x10^{12}$/L	**Males:** $4.5\ x10^{12}$/L -$5.9\ x10^{12}$/L **Females:** $4.1\ x10^{12}$/L-$5.1\ x10^{12}$/L	Normal	No treatment given
		White Blood Cell	$5.90x10^9$/L	$4.5\ x10^9$/L -$10.0\ x10^9$/L	Normal	No treatment given
09/11/21	Blood	Grouping and Cross matching	O positive	A (+/-) B (+/-) AB (+/-) O (+/-)	Patient has blood group O+	Not Applicable

Table 2.2: Results of Diagnostic investigations carried Out on Patient Cont'd…

Ordered Date	Specimen	Investigations	Results	Normal values	Interpretation	Remarks
09/11/21	Blood	**Renal Function Test**				
		Sodium	142.2 mEq/L	135-145 mEq/L	The kidneys are	No treatment given
		Potassium	4.2 mEq/L	3.5-5.0 mEq/L	functioning really well.	
		Chloride	105 mEq/L	97-107 mEq/L		
		Creatinine	1.1 mg/dL	0.7-1.4 mg/dL		
		Urea	8.08 mmol/L	2.50-8.30 mmol/L		

B. Causes of Patient's Condition

With references to the literature review on the causes and diagnostic investigations including patient's history. The exact cause of patient's condition could be as a result of weakness in the floor of the inguinal canal

C. Clinical Features/ Signs and Symptoms

Table 2. 3: Clinical Features of patient Compared with those in the Literature Review

Clinical Features in Literature Review	**Clinical Features Exhibited by Patient**
1. Bulge in the area of the pubic pone	1. There was a bulge in the area (right side)
2. Burning sensation at the bulge	2. Patient complained of a burning sensation at the bulge
3. Pain in the groin	3. Patient complained of groin pain
4. Heavy sensation in the groin	4. Patient complained of heavy sensation in the groin
5. Pressure in the groin	5. Patient reported of pressure in the groin
6. Pain and swelling around the testicles	6. Patient complained of pain and swelling around the testicles
7. Vomiting	7. Patient did not vomit
8. Cramping abdominal pain	8. Patient did not complain of cramping abdominal pain
9. Abdominal distention	9. Patient did not complain of abdominal distention

With reference to table 2.3, patient was truly having right inguinoscrotal hernia since he exhibited most of the clinical manifestations of the condition

D. Specific Treatment Given to Patient

According to Weller (2014), Treatment refers to the mode of dealing with a patient or disease. The following drugs were used in the treatment of the condition both preoperatively and postoperatively:

Drugs ordered preoperatively:

4. Sodium Chloride infusion 0.9% (500ml) 2liters x 48 hours
5. Dextrose 5% infusion (500ml) 2liters x 48 hours
6. Ringers lactate solution (500ml) 1.5liters x 48 hours

Drugs ordered postoperatively:

1. Injection Amoxiclav 1.2g bd for 48hours
2. Intravenous Metronidazole 500mg tds × 48hours
3. Injection Pethidine 50mg qid × 24 hours
4. Suppository Diclofenac 100mg bid × 48 hours

Discharge Drugs

1. Tablet Ciprofloxacin 500mg bd x 5 days
2. Tablet Metronidazole 400mg tds x 5days
3. Tablet Zincovit once daily x 30 days
4. Suppository Diclofenac 100mg bd x 3 days.

Table 2. 4: Treatment Given to Patient as Compared with Literature Review

Treatment as in literature review	**Treatment given to patient**
1. Antibiotics such as Ciprofloxacin, Cefuroxime and Metronidazole	1. Antibiotics were given: • Injection Amoxiclav 1.2g bd for 48hours • Intravenous Metronidazole 500mg tds × 48hours • Tablet Ciprofloxacin 500mg bd x 5 days • Tablet Metronidazole 400mg tds x 5days
2. Analgesic such as pethidine	2. Analgesics were given: • Injection Pethidine 50mg qid × 24 hours • Suppository Diclofenac 100mg bid × 48 hours • Suppository Diclofenac 100mg bd x 3 days
3. Fluid resuscitation	3. Intravenous fluids were given • Sodium Chloride infusion 0.9% (500ml) 2liters x 48 hours • Dextrose 5% infusion (500ml) 2liters x 48 hours • Ringers lactate solution (500ml) 1.5liters x 48 hours
4. Surgery such as herniotomy, herniorrhaphy and hernioplasty	4. Herniorrhaphy was done
5. Haematinics was not in literature review	5. Haematinics was given: • Tablet Zincovit once daily x 30 days

From the above table, comparison of drugs in the literature review with drugs given to patient, the treatments given to patient were in line with the literature. Haematinics such as Tablet Zincovit was given to prevent any postoperative anaemia.

Table 2. 5: Pharmacology of Drugs Administered to Patient

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
09/11/21	Intravenous normal saline (0.9%)	**Dosage** Amount depends on patient's fluid and electrolyte level. **Route** Intravenously	**Dosage** 2 litres for 48 hours **Route** Intravenously	Isotonic solution	To correct fluid and electrolyte imbalance	Patient's body fluids and electrolytes were raised	over hydration, hypocalcaemia. None of these side effects were observed.
09/11/20	Ringers lactate solution	**Dosage** Amount depends on patient's fluid and electrolyte level. **Route** Intravenously	**Dosage** 1.5 litres for 48 hours **Route** Intravenously	Crystalloid (Isotonic solution)	Restores normal fluid and electrolyte balance especially bicarbonates	Patient was provided with the needed body fluid and electrolyte	Over hydration, hypocalcaemia, alkalosis None of these side effects were observed.

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
09/11/21	Dextrose 5% infusion	**Dosage** Amount depends on patient's fluid and electrolyte level. **Route** Intravenously	**Dosage** 2 liters for 48 hours **Route** Intravenously	Hypertonic solution	To replace lost fluids and provide calories to the body	Patient provided with the needed calories	High blood sugar, dry skin, stomach upset None was observed in patient
12/11/21	Amoxicillin + Clavulanic Acid (Co-Amoxiclav)	**Dosage** 1.2g every twelve hours for 1 day **Route** Oral and Intravenously	**Dosage** 1.2g bd for 48hours **Route** Intravenously	Antibacterial (Penicillins, Broad-spectrum with betalactamase Inhibitor)	To inhibit bacteria growth	Patients condition improved	Cholesteric jaundice, Hepatitis, Nausea, Vomiting, Dizziness, Headache None of these side effects were observed.

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
12/11/21	Metronidazole (Flagyl)	**Dosage** **IV**: 500 mg every 8 hours usually treated for 7 days **MOUTH**: 400mg every 8 hours **Route** Oral and IV.	**Dosage** **IV**: 500mg tds x 24 hours **MOUTH**: 400mg tds x 5days **Route** Intravenously, Orally	Nitroimidazole Derivatives	It inhibits nucleic acid synthesis by forming nitroso radicals, which disrupt the DNA of microbial cells.	Patient's condition improved.	Ataxia, Erythema multiforme. None of these side effects were observed.
12/11/21	Pethidine hydrochloride	**Dosage** 25–100 mg, then 25-100 mg after 4 hours **Route** Oral, IM, IV, Subcutaneous	**Dosage** 50mg qid for 24hours **Route** Intravenously	Narcotic analgesic	It has a kappa-opiate receptor agonist. It inhibits nociceptive neurotransmitters such as noradrenaline.	Patient was relived of pain	Biliary spasm, dysuria, hypothermia, tremor. None was observed in patient

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	Drug	Dosage/ Route of Administration (Literature)	Dosage/ Route of Administration Given to Patient	Classification	Desired Effect	Actual Action Observed	Side Effect/ Remedies
12/11/21	Diclofenac	**Dosage** 75-150mg in divided doses **Route:** Oral, Rectal, IM	**Dosage:** 100mg bd for 5 days **Route** Rectally	Nonsteroidal anti-inflammatory drug	Diclofenac inhibits cox-1 and -2, the enzymes responsible for production of prostaglandins.	Patients pain reduced	Diarrhoea, dizziness, Headache, skin reactions None was observed in patient
14/11/21	Ciprofloxacin	**Dosage** 500 mg every 24hours **Route** Oral, IV	**Dosage** 400mg bd for 5days **Route** Orally	A broad-spectrum antibiotic of the fluoroquinolone class	An antibiotic used to treat a number of bacterial infections	Patient condition improved	heartburn, diarrhoea, pale skin. None of these side effects were observed.

Table 2.5: Pharmacology of Drugs Administered to Patient Cont'd…

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remedies**
12/11/21	Zincovit	**Dosage** 1 tablet daily **Route** Oral	**Dosage** 1 tablet daily for 30 days **Route** Orally	Multivitamin and Multimineral supplement	It helps in the production of antibodies and hemoglobin by keeping the blood sugar level in the normal range.	Patient haemoglobin improved	Excessive thirst, salivation. None of these side effects were observed.

E. Complications

With reference to the complications listed in the literature review such as Strangulation, Fistula formation and Intestinal obstruction etc., Patient exhibited no complications of inguinoscrotal hernia and had no complication after the surgery.

2.2 Patient/Family Strengths

Strength refers to the ability to do things that need lot of physical or mental effort (McIntosh, 2013). The following strengths were observed in my patient and family during their period of hospitalization.

1. Patient could verbalize the degree of pain
2. Patient was willing to learn about her condition and treatment regimen
3. Patient could verbalize his state of anxiety
4. Patient could verbalize the intensity of his pain
5. Patient knew how to keep the operative site clean
6. Patient could sit up in bed unassisted

2.3 Patient's Health Problems

Problem is defined as a situation, person that needs attention and needs to be dealt with or solved (McIntosh, 2013). From the data collected during assessment, the following health problems were noticed on patient:

1. Patient complained of pain in the groin (09/11/21)
2. Patient lacks information on hernia and its treatment regimen (09/11/21)
3. Patient was anxious about outcome of surgery (10/11/21)
4. Patient complained of pain at incisional site (12/11/21)
5. Patient had a wound (12/11/21)
6. Patient complained of body weakness (12/11/21)

2.4 Nursing Diagnosis

According to NANDA International, nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community (Herdman & Kamitsuru, 2014).

1. Acute pain (inguinal region) related to scrotal mass (09/11/21)
2. Deficient knowledge related to lack of information on causes, management, signs and symptoms, complications and prevention of hernia (10/11/21)
3. Anxiety related to impending surgery (herniorrhaphy) (11/11/21)
4. Acute pain (incisional site) related to surgical manipulation of tissues (12/11/21)
5. Risk for infection evidenced by surgical manipulation of tissues (12/11/21)
6. Partial self-care deficit (bathing and grooming) related to body weakness (12/11/21)

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the third phase of nursing process. Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan. In this phase, there is identification of some specific health problems, formulation of nursing diagnosis, goals setting and objectives to achieve. In nursing, planning deals with development and prioritization of goals, care designed and systematic care rendering to the patient and family continuously forward goals achievement. Care plan is a holistic quantification of patient problems and appropriate remedies to them. The care plan is prioritized base on urgency. It also serves as a communication link between the health team and the patient. The following are very essential in the care plan.

1. Date/Time
2. Nursing diagnosis
3. Nursing objectives
4. Nursing orders
5. Nursing interventions
6. Evaluation of interventions
7. Remarks
8. Signature

3.1 Objectives/Outcome Criteria for Patient/ Family Case Study

1. Patient would be relieved from inguinal pain within 24 hours of hospitalization as evidenced by;

a. Patient verbalizing relief from pain
b. Nurse observing patient to have a relaxed facial expression

2. Patient would gain adequate knowledge on disease process and treatment regimen within 12 hours of hospitalization as evidenced by;
    a. Patient verbalizing understanding of disease process and postoperative expectations
    b. Nurse observing patient adheres to treatment regimen
3. Patient would be relieved from anxiety within 24 hours as evidenced by;
    a. Patient verbalizing that he is no longer anxious
    b. Nurse observing patient cooperate with care and appear relaxed
4. Patients would be able to perform self-care activities without assistance within 72 hours as evidenced by;
    a. Patient verbalizing that he can perform self-care activities without assistance.
    b. Nurse observing patient perform activities of daily living without assistance.
5. Patients would be relieved from postoperative pain within 24 hours of hospitalization as evidence by;
    a. Patient verbalizing relief from pain
    b. Nurse observing patient to have a relaxed facial expression
6. Patients would be protected from infection throughout the period of hospitalization as evidence by;
    a. Patient being able to identify interventions to reduce potential risks for infection.
    b. Nurse maintaining safe aseptic environment at all times

Table 3. 1: Nursing Care Plan for Patient

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
09/11/21 4:30pm	Alteration in comfort (inguinal pain) related to scrotal mass	Patient would be relieved from inguinal pain within 24 hours of hospitalization as evidenced by; expression 1. Patient verbalizing relief from pain 2. Nurse observing patient to have a relaxed facial	1. Reassure client and relatives. 2. Encourage Diversional therapy 3. Restrict visitors and relatives. 4. Apply cold compress. 5. Serve prescribed analgesics	1. Client and relatives were reassured that all measures will be put in place to help relieve him of the pain. This helped to allay their fears. 2. Client was engaged in conversations about his business to divert his mind from the pain. 3. All visitors and relatives were made to go outside the ward so that the client could have enough rest. 4. Padded ice packs were applied to the site of pain every 2 hours. This helped the patient to relax and also ease the pains. 5. Supp Diclofenac 100mg was given	10/11/20 4:30pm	Goal fully met as evidenced by; 1. Patient verbalized relief from pain 2. Nurse observed patient to have a relaxed facial	

Table 3.1: Nursing Care Plan for Patient Cont'd…

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
10/11/21 6:00pm	Deficient knowledge related to causes, management, signs and symptoms, complications and prevention of hernia.	Patient would gain adequate knowledge on disease process and treatment regimen within 12 hours of hospitalization as evidenced by; 1. Patient verbalizing understanding of disease process and postoperative expectations 2. Nurse observing patient adheres to treatment regimen	1. Assess patient's level of understanding. 2. Educate patient on hernia and his impending surgery 3. Give preoperative instructions on NPO time, skin preparation and premedication. 4. Allow patient and family to ask questions on goiter 5. Answer all questions honestly and in plain language 6. Use resource teaching materials	1. Patient was asked series of questions to assess his level of understanding on goiter. 2. Patient was educated on his goiter and what to expect during and after thyroidectomy. 3. Instructions such as NPO time, skin preparation and premedication were made know to patient. 4. Patient and family were allowed to ask questions. 5. Questions were answered honestly and in plain language. 6. Patient was shown images on the internet pertaining to the issues that were discussed.	11/11/20 6:00am	Goal fully met as evidenced by; 1. Patient verbalized understanding of disease process and postoperative expectations 2. Nurse observed that patient adhered to treatment regimen	

Table 3.1: Nursing Care Plan for Patient Cont'd…

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
11/11/21 7:30am	Anxiety related to impending surgery	Patient would be relieved from anxiety within 24 hours as evidenced by; 1. Patient verbalizing that he is no longer anxious 2. Nurse observing patient cooperate with care and appear relaxed	1. Assess patient level of anxiety 2. Provide preoperative teaching 3. Validate source of fear or anxiety 4. Note expressions of distress 5. Reassure patient as to how pain will be controlled during and after the surgery 6. Introduce patient to the operating room staffs	1. Patients level of anxiety was assessed 2. Resources such as face mask, hair net and their uses were shown to patient before the surgery 3. Source of fear was validated and all misconceptions that had led to fear were clarified 4. Expression of distress such as restlessness were noted 5. Patient was told anesthesia will be given to cause sleep so he would not feel anything during and after the procedure 6. Patient was introduced to the operating room staffs to help establish rapport and provide psychological comfort	12/11/20 7:30am	Goal fully met as evidenced by; 1. Patient verbalized he is no longer anxious 2. Nurse observing patient cooperating with care and looked relaxed	

Table 3.1: Nursing Care Plan for Patient Cont'd…

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
12/11/21 11:45am	Acute pain (incisional site-anterior neck) related to surgical manipulation of tissues	Patients would be relieved from postoperative pain within 24 hours of hospitalization as evidence by; 1. Patient verbalizing relief from pain 2. Nurse observing patient to have a relaxed facial expression	1. Assess pain, noting location, intensity (0-10 scale), and duration. 2. Place in semi-Fowler's position and support head and neck with sandbags or small pillows. 3. Instruct to avoid hyperextension of the neck. 4. Give cool liquids to sooth the throat 5. Teach relaxation techniques to help alleviate pain. 6. Administer analgesics	1. Patients pain was assessed; noting location, duration and using the numerical pain rating scale (0-10). 2. Patient was placed in a semi-fowlers position with the head and neck supported with small pillows. 3. Patient was instructed to avoid hyperextension of the neck 4. Patient was served with vita-milk 5. Relaxation techniques were employed; watching TV. 6. Injection Pethidine 50mg was administered	13/11/21 11:45am	Goal fully met as evidenced by; 1. Patient verbalized that he has been relieved from pain 2. Nurse observed that patient had a relaxed facial expression	

Table 3.1: Nursing Care Plan for Patient Cont'd…

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
12/11/21 11:50pm	Risk for infection evidenced by surgical manipulation of tissues	Patients would be protected from infection throughout the period of hospitalization as evidence by; 1. Patient being able to identify interventions to reduce potential risks for infection. 2. Nurse maintained safe aseptic environment at all times	1. Adhere to aseptic policies and procedures of facility 2. Verify sterility of all items before wound dressing 3. Examine incision site of infection. 4. Apply sterile dressing always during dressinsg changes 5. Teach patient how to keep operation site clean 6. Administer antibiotics as prescribed.	1. Aseptic policies and procedures were always adhered to. 2. Sterility of all items for dressings were verified 3. Incisional site was examined for signs of infection such as redness, odour 4. Sterile dressings were applied after each dressing change 5. Patient was told to keep operative site clean 6. Injection Amoxiclav 1.2g was served	14/11/21 11:50am	Goal fully met as evidenced by; 1. Patient being able to identify interventions to reduce infection 2. Nurse maintained safe aseptic environment at all times	

Table 3.1: Nursing Care Plan for Patient Cont'd…

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
12/11/21 04:00pm	Partial self-care deficit (bathing and grooming) related to body weakness	Patients would be able to perform self-care activities without assistance within 48 hours as evidenced by; 1. Patient verbalizing that he can perform self-care activities without assistance. 2. Nurse observing patient perform activities of daily living without assistance.	1. Reassure Patient 2. Perform assisted bathroom bath and groom Patient. 3. Maintain patient's oral hygiene 4. Care for patient's hands and feet. 5. Change bed linen when soiled.	1. Patient was reassured that measures will be put in place to bath him, care for his mouth and care for his hands and feet. 2. Patient was groomed and made comfortable in bed. 3. Patient's mouth was cared for using tooth brush and paste and rinsed with water. This was done to prevent Patient from developing any oral infections. 4. Patient's hands and feet were cared for using warm water into which he soaked his feet and hands. A soft brush was used to scrub his feet to remove any dirt and also his nails were trimmed short to prevent them from harboring dirt. 5. Bed linens were changed regularly to promote client's comfort	14/11/21 12:00pm	Goal fully met as Patient verbalized an increase in energy level and nurse observed patient display improved ability to participate in activities.	

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

Implementation refers to nursing action or interventions that have been employed based on the nursing diagnosis to achieve the set goals or is a specified set of activities designed to put into practice an activity or program. It is the fourth stage in the nursing process. This involves all the nursing procedures which were carried out on the client with the aim of helping the client to regain his normal strength.

This chapter describes the actual care rendered to client and family during admission, preparation of Mr. D.N.N. and family toward their discharge, follow-up visit and the subsequent visit during this period of care study. This phase facilitates some specific nursing activities and actions needed to carry out the intervention. The phase permits the continuity assessment of the patient to gather data about patient response to nursing intervention and other newly rising problems.

4.1 Summary of Actual Nursing Care Rendered to Patient and Family.

This involves a summary of all nursing interventions rendered to Mr. D.N.N. and family during his hospitalization. It encompasses all daily activities that aimed at helping the patient for recovery and discharge. It is written right from the day of admission till discharge.

Nursing care rendered on Mr. D.N.N. started immediately he was admitted on the 09th November, 2021. Most importantly, the main aim of the nursing care is to ensure adequate comfort and promote quick recovery without complications. The nursing care rendered also aimed at his physical, psychological and spiritual needs.

First Day of Admission (09th November, 2021)

Mr. D.N.N. was admitted into the Male Surgical ward on Tuesday 9th of November, 2021 at 4:30pm accompanied by wife in a conscious and ambulatory state, through the Out Patient Department of the Regional Hospital, Sunyani with the diagnosis of lower Right scrotal hernia. Patient had a history of scrotal swelling associated with pain in the abdomen. The patient and his wife were welcomed. It was a planned admission. I personally collected the patient's particulars. The patient's identity was verified by mentioning his name for him to respond. He was then warmly welcomed and immediately made comfortable in an admission bed. His particulars such as name, sex, age, and residential address were entered into the admission and discharge book and the daily ward state. Vital signs were checked and recorded accurately as follows:

5. Temperature 36.0^{o}C
6. Pulse 80bpm
7. Respiration 22cpm
8. Blood Pressure 120/70mm/Hg

It was realised that patient was anxious because of his impending surgery hence he was reassured to allay all fears and anxiety and was made to relax in bed. Physical examination on the patient was performed from head to toe and patient was observed to have swollen groin.

The following treatment plan were ordered preoperatively:

1. Sodium Chloride infusion 0.9% (500ml) 2liters x 48 hours
2. Dextrose5% infusion (500ml) 2liters x 48 hours
3. Ringers lactate solution (500ml) 1.5liters x 48 hours

Investigations ordered included:

1. Full Blood Count
2. Blood for grouping and cross matching
3. Renal function test

Blood sample was taken, labelled with all requisite information and sent to the laboratory for investigations. The time vital signs will be checked were explained to patient and relatives present. Hospital policies regarding visiting periods and payment of bills were explained to the patient and relatives. Patient relatives were told to visit patient between the hours of 5:30am to 6:30am in the morning and 5:00pm to 6:00pm in the evening. They were made to understand that the NHIS only supports few aspects of the healthcare he was receiving and for that reason majority of the payments will need to be made before drugs can be issued to him. Patient was properly oriented to the ward environment and its annexes. His wife was told to bring Mr. D.N.N. pyjamas and cup for drinking water in addition to his towel, sponge, tooth paste and brush and other toiletries. His property and valuables were kept by his wife since the ward does not have a room for keeping those valuables. Patient was then introduced to the other patients who were on the ward. He was introduced to the staffs present and was assured of competent healthcare team.

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. D.N.N. and his wife were 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 and his wife 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 event. Mr. D.N.N. and his wife 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. I decided to choose this patient for the study because I wanted to know more about the condition and how they become large and cause problems in some individuals.

On admission at 4:30pm a quick assessment of his general appearance carried out on Mr. D.N.N. showed that he was having severe inguinal pains. A nursing diagnosis of Alteration in comfort (inguinal pain) related to scrotal mass was formulated. An objective was set for patient to be relieved from inguinal pain within 24 hours. The following interventions were implemented; Client and relatives were reassured that all measures will be put in place to help relieve him of the pain. This helped to allay their fears. Client was engaged in conversations about his business to divert his mind from the pain. All visitors and relatives were made to go outside the ward so that the client could have enough rest. Padded ice packs were applied to the site of pain every 2 hours. This helped the patient to relax and also ease the pains. Suppository Diclofenac 100mg was given.

Upon interacting with patient at 6:00pm, patient lacked enough information on disease condition (hernia) and treatment regimen (Herniorrhaphy). A nursing diagnosis of Deficient knowledge related to causes, management, signs and symptoms, complications and prevention of hernia was made. An objective was set for patient to help him gain adequate knowledge within 12 hours. The following interventions were implemented; Patient was asked series of questions to assess his level of understanding on hernia. Patient was educated on his hernia and what to expect during and after herniorrhaphy. Instructions such as NPO time, skin preparation and premedication were made know to patient. Patient and family were allowed to ask questions. Questions were answered honestly and in plain language. Patient was shown images on the internet pertaining to the issues that were discussed.

At 10:00pm, his vital signs were checked and recorded as indicated in the appendix. Patient then went to bed at 10:30pm.

Second Day of Admission (10th November, 2021)

On the second day of admission, patient woke up at 5:30am. Patient was assisted to perform his personal hygiene and his bed was straightened to make it free from creases and crumps. His due medications were served and his vital signs were checked and recorded at 6am as indicated in the appendix.

At 06:00am evaluation of the set objective to help patient gain adequate knowledge on disease process and treatment regimen on 10th November, 2021 was done and goal was fully met as patient verbalized understanding of disease process and postoperative expectations and nurse observed that patient adhered to treatment regimen.

Patient took milo and bread as breakfast in the morning.

At 7:30am, patient verbalized feelings of anxiety due to the impeding surgery hence the nursing diagnosis of Anxiety related to impending surgery was formulated. An objective was set to relieve patient from anxiety within 24 hours. The following interventions were made; Patients level of anxiety was assessed. Resources such as face mask, hair net and their uses were shown to patient before the surgery. Source of fear was validated and all misconceptions that had led to fear were clarified. Expression of distress such as restlessness were noted. Patient was told anesthesia will be given to cause sleep so he would not feel anything during and after the procedure. Patient was introduced to the operating room staffs to help establish rapport and provide psychological comfort.

At 9:00am, the surgical team came for rounds and the plan was to continue treatment and keep monitoring his vital signs.

At 1:00pm, patient had his lunch which was rice and vegetable stew with fish.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix.

At 04:30pm evaluation of the set objective to relieve patient from pain on 09th November, 2021 was done and goal was fully met as patient verbalized relief from pain and nurse observed patient to have a relaxed facial.

At 5:00pm, he ate fufu and light soup as supper.

At 10:00pm, patient vital signs were checked and recorded and all due medications were administered. Patient slept around 10:20pm

Third Day of Admission (11th November, 2021)

On the third day of admission patient woke up at 5:00am. He was assisted in maintaining his oral hygiene, he had his bath and emptied his bowel. His due medications were served and his vital signs had already been checked and recorded at 6am as indicated in the appendix.

At 07:30am evaluation of the set objective to relieve patient from anxiety on 11th November, 2021 was done and goal was fully met as patient verbalized, he is no longer anxious and nurse observed patient cooperating with care and looking relaxed.

At 7:40am, he took Hausa porridge with bread as breakfast.

During ward rounds at 9:00am, the decision was made to perform patient's surgery the following morning hence he was asked to take clear fluid diet and maintain nil per oral regimen for about 8 hours prior to the surgery.

Patient drunk Vitamilk in the afternoon around 1:20pm.

I scheduled the first home visit this day around 1:40pm, patient and his relatives were informed about it.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix.

His evening vital signs was checked and recorded; due medications were served. Patient went to bed at 10:30pm.

Fourth Day of Admission (12th November, 2021)/First Post-Operative Day

Report from the night nurses indicated that client woke up around 5:00a.m. He emptied the bowel; took his bath and he was assisted to brush his teeth with tooth brush and paste. His vital signs had already been monitored at 6:00am as indicated in the appendix and due medication had been served. He was thanked for his co – operation and was put back into a comfortable position.

At 6:30am, Pre-operative preparation with psychological preparations, physiological preparations and physical preparations were ensured prior to surgery.

Psychological Preparations

He was informed that the surgery was the only reliable choice of treatment and was asked to ask questions of concern and to express his emotions freely to reduce the level of anxiety. All questions asked were answered honestly and tactfully. He was introduced to other patients who have already gone through the same surgery and were recovering. The anesthetist and the operating theatre nurse were invited to talk to him briefly on the theatre environment and what to expect in the theatre including the outcome of the surgery. He was informed that anesthesia would be given to prevent him from feeling pains whiles the surgery is going on and analgesics such as morphine injection and diclofenac tablet will be administered to relieve him of any post-operative pain. This helped in the reduction of his anxiety. Finally, the consent form which is a legal document that permits the surgeon to operate on the patient and protects the patient against unauthorized surgery was read and explained to him by the Surgeon. He signed the consent form to show his agreement to the procedure with a nurse as a witness at the nurse's station. His facial expression looked more cheerful after preparing him psychologically.

Physiological Preparations

This was done preoperatively to establish a base line data to detect any abnormalities in the normal functioning of the body system and to correct any electrolyte imbalance in the patient. Laboratory investigations were requested and done and the results shown to the doctor and were later attached to the patient's admission papers. These revealed that the patient was fit for the surgery.

It also guided the doctor to prescribe the correct drugs and also helped in the preparation of the patient to go through a successful surgery. The patient was taught deep breathing and coughing exercises. He was also encouraged to rest before the surgery. His vital signs was monitored preoperatively and immediately before patient was taken to the theatre. An IV line was set for IV fluids intake both preoperatively, intraoperatively and postoperatively.

Physical Preparations

This was done to reduce the number of microorganisms on the skin surface thereby reducing infection. Patient was examined from head to toe and no other abnormality was found. He was asked and examined if he had any dentures which should be removed and kept in safe custody but on examination, no dentures were found. Patient had his bath. The patient was given the theater gown to put on. The physical preparations were continued at the theater.

At 09:30am, Patient was prepared and sent to the main theater for hernia repair (herniorrhaphy). The surgery was started at 10:00am and was finished around 10:55am.

After the surgery patient was taken to the theater recovery ward before transferred to ward per stretcher. Patient level of consciousness was assessed by calling his name and pinching him for a response. Patient had clean wound dressing indicating no sign of bleeding.

Post Operative Nursing Care

- Client was put in the supine position without a pillow with the head tilted to one side to prevent aspiration of secretions from mouth.

- Emergency equipment including oxygen apparatus, suction machine, endotracheal tube was placed at the bed side of client in case of cyanosis or difficulty in breathing.
- Respiratory, circulatory and neurologic functions were frequently assessed and documented appropriately.
- Patient was assessed for immediate post-operative complications such as hypoxemia.
- Patient oxygen saturation was frequently monitored.
- Airway patency was ensured throughout the immediate post op period
- Vital signs (temperature, pulse, respiration and blood pressure) was checked 2 hours and 4 hourly as condition improved.
- The incisional site was observed for any bleeding which might lead to shock.
- Quick assessments were continuously made on consciousness, airway patency, incisional site for bleeding
- Urethral catheter was checked for kinking/smooth flow.
- Patient was kept on nill per os
- Intravenous fluids were administered within the first 24 hours
- Sips of water in about 9 hours after the surgery
- Maintain energy and rehydrate
- Gradually encouraged oral intake as bowel sounds return
- Prescribed medications were served
- The therapeutic effects as well as the side effects of the drugs are observed
- Patient was constantly reassured
- Deep breathing technique was enforced
- Diversional therapy
- Relatives are made comfortable and reassured
- Deep breathing-prevent hypostatic pneumonia

- Educate on early ambulation
- Patient was encouraged to do passive exercise
- Daily personal hygiene was ensured such as moth care.
- Enough or adequate fluid and roughages are given to prevent constipation
- Client emptied his bowel whenever he felt the urge to.
- Incisional site was observed
- Wound is assessed for its state in terms of dryness, infection, gaping or discharge
- The dressings were changed daily
- The wound was dressed daily strictly under aseptic condition.

At 11:45am, patient complained of pain at the incisional site. Nursing diagnosis of Acute pain (incisional site) related to surgical manipulation of tissues was made. An objective was set to relieve patient from postoperative pain within 24 hours. The following interventions were implemented; Patients pain was assessed; noting location, duration and using the numerical pain rating scale (0-10). Patient was placed in a semi-fowlers position with the head and neck supported with small pillows. Patient was instructed to avoid hyperextension of the neck. Patient was served with vita-milk. Relaxation techniques were employed; watching TV. Injection Pethidine 50mg was administered.

At 11:50am, a nursing diagnosis of Risk for infection evidenced by surgical manipulation of tissues was formulated. An objective was set to protect patient from infection throughout the period of hospitalization. The following interventions were made; Aseptic policies and procedures were always adhered to. Sterility of all items for dressings were verified. Incisional site was examined for signs of infection such as redness, odour. Sterile dressings were applied after each dressing change. Patient was told to keep operative site clean. Injection Amoxiclav 1.2g was served.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix.

At 4:00pm, patient complained of body weakness, hence the nursing diagnosis of Partial self-care deficit (bathing and grooming) related to body weakness was made. An objective was set to help patient perform self-care activities without assistance within 48 hours. The following interventions were implemented; Patient was reassured that measures will be put in place to bath him, care for his mouth and care for his hands and feet. Patient was groomed and made comfortable in bed. Patient's mouth was cared for using tooth brush and paste and rinsed with water. This was done to prevent Patient from developing any oral infections. Patient's hands and feet were cared for using warm water into which he soaked his feet and hands. A soft brush was used to scrub his feet to remove any dirt and also his nails were trimmed short to prevent them from harboring dirt. Bed linens were changed regularly to promote client's comfort.

At 10:00pm, due medications were administered and vital signs was checked and recorded as indicated in the appendix. Report from the night nurses indicated that, patient slept around 10:15p.m.

Fifth Day of Admission/Second Post-Operative Day (13th November, 2021)

Report from the night nurses indicated that client woke up around 5:30a.m. He emptied the bowel, took his bath and was able to brush his teeth with tooth brush and paste. His vital signs had already been monitored at 6:00a.m as indicated in the appendix and due medication had been served.

At 9:00am, patient was reviewed by the medical team and the plan was to continue treatment.

At 11:45am evaluation of the set objective to relieve patient from postoperative pain on 12th November, 2021 was done and goal was fully met as patient verbalized that he has been relieved from pain and nurse observed that patient had a relaxed facial expression.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix.

In the evening at 5:00pm, patient was served with rice and stew and was able to eat more than half of it. Patient ensured his oral hygiene by brushing the teeth with tooth brush and paste and also took his bath with warm water after meals and also before bedtime. This indicated that the education I gave to patient to ensure personal hygiene was adhered to and therefore he was commended for that.

At 10:00pm, his due medications were administered and vital signs were monitored as indicated in the appendix. Patient slept around 10:20pm.

Day of Discharge/Third Post-Operative Day (14th November, 2021)

Patient woke up with a cheerful facial expression this day awaiting his possible discharge. His personal hygiene needs were ensured. At 6am, his vital signs was checked and recorded, with his due medications also served.

At 7:30am, patient took Hausa porridge for breakfast.

At 8:30am, patient's wound was dressed aseptically to prevent any infection. Removal of stiches was carried out.

At 9am, ward rounds was carried out, patient made no complains on review, he was discharged to go home as his condition had improved.

At 11:50am evaluation of the set objective to help patient not to develop any form of infection on 12th November, 2021 was done and goal was fully met as patient was able to identify interventions to reduce infection and nurse maintained safe aseptic environment at all times.

At 12:00pm evaluation of the set objective to help patient perform self-care activities without assistance on 12th November, 2021 was done and goal was fully met as patient verbalized an

increase in energy level and nurse observed patient display improved ability to participate in activities.

Patient was informed that he has been discharged. I enquired whether he left any valuable items with any nurse and the response was no. Necessary documents were recorded into the admission and discharge book as well as the ward state. Assessment of patient bills were made with the help of National health insurance scheme. Patient was educated on the need to eat food containing high fiber like whole grains, the entire essential food nutrients, for example protein, vitamins and irons, as well as maintaining good personal hygiene. Patients used linen was removed and placed in the laundry basket. Bleach solution was used to disinfect the bed as well as the bed side locker.

4.2. Preparation of Patient/Family for Discharge and Rehabilitation

Preparation for discharge commenced from the time of admission at the hospital, on Tuesday 9th of November, 2021 at 4:30pm till the last day of visit, 3oth November, 2021. The patient and family were informed that staying in the hospital was for a temporal period of time. Education of patient and family was reemphasized. This was aimed at helping the patient and relatives in the provision of adequate care. Prior to patient discharge, health education was given to the patient and relatives on the importance of diet and avoiding over the counter medication, should neither smoke nor drink alcohol. Patient was encouraged to take in food rich in the essential food nutrients. Patient was also told to exercise more often. Patient and his family were also educated on the need to maintain personal and environmental hygiene to help improve immunity. A great emphasis was made on the need to continue with medication and to report to the hospital if any problem does occur. Patient was informed to come for review on 22nd November, 2021. Necessary information was recorded into the admission and discharge book as well as the ward state.

4.3 Follow Up/ Home Visits/Continuity of Care

Home visiting is a long – established method of enabling patients and families cope with changes in their lives. It should be planned carefully especially with the first visit as it can foster cordial relationship, build and assist nurses to demonstrate the contributions they can make in enabling patient's relatives to deal with their current health needs.

First Home Visit (11th November, 2020)

My first home visit was made on 11th November, 2021, thus; the third day of admission. The purpose of this visit was to assess the home environment of my patient and to give appropriate health educations to his family and safeguard methods to prevent themselves from injury and to identify any nearest health facility for possible referrals and also to identify any tiggering factors to patient's condition. I was given direction to the house by the patient. I left Regional Hospital, Sunyani around 2:30pm and safely arrived at Kotokrom at before 3:00pm. I alighted at Cape Junction. I was told to take the rough road leading to where the sign board of Assemblies of God Church is located. It took me about five minutes to get to the church premises where i was able to locate the house which was right in front of the church building. On arrival I met my patient's family. They were very happy to see me. I greeted them and they responded nicely. They offered me a seat and served me with a glass of water. I was asked of my mission so I explained the need for the visit. Mr. D.N.N. and his family live in a self-contained house built with blocks, painted green and well roofed with aluminum iron sheets. There are five separate rooms each having bathroom and toilet. Each room had windows but were closed so I educated them on the need to open the windows to promote proper ventilation. Their source of water was tap water. I also realised that water containers were covered. The wastes generated in the house are kept in a zoom-lion branded dust bin which was covered and is emptied every day by the zoom-lion waste truck. The surrounding was cleaned and tidy and I encouraged them to keep it up. The members were advised on the need to maintain good

personal and environmental hygiene. Based on the above findings, I reinforced on the need to continue to cover water containers and also food to prevent contamination. The need to ensure proper ventilation was also stressed on. Hand washing with soap before eating and after visiting toilet and their importance were stressed. They were also encouraged to continue good refuse disposal to prevent environmental pollution and breeding of mosquitoes. They were therefore reassured that patient will soon get well and be discharged home.

I thanked them for their hospitality. I left the house around 4:30pm. I identified on the first home visit that patient's house was closer to a health facility by name 21st Clinic. I therefore took the opportunity to inform one community health nurse about handing over patient to her.

Second Home Visit (20th November, 2021)

This visit was made on 20th November, 2021. I made this visit to find out how patient was doing and to see if he was following his treatment regimen and also to remind the patient of the review date which was Monday 22nd November, 2021. On assessment patient windows were opened as they were educated to do. The environment was neat and they were commended for that. The importance of taking drugs as ordered was reinforced to patient and family. Education on good nutrition was stressed on to help protect patient and family from any diseases. Patient and family were thanked for their cooperation and permission was sought to leave. I promised them of another visit which will be my last. Patient's son Mr. E.D.N. escorted me to the road side where I bordered a taxi to my house.

Review (22nd November, 2021)

On 22nd November, 2021, patient was met at the Out Patient Department of Regional Hospital, Sunyani at 8:00am. I accompanied him to get his information registered into the hospitals system. The vital signs was checked and recorded as follows;

Temperature	36.0 degree Celsius
Pulse	72 beats per minute

Respiration 22 cycles per minute

Blood pressure 110/80MmHg

At the Out Patient Department, patient went to consulting room 1. Upon assessment by the doctor, Mr. D.N.N. was doing well. Patients wound had healed by first intention and he was no longer in pain. Patient had no complains and physical examination performed by the medical officer proved that patient was not in any sort of discomfort. I reinforced the education that I had already given to him. Patient thanked me for my care and concern so far. I escorted him to the hospital entrance.

Third Home Visit (30th 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. I passed by 21st Clinic to inform the community health nurse to accompany me to patients house so I could hand over patient to her. On arrival at patints house, we were welcomed by patient and his entire family. We were offered seats. I introduced the community health nurse to the patient and his family. No complaints were made by the patient. The environment was tidy as there were no rubbish nor stagnant water around. Patient commended me for good work done. 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. After interacting with patient and family for a while, I reemphasized on health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I handed over patient to the community health nurse to continue with care. I terminated my care and 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 eventually sought permission to leave and bid them the final farewell.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/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 (Hinkle & Cheever, 2014). 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. Patient was relieved of severe inguinal pain

On admission (09th November 2021) at 4:30pm a quick assessment of his general appearance carried out on Mr. D.N.N. showed that he was having severe inguinal pains. A nursing diagnosis of Alteration in comfort (inguinal pain) related to scrotal mass was formulated. An objective was set for patient to be relieved from inguinal pain within 24 hours. The following interventions were implemented; Client and relatives were reassured that all measures will be put in place to help relieve him of the pain. This helped to allay their fears. Client was engaged in conversations about his business to divert his mind from the pain. All visitors and relatives were made to go outside the ward so that the client could have enough rest. Padded ice packs were applied to the site of pain every 2 hours. This helped the patient to relax and also ease the pains. Suppository Diclofenac 100mg was given.

On 10th November, 2021 at 04:30pm evaluation of the set objective to relieve patient from pain on 09th November, 2021 was done and goal was fully met as patient verbalized relief from pain and nurse observed patient to have a relaxed facial.

2. Patients gained knowledge on disease condition

On 9th November, upon interacting with patient at 6:00pm, patient lacked enough information on disease condition (hernia) and treatment regimen (Herniorrhaphy). A nursing diagnosis of Deficient knowledge related to causes, management, signs and symptoms, complications and prevention of hernia was made. An objective was set for patient to help him gain adequate knowledge within 12 hours. The following interventions were implemented; Patient was asked series of questions to assess his level of understanding on hernia. Patient was educated on his hernia and what to expect during and after thyroidectomy. Instructions such as NPO time, skin preparation and premedication were made know to patient. Patient and family were allowed to ask questions. Questions were answered honestly and in plain language. Patient was shown images on the internet pertaining to the issues that were discussed.

On 10th November, 2021 at 06:00am evaluation of the set objective to help patient gain adequate knowledge on disease process and treatment regimen on 09th November, 2021 was done and goal was fully met as patient verbalized understanding of disease process and postoperative expectations and nurse observed that patient adhered to treatment regimen.

3. Patient was relieved from anxiety

On 10th November 2021, at 7:30am, patient verbalized feelings of anxiety due to the impending surgery hence the nursing diagnosis of Anxiety related to impending surgery was formulated. An objective was set to relieve patient from anxiety within 24 hours. The following interventions were made; Patients level of anxiety was assessed. Resources such as

face mask, hair net and their uses were shown to patient before the surgery. Source of fear was validated and all misconceptions that had led to fear were clarified. Expression of distress such as restlessness were noted. Patient was told anesthesia will be given to cause sleep so he would not feel anything during and after the procedure. Patient was introduced to the operating room staffs to help establish rapport and provide psychological comfort.

On 12th November, 2021 at 07:30am evaluation of the set objective to relieve patient from anxiety on 11th November, 2021 was done and goal was fully met as patient verbalized, he is no longer anxious and nurse observed patient cooperating with care and looking relaxed.

4. Patient was relieved from post-operative pain

On 12th November,2021 at 11:45am, patient complained of pain at the incisional site. Nursing diagnosis of Acute pain (incisional site) related to surgical manipulation of tissues was made. An objective was set to relieve patient from postoperative pain within 24 hours. The following interventions were implemented; Patients pain was assessed; noting location, duration and using the numerical pain rating scale (0-10). Patient was placed in a semi-fowlers position with the head and neck supported with small pillows. Patient was served with vita-milk. Relaxation techniques were employed; watching TV. Injection Pethidine 50mg was administered.

On 13th November, 2021 at 11:45am evaluation of the set objective to relieve patient from postoperative pain on 12th November, 2021 was done and goal was fully met as patient verbalized that he has been relieved from pain and nurse observed that patient had a relaxed facial expression.

5. Patient was successfully protected from any form of infection

On 12th November,2021 at 11:50am, a nursing diagnosis of Risk for infection evidenced by surgical manipulation of tissues was formulated. An objective was set to protect patient from infection throughout the period of hospitalization. The following interventions were made; Aseptic policies and procedures were always adhered to. Sterility of all items for dressings were verified. Incisional site was examined for signs of infection such as redness, odour. Sterile dressings were applied after each dressing change. Patient was told to keep operative site clean. Injection Amoxiclav 1.2g was served.

On 14th November, 2021 at 11:50am evaluation of the set objective to help patient not to develop any form of infection on 12th November, 2021 was done and goal was fully met as patient was able to identify interventions to reduce infection and nurse maintained safe aseptic environment at all times.

6. Patient was able to perform self-care activities unassisted

On 12th November,2021 at 4:00pm, patient complained of body weakness, hence the nursing diagnosis of Partial self-care deficit (bathing and grooming) related to body weakness was made. An objective was set to help patient perform self-care activities without assistance within 48 hours. The following interventions were implemented; Patient was reassured that measures will be put in place to bath him, care for his mouth and care for his hands and feet. Patient was groomed and made comfortable in bed. Patient's mouth was cared for using tooth brush and paste and rinsed with water. This was done to prevent Patient from developing any oral infections. Patient's hands and feet were cared for using warm water into which he soaked his feet and hands. A soft brush was used to scrub his feet to remove any dirt and also his nails were trimmed short to prevent them from harboring dirt. Bed linens were changed regularly to promote client's comfort.

On 14th November, 2021 at 12:00pm evaluation of the set objective to help patient perform self-care activities without assistance on 12th November, 2021 was done and goal was fully met as patient verbalized an increase in energy level and nurse observed patient display improved ability to participate in activities.

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

Despite the numerous problems identified, with the individualized comprehensive nursing care and support from other members of the health team and co-operation of patient and family, all of the goals set were fully met. The care plan was therefore not amended.

5.3 Termination of Care

Care of patient and family ended on the 30th November, 2021 which was my last home visit. This ended the interaction between the health team and Mr. D.N.N. and his family. The preparation for termination started on day of admission through discharge, review to the third home visit. During these periods, patient and family were educated on various topics.

I passed by 21st Clinic to inform the community health nurse to accompany me to patient's house so I could hand over patient to her. On arrival at patient's house, we were welcomed by patient and his entire family. We were offered seats. I introduced the community health nurse to the patient and his family. No complaints were made by the patient. The environment was tidy as there were no rubbish nor stagnant water around. Patient commended me for good work done. 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. After interacting with patient and family for a while, I reemphasized on health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I handed over patient to the community health nurse to continue with care. I

terminated my care and 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 eventually sought permission to leave and bid them the final farewell.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation (Weller, 2014).

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.

6.1 Summary

Mr. D.N.N. was admitted into the Male Surgical ward on Tuesday 9th November, 2021 at 4:30pm accompanied by wife in a conscious and ambulatory state, through the Out Patient Department of the Regional Hospital, Sunyani with the diagnosis of lower Right scrotal hernia. Routine care such as maintenance of personal hygiene, monitoring of vital signs, wound dressing, feeding, pain management, education on condition and administration of drugs were carried out successfully.

The following diagnostic investigations were done on the patient;

1. Full Blood Count
2. Blood for grouping and cross matching
3. Blood for renal function test and electrolytes

The following drugs were used in the treatment of the condition both preoperatively and postoperatively:

Drugs ordered preoperatively:

1. Sodium Chloride infusion 0.9% (500ml) 2liters x 48 hours
2. Dextrose 5% infusion (500ml) 2liters x 48 hours
3. Ringers lactate solution (500ml) 1.5liters x 48 hours

Drugs ordered postoperatively:

4. Injection Amoxiclav 1.2g bd for 48hours
5. Intravenous Metronidazole 500mg tds × 48hours
6. Injection Pethidine 50mg qid × 24 hours
7. Suppository Diclofenac 100mg bid × 48 hours

Discharge Drugs

8. Tablet Ciprofloxacin 500mg bd x 5 days
9. Tablet Metronidazole 400mg tds x 5days
10. Tablet Zincovit once daily x 30 days
11. Suppository Diclofenac 100mg bd x 3 days.

Six health problems were identified. Objectives were set, nursing orders were implemented for the identified health problems and some of the nursing interventions carried out were reassurance, monitoring, adequate ventilation, thorough education on the disease condition, introduction of patient and family to patients with similar conditions who were doing well and drugs administration which includes, intravenous fluids, analgesics and antibiotics as prescribed by the physician and goals were fully met. Recovery was satisfactory postoperatively. The discharge planning started from the day of admission till the actual day of discharge on 14th November, 2021.

Three home visits (thus during admission and after admission) were made to the patient and family to know the situation of the home environment and identify any problems which

would be harmful to health. Health education was given on the problems identified in the house to help prevent contracting certain diseases.

On review, after discharge, he was declared fit and well but was advised not to do strenuous activities and lifting heavy objects. He and his relative were advised to take enough roughages and water to prevent constipation. The care of patient's and family was terminated on the 30th November, 2021 during the third home visit after review when Mr. D.N.N. was very well and was subsequently handed over to the community health nurse.

6.2 Conclusion/Recommendation

The patient care study has helped me gain knowledge about nursing care rendered to clients, this study has also helped me to know how to collect relevant information from patients, identify health problems, analyze and formulate a nursing care plan using the nursing process approach. Recommendations of patient /family, medical team, opinions and appraisal of their co-operation towards the achievement of goals which promoted the well-being of patient / family physically, psychosocially and spiritually.

This study has enabled me to put into practice the knowledge acquired during my three years training in the institution, it has helped me to be prepared to nurse clients effectively in the near future regardless of their condition with the help of nursing process adopted.

I therefore recommend that the patient/family case study should be maintained as a facade of the nurse trainee and fully establish in the country health care delivery system to aid in the improvement of health for the country.

APPENDIX I

Table 6. 1: Vital Signs of Patient Throughout the period of hospitalization

Date	Time	Temperature (ºC)	Pulse (bpm)	Respiration (cpm)	Blood pressure (mmHg)
09/11/21	4:30pm	36.0	80	22	120/70
	6:00pm	36.5	78	18	120/70
	10:00pm	36.7	68	21	120/70
10/11/21	6:00am	35.4	80	18	120/80
	10:00am	36.4	97	24	110/70
	6:00pm	37.7	70	24	120/60
	10:00pm	36.0	68	18	110/70
11/11/21	6:00am	37.6	75	18	130/80
	10:00 am	35.4	64	19	120/80
	2:00pm	36.0	72	21	110/80
	6:00pm	37.4	70	18	110/70
	10:00pm	36.7	68	21	120/70
12/11/21	6:00am	36.0	62	22	110/80
	10:00am	36.5	88	19	120/80
	2:00pm	37.4	81	20	110/60
	6:00pm	36.3	82	22	120/80
	10:00pm	36.9	79	20	120/80

Table 6.1: Vital Signs of Patient Throughout the period of hospitalization cont'd…

Date	Time	Temperature (ºC)	Pulse (bpm)	Respiration (cpm)	Blood pressure (mmHg)
13/11/21	6:00am	36.4	71	21	120/60
	10:00pm	36.6	68	18	120/70
	6:00pm	36.6	78	20	110/70
	10:00pm	36.7	69	18	120/80
14/11/21	6:00am	36.1	75	18	120/80
	10:00 am	36.4	64	19	120/80

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SIGNITORIES

1. NAME OF CANDIDATE: TETTEH MARGARET

SIGNATURE.....

DATE.....05/10/2022.....

2. THE MALE SURGICAL WARD IN-CHARGE, (BONO REGIONAL HOSPITA SUNYANI)

NAME: .....MRS, GRACE KWAKYE.....

SIGNATURE.....

DATE.....06/10/2022.....

3. NAME OF SUPERVISOR: MR. DRAMANI F. AYAMBA

SIGNATURE.....

DATE.....05/10/2022.....

4. NAME OF PRINCIPAL: HOLY FAMILY NMTC, BEREKUM.

NAME: MONICA NKRUMAH

SIGNATURE.....

ACADEMIC CO-ORDINATOR - NURSING
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