HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT / FAMILY CARE STUDY ON UTERINE FIBROID

BY

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

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PREFACE

Although the origin of nursing predate the mid -19th century, the history of professional nursing traditionally begins with Florence Nightingale. Nightingale, the well-educated daughter of wealthy British parents, defied social conventions and decided to become a nurse. The history of nursing first started to become more continuous and defined with Christianity when Christians cared for the sick, fed the hungry and buried the dead. Therefore, it was said that the history of nursing is tied to the church. When it became apparent that love and nurturing alone were not enough to cure disease, the need for a more educated frame work for nurses began to form. As a result of this, Florence nightingale in 1860, fulfilled her dream concerning nursing by establishing the Nightingale Training School for Nurses. It was the first formal, fully organized training program for nurses.

In this 21st century, many nursing schools have been established to help build on the previous skills and experiences that were acquired through long years of housekeeping, assisting in child bearing and care of formal sick relatives.

The Patient/Family Care Study is a detailed written report of nursing care rendered to an individual and family within a specific period of time. In the model of contemporary nursing care, every patient will have a nurse who is the primary decision maker when it comes to their care plan during their hospital stay and if it was readmission. It explores nursing rendered to patients from time of encounter to the termination of nurse-patient relationship. It gives an in-depth description and explanation of how a patient's response to a specified disease condition is diagnosed and given intervention.

The Patient/Family Care Study involves a record of nursing care, identifying the problems of a nursing patient and how they are dealt with by the nurse in the course of finding solution to the problems. It provides a systematic way of collecting data, analysing information, and reporting the results of nursing care. Nursing care when rendered properly helps the patient to meet his physical, psychological, social and spiritual needs.

Currently, patients are nursed using the nursing process. The nursing process is goal-oriented method of caring that provides a framework to nursing care. The nurse ensures that the patient is assessed, diagnosed, and receives continuity of care across appropriate healthcare providers and departments. It involves six major steps which are assessment (what data is collected), diagnosis (what is the problem), outcome identification (objective/outcome criteria), planning (how to manage the problem), implementation (putting plan into action), and evaluation (did the plan work). This Patient/Family Care Study is based on the concept of holistic care, taking into account all factors affecting the health of the individual. It therefore involves the interaction between the patient, his family, the community in which he stays and the health team. It is done using the nursing process approach. Evidence-based practice is a conscientious, problem solving approach to clinical practice that incorporates the best evidence from well-designed studies, patient values and preferences, and a clinician's expertise in making decisions about a patient care. This care study is carried out in partial fulfilment of the requirement for the award of professional license by the Nursing & Midwifery Council of Ghana. It encourages learning by doing, development of analytical and decision-making skills as well as reporting skills. Based on the nursing process, the students become familiar with the use of the nursing process as a basis for practice thereby encouraging evidenced based nursing care. For the purpose of confidentiality and anonymity, initials of the characters are used instead of their real names.

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All praise and thanks be to God, the Almighty who has granted me the strength, knowledge, understanding and opportunity throughout the period of commencement and finally the conclusion of this patient/family care study successfully. A big thanks to my Mother Ms. Koranteng Patricia for the love, financial support and contribution throughout my education. My warmest gratitude goes to my patient Madam S.E and family for their uttermost cooperation throughout the period of conducting the care study. Without their consent to be studied and enormous participation, this care study would never have been materialized.

I also wish to express my greatest appreciation to the entire teaching and non-teaching staff of Holy Family Nursing and Midwifery training college, Berekum for the tuition and guidance they gave me during the writing of this care study, especially my Supervisor Ms. Grace Asantewaa for her time, guidance and support throughout the period of conducting the care study. Again, I give thanks to the entire staff of the Female Surgical Ward of the St. Theresa's Hospital, Nkoranza for their support and guidance to make this a success, not forgetting my classmates in the RGN22 class, their support and encouragement has brought this piece into existence. I say God bless you all.

Finally, I acknowledge and thank all authors and publishers whose works have been used as references in this care study. May the Almighty God richly bless you all. Amen.

INTRODUCTION

Presented in this care study is a report of nursing care rendered to Madam S. E. who was diagnosed of Uterine fibroid. She was admitted to the Female Surgical Ward of the St. Theresa's Hospital, Nkoranza on 21st November, 2021 at 9am

With the use of nursing process six problems identified, and were developed into nursing diagnosis with nursing orders which were implemented to help solve these problems and promote recovery.

Using the nursing care plan, effective nursing care was carried out on the patient to ensure full recovery of Madam S. E. Among the care provided to her were bed making, monitoring of vital signs (temperature, pulse, respiration, and blood pressure), proper positioning in bed, administration of medication, and patient/family education on personal hygiene.

The following were health problems identified on Madam S. E. during the period of hospitalization. They include;

1. Patient complained of pain at the pelvic region.
2. Patient complains of feeling anxious.
3. Patient has an incisional wound.
4. Patient has alteration in feeding.
5. Patient cannot perform daily activities, thus; bathing and grooming.
6. Patient has deficient knowledge about her condition.

These problem were written in daily basis.

Diagnostic investigations requested for Madam S. E. included;

Full Blood Count. , Hysteroscopy, Serum electrolytes, Blood for grouping and cross matching

Plan of treatment for Madam S. E. was as follows;

- Keep urethral catheter for at least 24hours.
- Intravenous ceftriaxone 2000mg, 12hourly for 48hours.
- Intravenous metronidazole 500mg, 8hourly for 48hours.
- Suppository diclofenac 100mg, 12hourly for 5days.
- Intravenous morphine 5mg, 6hourly for 24hours
- Intravenous paracetamol 1000mg, 8hourly for 2days
- Monitor vital signs closely.

She was discharge on 26th November, 2021 when her condition had improved and was declared fit to go home with no complains. Goals were fully met during evaluation of all the care rendered. She reported to the hospital for review on the 8th of December, 2021. Three home visits were embarked on. The first home visit was done while patient was still on admission on 22nd of November, 2021, second home visit was on 6th December, 2021 and third home visit was on the 15th December, 2021. The care was finally terminated on third home visit which was on the 15th December, 2021 after handing her over to a community nurse (Y.E) at the Sessiman health center, for further management.

According to the nursing process, the study has been divided into six chapters as follows;

1. Assessment of Patient and Family.
2. Analysis of Data.
3. Nursing Care Plan for Patient and Family.
4. Implementation of Patient and Family Care Plan.
5. Evaluation of Care Rendered to Patient and Family.
6. Summary and Conclusion of Care Rendered to Patient and Family.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the collection of subjective and objective patient information on which to base the plan of care (Smeltzer,et al, 2014). Assessment is the first stage in the nursing process and is intended to collect information about the patient to enable identification of the patient's problem, strengths, weakness and resources. Assessment is done through interviews, laboratory investigations and physical examinations. Some of the methods employed in the acquisition of the client's information are interviewing, active and passive conversation and observation. It includes the patient's particulars, patient/family medical and surgical history, patient's socioeconomic history, patient's developmental history, Obstetric history, patient's lifestyle and hobbies, patient past medical and surgical history, patient present medical and surgical history. It also includes admission of patient, patient and family concept of her illness, literature review on the condition from which analysis will be made to identify the patient problems and validation of data. These help the nurse to determine the health status of the patient and her family in order to plan an effective nursing care towards recovery. All information was gathered from the patient and her relatives, as well as the patient's e-folder.

1.1 Patient Particulars

Patient refers to a person who is receiving medical treatment in the hospital (Hornby, 2006). Particulars is also defined as information about a person, especially when officially recorded (Mclntosh, 2013). For confidentiality reasons, all names in this write up will be abbreviated, hence, the client would be referred to as Madam S.E. Client is fair in complexion and tall, weighing 51kg and with 1.8m height. She is 47 years of age. Madam S.E is the last born to her parent; MR. A.K and Madam A.A, who had eight children in total. Madam S. E. is married with two children and a Christian. Her spouse's name is Y.K. and their children are all girls. The oldest child, L.K is 25 years and the youngest, E.K is 23 years of age. Her oldest child, L.K Madam S.E. hails from Oforikrom but currently stays at Sessiman (house number MB 0050) with her nuclear family. Both Oforikrom and Sessiman are under the Nkoranza south municipality in the bono east region of Ghana. Madam S.E had formal education up to the junior high school level equivalent and did not learn any craftsman's job. She is currently a trader at Nkoranza. She worships with the Ebenezer Presbyterian church at Nkoranza "Fie", also in the Nkoranza south municipality. Madam S.E. is a Bono by tribe and speaks fluently in the Bono languages.

1.2 Family's Medical/Surgical History

It is a record of health information about a person and his or her family. (Weller B, 2014). Interacting with Madam S.E. and family revealed that there is a hereditary disease in the family thus hypertension, although she is not hypertensive, but three of her siblings are, apart from that there is no other familial or genetic diseases such as epilepsy, diabetes mellitus, asthma, mental sub-normality or any other abnormality in their family. Patient revealed that there are no known allergies in the family. Her grandfather died on an account of hypertensive crisis. She has ever been hospitalized at the St. Theressa's Hospital on account of anaemia. She has gone through caesarean session twice. She uses over-the-counter drugs and herbal preparations for minor sicknesses like headache, constipation, and body aches but always seek for medical attention when the condition worsen.

1.3 Patient and Family Socio-Economic History

Madam S.E. is a trader and the husband is a farmer, together their income is the family's source of livelihood. She lives with her husband and children (nuclear family) after she got married to him. The relationship that exists among the family members is so cordial and much cohering. She said there is unity among family members. According to Madam S.E. in terms of financial needs, each member joins hands to solve the problem. She couldn't disclose her total income per year to me and said it is confidential. According to patient, the source of money for medical care is from their income. She is enrolled on the National Health Insurance Scheme (NHIS) and thus it plays a vital role in the reduction of her medical cost. She attends activities such as funerals, engagements etc. of loved ones but doesn't really belong to any association in the community.

1.4 Patient's Developmental History

Development refers to the biological, psychological and emotional changes that take place in an individual from birth until the end of adolescence as the individual progresses from dependency to increasing autonomy. Growth means the gradual increase in size of the body and its organs. (Livio, 2009). According to her, a traditional birth attendant delivered her at home at Oforikrom, a suburb in the Nkoranza south municipality, Bono East region of Ghana. Her delivery was through spontaneous vaginal delivery, one full of herbal preparations. She does not know of her childhood immunization status. She was not exclusively breastfed. Madam S.E was introduced to supplementary foods like porridge at four months and then introduced to other supplementary foods like mashed yam, oil and "banku" in the subsequent months. Madam S.E crawled at about eight months and walked at about ten to eleven months. She had her menarche at age sixteen with a normal monthly flow with slight menstrual pains and the presence of the secondary characteristics like breast growth. She has not reached her menopausal age as she still continues to have her monthly menstrual cycles, even though they are not as regular as when she was in her teen ages. She has no skin pigmentation. Madam S.E was born without any physical abnormalities and still does not have any physical abnormalities at her age.

Erick Erickson psychological theory

1. Trust versus Mistrust (Birth to 18 month).
2. Autonomy versus Shame and doubt (18 month and 3 years).
3. Initiative and guilt (3 years to 6years)
4. Industry versus inferiority (6 to 12years).
5. Identity versus role confusion (12 to 20years).
6. Intimacy versus isolation(20 to 35years)
7. Generativity versus stagnation (35 to 65years)
8. Integrity versus despair (65 to death)

Comparing Madam S. E's developmental history with that of Erikson's psychosocial stages of development, Madam S.E is at the stage of generativity versus stagnation. She feels not stagnant in life but productive, per her culture, her responsibilities in life were to produce children, nurture and care for them and maintain the family together. In her view, she has been very successful in achieving what is expected of her even though there are some challenges.

1.5 Patient's Obstetric History

Madam S.E had her menarche at the age of sixteen (16). Her menstrual cycle is 30 days lasting usually for 7days and has slight pain during her menses. She uses sanitary pads during her menstrual period. Patient has had two pregnancies and two deliveries both of which she did caesarean section and have two female children. She has no history of abortion. Madam S.E. said all her pregnancies were carried to term full without any complications except some minor disorders of pregnancy like heart burns, frequency of micturition, lower abdominal pains for both pregnancies. She also had no pregnancy induced diseases like hypertension and diabetes. The birth interval for her two children is two years and are all alive.

1.6 Patient's Lifestyle and Hobbies

Life style simply refers to the pattern of daily living that an individual develops (Weller, 2014). As an everyday habit, Madam S.E wakes up almost always around 5am every morning, to brush her teeth right before saying her morning prayers. She bathes twice daily (morning and evening) and has a bowel movement at least once daily. Right after performing her morning chores which mostly consist of cooking and cleaning, Madam S.E leaves for work early at around 7:30am to help her reach out to the early buyers/consumers of her trade work. On weekends, usually Saturdays, she does her washing, cleans the house and does her cooking for the week. Madam S.E goes to church on Sundays. She doesn't really enjoy breakfast but when she does, she takes in tea with a little milk and sugar. Her lunch is usually banku with okra stew since it is her favourite food. Madam S.E supper is usually skipped since she gets so tired from work. She once liked "ampe" as a hobby but due to realities of life, she now occasionally watches television as a hobby. Madam S.E enjoys any kind of alcoholic beverages especially beer but not a chronic drinker. She is an extrovert in nature who likes hanging around with friends and loved ones. Madam S.E does not smoke. Madam S.E says her prayers and goes to sleep at around 9 pm every night.

1.7 Patient's Past Medical/Surgical 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).

According madam S. E. , she has been having minor ailment, which has always been treated at the Out patients department (OPD) level or with “over the counter” drugs from the pharmacy shops. Even though Madam S.E is not aware about her immunization at birth, she has never suffered from any of the vaccine preventable diseases. Information gathered from her current folder also revealed that client has not been diagnosed with many conditions. Some of the diagnosed conditions in the client folder are malaria, gastroenteritis, vulvovaginitis and anaemia. The folder recorded no history of surgery but client claims she had been to the operation room (caesarean section) twice in another hospital, for caesarean section when giving birth to both her two daughters and had a successful surgery without any post- operative complications after surgery. She has not had any allergies to any drugs or any form of treatment. None of her hospitalization has resulted in any severe complications. Madam S.E is also not having any form of physical impairment due to an illness. She is not on any form of medications currently. She is not a fan of medical check-ups.

1.8 Patient’s present medical history.

History of present illness is a complete, clear account of the problems prompting the patient to seek care (Bickley & Szilagyi, 2009). On the 8th of October, 2021, patient reported to Nkoranza health centre on account of irregular menstrual flow. A queried diagnosis of multiple intramural myoma was made and client was referred to St. Theresa’s hospital for further management and treatment. On reaching the hospital, client was seen on OPD basis on account of menorrhagia with unknown cause at the moment. She was made to undertake pelvic ultrasound and that result was brought for review on the 13th of October, 2021. The result was suggestive of bleeding uterine fibroids. The treatment plan then was injection Provera 15ml stat then oral zincofer, 1tablet twice daily for 15days. The surgeon proposed hysterectomy for the patient. On 20th of October, 2021, the irregular menstrual flow was still persisting, hence Madam S.E reported to St. Theresa's hospital to accept the hysterectomy and she was booked for an elective hysterectomy on the 22nd November, 2021. Client received an anaesthetic assessment that day which revealed that client has had two previous exposure to subarachnoid block type of anaesthesia.

Madam S.E reported to the facility on the 21st November, 2021 around 9am, for the elective hysterectomy. Vital signs checked and recorded as follows: temperature 36.5^{o}C, blood pressure 119/80mmHg, pulse 92bpm, respiration 20cpm, and pulse oximetry 99%. She came in with the eldest daughter and her sister. The complains she presented were pelvic pain and fear of impending surgical procedure.

1.9 Admission of Patient

On the 21st November, 2021, around 9am, Madam S.E reported straight to the femal surgical ward for an elective total hysterectomy. She was accompanied by her eldest daughter and her sister. On arrival, patient and relatives were welcomed and offered a seat at the nurses station. Introduction of myself and other stuffs present to the patient and her relatives was done. Her admission was confirmed by calling her name written on the e- folder card handed to me and she responded. I also entered her card number on the ward computer and further mentioning her name for response. Her admission was stated clearly there by the Surgeon. She was seen by Dr. A. K. who ordered for the following;

1. Full blood count.
2. Intravenous fluids: 1L ringer's lactate.
3. 1L 0.9% sodium chloride for preload.

4. To get a consent form signed.
5. To do serum electrolyte.
6. Pass urethral catheter.
7. To be kept on nil per os.
8. To secure at least 1 unit of whole blood (this was already secured as the client was told about it on the day she was being booked)
9. Last anaesthetic assessment.
10. Hysteroscopy.

Patient was put into a well laid admission bed and made comfortable in bed. Family of Madam S.E were reassured and made comfortable in the waiting area. Assessment (head to toe) of madam S.E. was done which revealed that patient was not in respiratory distress, She was well hydrated with capillary refill being less than two seconds, there was no pedal oedema observed and was conscious. Vital signs was checked and recorded on arrival as follows: temperature: 37.5 degrees Celsius, blood pressure:119/80mmHg, pulse rate: 92 beats per minutes, respiration count: 20cycle per minutes, oxygen saturation (pulse oximetry): 99%, random blood sugar: 6.1mmol/L. intravenous line was secured and blood sample obtained for full blood count, serum electrolytes and blood grouping. Intravenous ringers' lactate 1L at a rate of 250 drops per hour set up as a preload before the surgery. She came with complains of pains at the pelvic region and fear of impending surgical procedure. Therefore at 10:00am a nursing diagnosis of pain related to pressure on surrounding pelvic structures secondary to growing tumours was formulated and objective was set to reduced patient pains within 48 hours of hospitalization. The following intervention were carried out on the patient to reduce the pain; patient was reassured of competent care, Pain assessment was done using pain rating scale score (0-10), patient perception about pain was assess, vital signs was monitored, patient and family were involved in therapeutic communication to divert patient attention from pain and intravenous paracetamol 1g served to relieve pain. Madam S.E was helped to change into appropriate clothing per the ward's protocols. All valuables were obtained and given to her relatives for safekeeping. Madam S.E was educated on the National Health Insurance Schemes. She was also introduced to other patients near her in the ward. Orientation of ward and its annexes were done for client and her relatives and were also informed about the routine ward activities like time of scheduled vital signs checking and also time of visiting. Client was having a blood group of AB Rh positive. Catheter size 20 was successfully inserted and secured with 20mls of distilled water. Client was kept on nil per os after its significance was made known to her. At 10:10am I went to interact with her, Patient was showing a feeling of apprehension and she was not cooperating. So I asked her to verbalize her fear and worry. She then revealed to me that she was anxious about the impending surgery. Therefore a nursing diagnosis of Anxiety related to unknown outcome of impending surgery was formulated and objective was set to relieve patient from anxiety within 12 hours of hospitalization. Nursing interventions carried out on Madam S. E. were; Patient and family were reassured of positive outcome and the competence of surgical team, patient was educated on hysterectomy and how it was going to be carried out, Patient and family were allowed to ask question to clear any doubts. Some recovering patients in the ward who had gone through various surgeries were introduced to the client to help reduce anxiety but this was also not the client's first time at the operation room. Client's particulars were entered into the admission and discharge book and the daily ward state, and nurses note was written. Consent form was duly signed after the procedure was adequately explained to the client, including the risks. The anaesthetic assessment was done around 1pm and it declared client as fit for the impending surgery.

Because I was involved in all the proceedings that transpired between the patient, myself and the other nurses, I was interested in caring for Madam S.E. throughout her current ailments. And as patient and family care study forms part of the requirements needed to obtain a license to practice by the Nursing and Midwifery Council of Ghana, I decided to use Madam S.E for my study. I first approached the Head of nurses in the surgical ward about my intention, who subsequently gave me guidelines and approaches to go about the study. I then approached Madam S.E. when she was comfortably resting in bed about my intention to use her as study. I made her aware about what will be expected of her and myself too. I explained to the patient and her relatives 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. I told them that I will visit their home while they are still on admission and also visit them when they are discharged home to continue the care being rendered. I also made it clear to the family that they have the right to withdraw from the arrangement whenever they feel to do so. Madam S. E. and family agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. I decided to choose this patient for the study because I wanted to know more about uterine fibroid and its managements.

1.10 Patient's concept of illness

Patient said she does not know the cause of the illness but did not attribute it to any spiritual force. She thinks and grieves about her illness and why this has befallen her. However, she believes she will be fine by the Grace of God and help rendered to her by the competent health team.

1.11 Literature Review

ANATOMY OF THE UTERUS

The uterus is a thick muscular chamber that opens into the roof of the vagina and usually tilts forward over the urinary bladder. Its function is to harbor the fetus, provide a source of nutrition, and expel the fetus at the end of its development. It is somewhat pear-shaped, with a broad superior curvature called the fundus, a midportion called the body (corpus), and a cylindrical inferior end called the cervix. The uterus measures about 7 cm from cervix to fundus, 4 cm wide at its broadest point, and 2.5 cm thick, but it is somewhat larger in women who have been pregnant. The lumen of the uterus is roughly triangular, with its two upper corners opening into the uterine tubes. It communicates with the vagina by way of a narrow passage through the cervix called the cervical canal. The superior opening of this canal into the body of the uterus is the internal Os and its opening into the vagina is the external Os. The canal contains cervical glands that secrete mucus, thought to prevent the spread of microorganisms from the vagina into the uterus. Near the time of ovulation, the mucus becomes thinner than usual and allows easier passage for sperm.

INTRODUCTION TO UTERINE FIBROIDS

Uterine leiomyomata or leiomyomas or fibroids are almost always benign tumour that originates from the smooth muscle wall of the uterus and may be single but usually occurs in clusters. They are most common in women of African descent and in women who have not borne children, and they are most often identified in women aged 30–45 years. New tumours rarely originate after menopause, and existing ones usually regress at that time but do not disappear (Encyclopædia Britannica, 2013). They arise from the muscle tissue of the uterus and can be found in the lining (intracavitary), muscle wall (intramural), and outside surface (serosa) of the uterus (SMELTZER, BARE, HINKLE, & CHEEVER, 2010).

CLASSIFICATION OF UTERINE FIBROIDS

Anatomical Classification of Uterine Fibroids according to their anatomic locations, there are four different types of leiomyomas; (Tochie, et al, 2020). Subserosal or subperitoneal leiomyomata are the most common and are usually asymptomatic unless very large. They originate in the myometrium and grow out toward the serosal surface of the uterus, lying beneath the peritoneum. They may lie just at the serosal surface of the uterus or may become pedunculated. They become parasitic when they derive their entire blood supply outside of the uterus, from omental vessels. Sometimes, their pedicles may atrophy and resorb. When they arise laterally, subserous tumours may extend between the two peritoneal layers of the broad ligament to become intraligamentary leiomyomas. Intramural or interstitial myomas are located within the uterine wall of the myometrium and may distort the shape of the uterine cavity and surface. They may manifest with swelling of the abdomen, menorrhagia and infertility. Submucosal fibroids are the most symptomatic. They originate in the myometrium and grow toward the endometrial cavity, protruding into the uterine cavity that they tend to compress. Their impact on the endometrium and its blood supply most often leads to irregular uterine bleeding. Other symptoms commonly associated are dysmenorrhea, infertility and recurrent abortions. This type of fibroids may also develop pedicles and protrude fully into the uterine cavity. Occasionally they pass through the cervical canal while still attached within the corpus by a long stalk. There, they are subject to torsion or infection. Cervical leiomyomas are a rare type. They are sometimes mistaken to vaginal leiomyomas, which may present with the same clinical features. They cause early pressure effects in regions of bladder neck, infection, dyspareunia and infertility.

INCIDENCE

Uterine fibroids are estimated to occur in 20% to 40% of women during their reproductive years. It is thought that women are genetically predisposed to develop this condition, which is almost always benign (SMELTZER, BARE, HINKLE, & CHEEVER, 2010). A higher incidence is seen with nulliparous women and those who are more than 35 years old. (GLYNN & DRAKE, 2012). By 50 years of age, 60% of all women will have had at least one uterine leiomyoma (Lewis, Bucher, Dirken, HEITKEMPER, & HARDING, 2014). They are most common in women of African descent (Encyclopædia Britannica, 2013). Fibroids are rare before puberty; an article from (KIM, KURITA, & BULUN, 2013) states that there are no cases of fibroids before puberty.

ETIOLOGY

The exact pathophysiology behind the development of uterine fibroids is unclear(OKOLO, 2008). Research suggests that the starting event for fibroid development begins with a single uterine smooth muscle cell(myometrium), which is then followed by deviations from the normal signalling pathways of cellular division (TOWNSEND, SPARKES, BALUDA, & McCLELLAND, 1970). Fibroids are considered to be estrogen-dependent tumours, and there is evidence showing that leiomyomas overexpress certain estrogen and progesterone receptors when compared to normal surrounding myometrium (BENASSAYAG, et al., 1999)

RISK FACTORS

1. One to two in 1000 women with uterine masses are estimated to have a uterine malignancy.
2. In postmenopausal women who are not on hormone replacement therapy,
3. Women responding poorly to gonadotrophin-releasing hormone (GnRH) agonists.

4. A history of tamoxifen use for more than five years is associated with a threefold increase in the risk of leiomyosarcoma.
5. Early menarche
6. Obesity
7. Late entry into menopause
8. Positive family history of uterine fibroids.
9. African descent.

Source: (BARJON & MIKHAIL, 2021)

PATHOPHYSIOLOGY

Fibroids are a result of the inappropriate growth of uterine smooth muscle tissue or myometrium. Their growth is dependent on estrogen and progesterone levels. The underlying pathophysiology is uncertain. (BARJON & MIKHAIL, 2021)

CLINICAL MANIFESTATIONS

- Mostly asymptomatic
- Vaginal bleeding, mostly menorrhagia and metrorrhagia.
- Pressure on the surrounding organs and include pain, backache, bloating, constipation,
- Irregular mass or several masses on palpation of the uterus
- Large tumors may cause a general enlargement of the lower abdomen.

Sources: (SMELTZER, BARE, HINKLE, & CHEEVER, 2010) and (Lewis, Bucher, Dirken, HEITKEMPER, & HARDING, 2014)

LABORATORY INVESTIGATIONS

- Personal medical and surgical and obstetric history.
- Physical examination by palpation of the uterus.

- Presence of clinical features presented by the client.
- The initial evaluation should include a beta-human chorionic gonadotropin test to rule out pregnancy.
- Full blood count, Thyroid stimulating hormone and a prolactin level to evaluate for the non-structural causes in the differential diagnosis.
- Radiologic studies- Transvaginal ultrasound is the gold standard for imaging uterine fibroids. It has a sensitivity of around 90 to 99% for the detection of uterine fibroids. Ultrasound can improve with the use of saline-infused sonography, which helps increase the sensitivity for the detection of subserosa and intramural fibromas. Fibroid appearance is as a firm, well-circumscribed, hypoechoic mass. On ultrasound, tend to have a variable amount of shadowing, and calcifications or necrosis may distort the echogenicity.
- Hysteroscopy is where the physician uses a hysteroscope to visualize the inside of the uterus. This imaging modality allows for better visualization of fibroids inside the uterine cavity. This method allows for the direct removal of intrauterine growths during the procedure.
- Magnetic Resonance Imaging MRI has the benefit of providing a better picture of the number, size, vascular supply, and boundaries of the fibroids as they relate to the pelvis. Nevertheless, it is unnecessary for a routine diagnosis when fibroids are suspected. It has not been shown to differentiate leiomyosarcoma from leiomyoma.

Source: (BARJON & MIKHAIL, 2021)

MEDICAL AND SURGICAL MANAGEMENT

SOURCES: (FISCELLA, et al., 2006), (HIRST, et al., 2008), (STEWART, et al., 2007)

Treatment of uterine fibroids may include medical or surgical intervention and depends to a large extent on the size, symptoms, and location, as well as the woman's age and her reproductive plans. Fibroids usually shrink and disappear during menopause, when estrogen is no longer produced. Simple observation and follow-up may be all the management that is necessary. The patient with minor symptoms is closely monitored. If she plans to have children, treatment is as conservative as possible.

Medical Management

- Alpha adrenergic blockers agents – to alleviate pain by relieving secondary smooth muscle spasms. An example is Phenoxybenzamine.
- Calcium channel blockers - to relieve pain by inhibiting the movement of calcium ions across the cell membrane and into smooth muscle cells. They also depress both impulse formation and conduction velocity. Example is Nifedipine.
- Anticonvulsants - The exact mechanism of action is unknown; however, it appears to interact with a high-affinity binding site in brain membranes (an auxiliary subunit of voltage-sensitive Ca^{2+} channels) to relieve chronic neurologic pain conditions. An example is Gabapentin.
- Metformin has been suggested, given the association with decreasing cancer incidence in diabetic individuals. It induces oxidative damage and, hence, is proapoptotic and antineoplastic.
- Gonadotropin-releasing hormone (GnRH) analogues, which induce a temporary menopause-like environment, may be prescribed to shrink the fibroids. This treatment consists of monthly injections, which may cause hot flashes and vaginal dryness. Treatment is usually short term (i.e., before surgery) to shrink the fibroids, allowing

easier surgery, and to alleviate anemia, which may occur as a result of heavy menstrual flow. This treatment is used on a temporary basis because it leads to vasomotor symptoms and loss of bone density (SMELTZER, BARE, HINKLE, & CHEEVER, 2010).

- Antifibrotic agents are under investigation for long-term treatment of fibroids. Mifepristone (RU-486, Mifeprex), a progesterone antagonist, has also been prescribed; it appears to be effective (FISCELLA, et al., 2006).

Surgical Management

- Hysteroscopic resection of myomas: a laser is used through a hysteroscope passed through the cervix; no incision or overnight stay is needed.
- Laparoscopic myomectomy: removal of a fibroid through a laparoscope inserted through a small abdominal incision.
- Laparoscopic myolysis: a laser or electrical needles are used to cauterize and shrink the fibroid
- Laparoscopic cryomyolysis: electric current is used to coagulate the fibroid.
- Uterine artery embolization (UAE): polyvinyl alcohol or gelatin particles are injected into the blood vessels that supply the fibroid via the femoral artery, resulting in infarction and resultant shrinkage. This percutaneous image–guided therapy offers an alternative to hormone therapy or surgery. UAE may result in infrequent but serious complications such as pain, infection, amenorrhea, necrosis, and bleeding. Although rare, deaths and ovarian failure may occur. Women need to weigh the risks and benefits carefully, especially if they have not completed childbearing. This procedure has been found to

cause fewer complications than hysterectomy, but women may need further treatment in the future (HIRST, et al., 2008).

- Magnetic resonance–guided focused ultrasound surgery (MRgFUS): ultrasonic energy is passed through the abdominal wall to target and destroy the fibroid. Although not yet widely used, this noninvasive procedure is approved by the U.S. Food and Drug Administration for premenopausal women with bothersome symptoms due to fibroids and who do not want more children. It is an outpatient treatment (STEWART, et al., 2007).

NURSING MANAGEMENT

Monitor vital signs and hemoglobin level. Assess client's blood loss for amount, color, and clots. Objectively assess pain with a 0 to 10 scale and administer analgesics as ordered. Encourage a diet high in iron-containing foods to prevent iron deficiency anemia and serving prescribed medications. But when surgery is indicated, the following applies:

PRE-OPERATIVE NURSING MANAGEMENT

Psychological Preparation

The client is reassured of competent health team and everything possible will be done to bring her condition under control. This helps to allay her fears and anxiety. Every procedure is explained to the client to win her co-operation. The nature of the operative environment is also explained to her so that she does not become frightened when she is sent to the theatre. The client is also introduced to patients who have undergone hesterectomy successfully and have recovered. She is also allowed to ask questions and the nurse provides answers to these questions. A religious leader may be asked to pray with the client if desired.

Rest and Sleep

Adequate rest and sleep is necessary as this relaxes the client, conserves energy and promotes health. The patient is put in comfortable bed. She is nursed in a quite environment which helps to relax the client and induce sleep. The client's room is well ventilated and light dimmed to induce sleep.

Observation

Vital signs are monitored. The site of intravenous line is checked for patency and flow of infusion is assessed. Intake and output chart is maintained to assess the fluid and electrolyte status of the client. The effects of the drug administrated are also observed and recorded in the nurse's notes

Nutrition

Prescribed intravenous infusion is monitored to ensure that it is dripping at the prescribed rate. The client is also encouraged to eat food rich in protein, carbohydrate and vitamins if her condition permits to help boost the immunity. However, food is withheld 6-8hours before the surgery to prevent regurgitation and aspiration during surgery.

Personal Hygiene

Client is assisted in maintaining personal hygiene

Exercise.

The importance of deep breathing exercises and how to perform it is explained to the client to prevent complications after surgery. The importance of passive limb exercise is explained to the client. The client is also taught how to turn from side to side in bed before the operation so that she would be able to perform it with ease after the surgery. This is done to improve circulation and to prevent bed sore.

Education

Patient is educated on her condition to enlighten her on the causes and management of uterine fibroid.

IMMEDIATE PRE-OPERARIVE MANAGEMENT

Client's vital signs is monitored and recorded which include temperature, pulse, respiration and blood pressure. The operative site is washed to remove dirt, grease and hair so as to reduce microbes on the skin. It is then rinsed and dried and antiseptic lotion applied on the site. It is then covered with sterile towel. Catheter is passed as prescribed by the surgeon. All ornaments and items are removed from the patient, e.g., Earrings, chain, dentures, beads, etc. Consent form is signed appropriately.

POST-OPERATIVE NURSING MANAGEMENT

Patient is received into a warm operational bed and reassured if conscious. She is placed in the recumbent position with the head turned to one side to prevent airway obstruction if unconscious. She is nursed in a bed with side rails raised to prevent her from falling. The operation note is quickly glanced through to identify any prescribed care needed. Client vital signs such as temperature, pulse, respiration, blood pressure is monitored every 15minutes for an hour, 30minutes an hour and 1hourly when she is fully conscious. The following are carried out when patient recovers from anesthesia. The location and intensity of pain are determined so that if it is due to position, she could be changed gently. Urinary and bowel elimination: The amount, color and odor of the first passage of urine are observed and any abnormalities reported. The client is not given anything by mouth until prescribed. Intravenous fluids are administered to maintain electrolyte balance and also prevent dehydration of the client. As bowel movement occurs, fluid diet, light diet, normal diet is introduced. The wound is inspected for any abnormality such as bleeding. Before the wound is dressed, it is inspected for signs of infection such as discharge of pus and discoloration. All observations made are documented in the nurse's notes. The client is gradually introduced to exercises such as deep breathing and passive limb movement as her condition improves. Client is also encouraged to sit out of bed as soon as her condition allows and also walk around the bed unassisted. The client and relatives are educated on the following; personal hygiene, care of the wound, nutrition, rest and sleep, follow-up or review, continuation of care, importance of adhering to instructions given to her.

COMPLICATIONS

Although the exact impact of fibroids on fertility is unknown, there is an apparent correlation between fibroids and infertility that is dependent on the location and size of the fibroid. Research by Pritts et al. showed that submucosal fibroids resulted in decreased rates of implantation and pregnancy as well as increased rates of spontaneous miscarriage due to their distortion of the endometrium. But more recently, Purohit and Vigneswaran stated that this research showed no evidence to suggest subserosa fibroids had any effect on fertility (PRITTS, PARKER, & OLIVE, 2009). Other complications include anemia, chronic pelvic pain, and sexual dysfunction (BARJON & MIKHAIL, 2021).

1.12 Validation of Data

Client presented condition and per the signs and symptoms seen in the client, and when compared to the literature review clearly showed that the client was having bleeding uterine fibroids. All pieces of information gathered in writing this report were compared with that of the clients to ensure that they are free of errors, bias or misinterpretations.

The diagnostic investigations also were in line and supportive of the literature review and the results confirms that data collected are having no discrepancies.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Data analysis is a process of inspecting, cleansing, transforming and modelling data with the goal of discovering useful information, suggesting conclusions and supporting decision making This is the act of comparing data collected on the client with standard. It is the second stage of the nursing process and includes patient/family's strength, health problem and diagnosis. For the purpose of the study, data analysis was done by comparing the data collected from the client and the family with the standards provided in the literature review of chapter one of this report. The areas of interest of analysis include;

- Comparison of data gathered with standards.
- Health problems
- Patient/family strengths
- Nursing diagnosis

2.1 Comparison of Data With Standards

This chapter compares the data gathered from the patient and significant others with the standards reviewed in the literature review. Data that will be emphasized on includes the following:

- Diagnostic investigations
- Clinical manifestations
- Cause of illness
- Treatment regimen
- Complications from the illness.

DIAGNOSTIC INVESTIGATIONS/TESTS

Diagnostic tests are approaches used in clinical practice to identify with high accuracy the disease of a particular patient and thus to provide early and proper treatment (Bolboaca, 2019). This section of this write-up compares the standard diagnostic investigations/tests employed for an ideal uterine fibroid and the diagnostic investigations/tests conducted on and for the patient. The following were the diagnostic investigations and tests conducted on and for the patient in her stay at St. Theresa's Hospital, Nkoranza, Bono East Region:

- Full blood count
- Serum electrolytes
- Blood grouping and matching.
- MRI (Hysteroscopy).

Comparison of Diagnostic Tests done to Literature Review

Diagnostic Test outlined in Literature Review.	**Test Carried Out on Patient**.
1, Full blood count.	1. Full blood was done.
2. Serum electrolytes.	2. Serum electrolytes was done.
3. Blood grouping and matching.	3. Blood grouping and matching was done.
4. Hysteroscopy.	4. Hysteroscopy was done.

From the above table one can conclude that Madam S. E. was rightly diagnosed since most of the diagnostic test outlined in literature review were carried out on her.

CAUSES OF PATIENT'S CONDITION.

Considering the presented complains, the support from ultrasonography and the physical examination, Madam S.E was truly having uterine fibroids but without a clear causing agent. It was attributed to her near menopausal era as suggested in the literature review.

Clinical Features of Madam S. E. Compared with those in the Literature Review.

Clinical features in Literature Review	**Clinical features exhibited by Madam S. E.**
1. Metrorrhagia	1. Metrorrhagia was present.
2. Menorrhagia	2. Menorrhagia was present
3. Pain	3. Patient complained of pelvic pains
4. Backache	4. No backache was reported by the patient
5. Bloating	5. No bloating was present
6. Constipation	6. Patient did not experience constipation.
7. Irregular mass or several masses on palpation of the uterus.	7. Irregular mass detected when the uterus was palpated.
8. Large tumour may cause a general enlargement of the lower abdomen.	8. Abdomen was not enlarged.

Patient presents with metrorrhgia, menorrhagia and client complains of pain in the pelvic region. An irregular mass was detected when her uterus was palpated. All these manifestations reveals that patient has uterine fibroid.

RESULTS OF DIAGNOSTIC INVESTIGATIONS CARRIED OUT ON MADAM S.E.

DATE	SPECIMEN	INVESTIGATION	RESULTS	NORMAL	INTERPRETATION	REMARKS
21/11/21	Blood	WBC	4.74 x 10^9 g/L	2.5 – 8.5 * 10^9/L	Normal range	Intravenous ceftriaxone prescribed as prophylaxis.
		Granulocytes absolute	3.5	2.0 -7.8 * 10^9/L	Normal range	
		Red blood cell	3.73	4.00 – 6.00 *12^9/L	Slightly below range	1 unit of blood with group AB procured as standby
		Haemoglobin level	10.4 g/dL	11.5 - 16.5 g/dL	Below normal range	
		Platelet level	220	150 – 450 10^9/L	Normal range	No treatment given
		Haematocrit	31.1	35 – 54%	Slightly below range	
		Mid cell absolute	0.3	0.1 – 1.0 * 10^9/L	Normal range	
		Blood sodium level	140mmmol/L	135 -145mmml/L	Normal range	No treatment given
		Blood potassium level	3.6mmol/L	3.5 -5.5mmol/L	Normal range	No treatment given
		Blood chloride level	107	90 – 110mmol/L	Normal range	No treatment given

		Pelvic ultrasound	Suggestive of subserosa fibroids. Three separate fibroids.	Fibroids should not be present on pelvic ultrasound	Not consistent with a normal pelvic ultrasound finding.	Elective hysterectomy.
08/11/21	Urine	Urine pregnancy test	Negative	Negative	Normal	No management given.
21/11/21	Blood	Grouping and cross matching	AB Rhesus positive	A, B, AB, O	-	-

SPECIFIC MEDICAL AND SURGICAL TREATMENT/MANAGEMENT

Preoperative medical/surgical care plan

- Planned total hysterectomy.
- Intravenous fluid 0.9% sodium chloride, 1.0L
- Intravenous fluid, ringer's lactate, 1.0L

Postoperative medical and surgical treatment and management

- Intravenous Ceftriaxone 2grams, 12hourly for 48 hours
- Intravenous Metronidazole 500mg, 8 hourly for 48 hours.
- Intravenous Paracetamol 1000mg, 8 hourly for 24 hours
- Suppository Diclofenac 100mg, 12hourly for 5 days.
- Intravenous Morphine 5mg, 6hourly for 24hours.
- Intravenous fluid, 5% dextrose, 2.0L.
- Intravenous fluid, 0.9% sodium chloride, 3.0L
- Oral Multivitamin 5mg, once daily for 5days
- Oral Folic acid 5m, once daily for 5days
- Oral Fersolate 200mg, once daily for 5days
- Oral Amoxiclav 625mg, 12hourly for 7days

TABLE3: PHARMACOLOGY OF DRUGS

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS
22/11/21	Ceftriaxone	Dosage 750mg to1.5mg three times daily Route Oral, IV / IM	2g 12hourly x 48 hours, intravenously.	Antibacterial Cephalosporin.	bactericidal activity results from inhibiting cell-wall synthesis by binding to 1 or more penicillin-binding proteins; exerts antimicrobial effect by interfering with synthesis of peptidoglycan	Patient did not experience any sign infection after surgery	Thrombocytoss ,rash, diarrhea, anemia.

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS
22/11/21	Metronidazole	**dosage**400 to 500mg three times daily **Route** Oral and IV	500mg 8hourly for 48hours, intravenously. Then Orally, 400mg 8hourly for 7days	Antibiotic Antibacterial Amebicide Antiprotozoal	Inhibits nucleic acid synthesis by disrupting DNA and causing strand breakage; amoebicidal, bactericidal, trichomonacidal;	Patient did not experience any sign infection after surgery	Dizziness, headache, vertigo, fatigue. None found in patient

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMARKS
22/11/21	Morphine	**Dosage** 2.5-10mg **Route** intravenous Subcutaneous and intramuscular 2-20mg	Intravenously, 5mg, 6hourly for 24hours.	Opioid agonist analgesic	acts as agonist at specific opioid receptors in the CNS to produce analgesia, euphoria, sedation;	Reduced the pain intensity for client	Light headedness, dizziness, euphoria, nausea, vomiting, and chest pains.

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS
22/11/21	Diclofenac	**Dosage** 50mg-100mg 12 hourly **Route** Oral, intravenous transdermal intramuscular and rectal	100mg, 12hourly for 5days, anally.	Nonsteroidal Anti-inflammatory drug (NSAID)	Produces an anti-inflammatory, analgesic and anti-pyretic effects possibly by inhibiting prostaglandin synthesis	Pain was relieved after drug was administered	Fatigue, tinnitus, rash, bleeding, dry mucous membranes, stomatitis, nausea, diarrhea.

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS
21/11/21	0.9% sodium chloride	Amount depends on patient fluid and electrolyte and age as well as by doctors' prescriptions	1 liter for 48 hours	Isotonic solution	Replacement of deficiency in sodium and chloride ions in the blood	patient maintained good hydration status	Fluid overload, hypernatremia, pulmonary edema. Non observed in the patient

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMARKS
21/11/21	Ringers' lactate	**Dosage** Amount depends on patient fluid and electrolyte and age as well as by doctors' prescriptions **Route,** Intravenous	1 litre for 48 hours	Isotonic solution	Replacement of electrolytes in the blood	Client was provided with the needed fluid and electrolytes	Hyperkalaemia, pulmonary edema, alkalosis. Non observed in the patient

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMARKS
22/11/21	5% dextrose in 0.9% sodium chloride	**Dosage** Amount depends on Patient fluid and electrolyte and age as well as by doctors' prescriptions. **Route** Intravenous	1 liter for 48 hours	Hypertonic solution	Replaces sodium, chloride and calories	Client was provided with the needed fluid and electrolytes	Fluid volume overload, pulmonary edema. Non observed in the patient

PHARMACOLOGY OF DRUGS CONT'D

DATE	**DRUG**	**DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE**	**DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT**	**CLASSIFICATION**	**DESIRED EFFECTS**	**ACTUAL ACTION OBSERVED**	**SIDE EFFECTS/ REMARKS**
22/11/21	Paracetamol	**Dosage** 0.5-1g every 4 to 6 hours **route** Oral and intravenous	Intravenously, 1000mg, 8hourl for 24hours.	Antipyretic Analgesic (nonopioid)	Antipyretic: Reduces fever by acting directly on the hypothalamic heat-regulating center to cause vasodilation and sweating, which helps dissipate heat. Analgesic: Site and mechanism of action unclear	Reduced the pain intensity for client	Headache, chest pains, thrombocytopenia, rash, hepatic toxicity, jaundice. Patient did not experience any of these.

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS
24/11/21	Amoxiclav (amoxicillin + clavulanate)	**Dosage** 625mg-1000mg bd x 7 **Route** Oral	Orally, 625mg 12hourly for 7days	Antibiotics (penicillin)	Bactericidal: Inhibits synthesis of cell wall of sensitive organisms, causing cell death	Served as a prophylaxis against infection.	Lethargy, seizures, thrombocytopenia, None was experienced

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMARKS
24/11/21	Multivitamin	**Dosage** 1 tablet daily **Route** oral	Orally, 5m, once daily for 5days	Vitamins and minerals supplement.	Replenishes vitamins and minerals in the body to support protein and DNA synthesis, general metabolism.	Maintained client's red blood cells in normal ranges.	Constipation, nausea, vomiting, dark stools. None was experienced

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMARKS
24/11/21	Folic acid	**Dosage** 400 micrograms/day **Route,** Oral	Orally, 5m, once daily for 5days	Vitamin supplement	Required for nucleoprotein synthesis and maintenance of normal erythropoiesis.	Maintained client's red blood cells in normal ranges.	Hypersentiviy causes allergic reactions. None was experienced

PHARMACOLOGY OF DRUGS CONT'D

DATE	DRUG	DOSAGE AND ROUTE OF ADMINISTRATION IN LITERATURE	DOSAGE AND ROUTE OF ADMINISTRATION TO PATIENT	CLASSIFICATION	DESIRED EFFECTS	ACTUAL ACTION OBSERVED	SIDE EFFECTS/ REMARKS
24/11/21	Fersolate	**Dosage** 130 -195mg ferrous iron 2-3 tablet daily in divided doses **Route** orally	**Dosage**, 200g, once daily for 5days **Route** Oral	Iron supplement	Replenishes iron in the body and blood, an essential component of haemoglobin.	Maintained client's red blood cells and haemoglobin levels in normal ranges.	Nausea, diarrhoea, flatulence, abdominal pains. None of these were experienced

COMPLICATIONS OF THE CONDITION

With reference to the complications listed in the literature review and the side effects corresponding to each of the individual drugs as listed in table 3, the client did not have any complications or side effects of any drug in her stay in the hospital. However, the client and the family were educated on the complications of the condition and the side effects of the individual drugs, and that if they should observe any of them, should report to the hospital or any health care providing facility near them for review

PATIENT/FAMILY STRENGTH.

This includes the activities and resources of client and relatives which enhance speedy recovery of patient.

1. Patient was conscious on admission, thus could voice out the site, frequency, duration and intensity of the pain (pain rating), as well as the aggravating and relieving factors.
2. Patient could verbalise the level of anxiety
3. Patient and family adheres to instructions concerning wound care.
4. Patient could eat 100mls of food served
5. Patient can tolerate daily activities
6. Client is willing to know more about the condition, the treatment modalities

HEALTH PROBLEMS

These are problems that affect the patient and can hinder her recovery if not resolved. Through assessment the following were identified;

Pre-operative

21st November, 2021

1. Patient complains of pain in the pelvic region.
2. Patient complains of feeling anxious.

Post-operative

22nd November 2021

1. Patient has an incisional wound.
2. Patient has alteration in feeding.

23rd November 2021

1. Patient cannot perform daily activities, thus; bathing and grooming.

24th November, 2021

1. Patient has deficient knowledge about her condition.

2.4 Nursing Diagnoses

A nursing diagnosis is defined by NANDA international (2013) as a clinical judgement concerning a human response to health condition/life processes, or vulnerability for that response, by an individual, family, group or community.

1. Pain related to pressure on surrounding pelvic structures secondary to growing tumour. (21/11/21).
2. Anxiety related to unknown outcome of impending surgery. (21//11/21)
3. Impaired tissue integrity related to surgical incision. (22/11/21).
4. Imbalance nutrition, less than body requirements related to not able to take required food secondary to surgery. (22/11/21)
5. Self-care deficit (bathing and grooming) related to weakness after surgery. (23/1121).

6. Knowledge deficit related to inadequate information on the cause and management of uterine fibroids. (24/11/21)

CHAPTER THREE

PLANNING FOR PATIENT / FAMILY CARE

3.0 Introduction

In this chapter, the nursing care plan is used to provide continuity of care and directions about what needs to be done for patient to relieve her of her problem. The patient care plan is written based on the data collected which is translated into nursing diagnosis.

3.1 Objectives of Care.

1. Patient will be relieved of pain within 48hours of hospitalization as evidence by;

a. Nurse observing patient having a cheerful face.

b. Patient verbalizing a feeling of improved comfort.

2. Patient and relative will be relieved from anxiety within 12 hours as evidence by;

a. Patient and relatives verbalizing they are no longer anxious.

b. The nurse observing relaxed facial expression of patient.

3. Patient will show no sign of surgical site infection within period of hospitalization as evidence by;

a. Nurse observing strict asepsis during wound dressing.

b. Patient verbalizing the need to keep incisional site dry.

4. Patient will be able to demonstrate optimal performance of activities of daily living within 48 hours as evidenced by;

a. Patient verbalizing that she no longer feels weak.

b. Nurse observing patient perform activities of daily living.

5. Patient will regain and maintain optimal nutrition balance (to body's requirement) throughout the period of hospitalization as evidenced by

a. Patient verbalizing an increase in appetite.
b. Nurse observing patient eating more than half of meal being served.

6. Patient and relative will gain adequate knowledge on uterine fibroid within the period of hospitalization as evidence by;

a. Patient and family being able to provide correct answers to questions being posed to them with the risk factors, causes clinical manifestation and management of uterine fibroid.
b. Nurse observing patient and family practiced knowledge gained on uterine fibroid.

TABLE 4: NURSING CARE PLAN OF MADAM S. E.

DATE	NURSING DIAGNOSIS	OBJECTIVE/OUTCONE CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE	EVALUATION	SIGN
21/11/21 10:00am	Pain related to pressure on surrounding pelvic structures secondary to growing tumours.	Patient will be relieved of pain within 48 hours of hospitalization as evidence by; 1 Nurse observing patient having a cheerful face. 2. Patient verbalizing a feeling of improved comfort.	1. Reassure patient and offer psychological support. 2. Perform assessment of the pain: location, characteristics, onset, duration and frequency 3. Determine patient's perception and understanding of the pain. 4.Check and record vital signs 5.Encourage the use of relaxation techniques; providing diversional activities 6. Administer the prescribed analgesics.	1. Patient reassured of competent care. 2. Pain assessment done using the pain rating scale score (0-10). 3. Patient's perception about the pain assessed. Patient does not know the possible causes of her pain. 4.Vital sign checked and recorded 5.Patient and family where involve in therapeutic communication to divert client attention from pain 6. Prescribe medication was administered (1g of Iv paracetamol).	23/11/21 10:00am	Goal fully met as patient report relieve of pelvic pain and nurse observing patient showing a cheerful Facial expression.	Y.O

NURSING CARE PLAN OF MADAM S. E. CONTINUED.

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
21/11/21 10:10am	Anxiety related to unknown outcome of impending surgery. .	Patient and relatives will be relieved from anxiety within 12 hours as evidence by; 1. Patient and relative verbalizing they are no	1. Reassure patient and family. 2. Discuss with patient and give full information about the surgery. 3.Allow patient to ask question to clear all doubt 4. Tactfully answer patient's question in a language she understands. 5. Introduce patient to a successfully recovered patient who had similar surgery.	1. Patient and family were reassured of positive outcome and the competence of surgical team. 2 .Patient was educated on hysterectomy and how it was going to be carried out. 3.Patient and family were allowed to ask question to clear any doubt 4. All question asked were tactfully answered in Ghanaian language (twi).	21/11/21 10:10pm	Goal fully met as patient verbalized that she does not feels anxious and fearful again and nurse observed that patient have relax facial expression and posture	Y.O

		longer anxious. 2. The nurse observing relaxed facial expression of patient	6. .Explain to patient what happen during anaesthesia and how post-operative pain will be manage after recovery from anaesthesia.	5. Client was introduced to madam V.T a 36-year woman who had similar surgery and recovered successfully. 6. .Details of anaesthesia and management of post-operative pain with analgesics were explained to patient.			

NURSING CARE PLAN OF MADAM S. E. CONTINUED.

DATE	NURSING DIAGNOSIS	OBJECTIVE/OUT CONE CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE	EVALUATION	SIGN
22/11/21 4:00pm	Impaired tissue integrity related to surgical incision.	patient will show no sign of surgical site infection within period of hospitalization as evidence by; 1. Nurse observing strict asepsis during wound dressing. 2. Patient verbalizing the need to keep incisional site dry	1. Assess the characteristic of the wound including colour, size, drainage and odour. 2. Assess changes in body temperature specifically increase body temperature. 3. Dress wound aseptically. 4. Encourage patient to avoid rubbing and scratching the wound edges.	1. Patient`s wound was assessed. A surgical wound with no drainage or odour. The wound characteristics were assessed every day when wound was cared for. 2. Patient`s temperature was assessed routinely, 4hourly every day. No temperature elevation recorded. 3. Aseptic technique was employed in wound care. 4. Patient was educated and encouraged on the need to avoid rubbing and scratching of the wound edges.	26/11/21 10:00am	Goal fully met as evidenced by Patient verbalized the need to keep incisional site dry and nurse observing strictly to asepsis technique during wound care.	Y.O

			5. Encourage a diet that meet nutritional needs to promote wound healing.	5. Patient was provided with diet rich in nutritional need of the body to promote wound healing.			

NURSING CARE PLAN OF MADAM S. E. CONTIUNED.

DATE/TIME	NURSING DIAGNOSIS	OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUTION	SIGN
23/11/21 At 8:00am	Self-care deficit (bathing and grooming) related to weakness after surgery.	Patient will be able to demonstrate optimal performance of activities of daily living within 48hours of hospitalization as evidenced by; 1. Patient verbalizing that she no longer feels weak. 2. Nurse observing patient perform activities of daily living.	1. Assess the patient`s strength level. 2. Brush patient`s teeth or assist patient to brush her teeth. 3. Use appropriate assistive devices in assisting patient in grooming. 4 .Feed patient or allow patient to feed herself as soon as	1. Patient was assessed using the FIM. Patient could not undertake any of the ADL`s in the first few hours after surgery. 2. Patient`s oral care was done for her in the initial stages, later patient was assisted till she gained self-independence. 3. Walkers were used for patient to help her early ambulation period.	25/11/21 At 8:00am	Goal fully met as evidenced by; patient verbalized that she is no longer feels weak and nurse observing patient performing activities of	Y. O.

			possible to promote self-dependence. 5. Serve bedpan for patient when necessary 6. Educate family and other significant to promote autonomy in patient`s performance of ADL`s.	4. Patient was fed in initial stages, later patient was allowed to feed by herself (assisted). 5. .Bedpan was served to patient when necessary. 6. Family and significant others were educated and encourage to promote autonomy in patient`s performance of ADL`s		daily living on her own.	

NURSING CARE PLAN OF MADAM S. E. CONTINUED.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUTION	SIGN
22/11/21 At 4pm	Imbalance nutrition (less than the body's requirement) related to not able to take in food temporarily, secondary to surgery.	Patient will regain and maintain optimal nutritional balance (to body`s requirement) throughout the period of hospitalization as evidenced by; 1. patient verbalizing an increase in appetite 2. Nurse observing patient eating more than half of meal serve.	1. Reassure patient by explaining to her why the need to restrict food temporarily. 2. Weigh patient daily. 3. Monitor intake and output of the patient. 4.plan diet with the patient and nutritionist (transitioning	1. Patient was reassured by explaining the concept on the need to restrict food temporarily immediate post-surgery and the gradual transitioning to normal solid food . 2. Patient was weighed every day. 3. Fluid intake and output were monitored and recorded every 24 hours.	26/11/21 At 10:05am	Goal was fully met as patient verbalized an increase in appetite and nurse observing patient eating more than half of meals serve.	Y. O

			From Nil per Os to liquid food then to solid food). 5. Provide mouth care to the patient. 6. When finally cleared from Nil per Os, served planned and recommended available food in clean environment to the patient,	4. Patient`s diet from the immediate post- surgery to normal solid food was planned with patient, the nutritionist, relatives and nurses. 5 .Patient`s mouth care was cared for twice daily with tooth brush and tooth paste (morning and evening) 6. After patient was cleared from Nil per Os, available diet was planned and served to her in a clean environment.			

NURSING CARE PLAN OF MADAM S. E. CONTINUED.

DATE	NURSING DIAGNOSIS	OBJECTIVE/OUTCONE CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE	EVALUATION	SIGN
24/11/21 8:00am	Deficient knowledge related to insufficient information	Patient and relative will gain adequate knowledge on uterine fibroid within 6 hours as evidence by; 1.Patient and family being able to provide correct answers to questions being posed to them on the risk factors, causes clinical manifestation and management of uterine fibroid	1.Assess current knowledge base of patient on the condition 2. Assess for readiness of learning new information about the illness. 3.Educate patient on the causes, treatment modalities and signs and symptoms of uterine fibroids	1. Patient's current knowledge base was assessed and she had very little knowledge about uterine fibroids. 2. Patient was assessed for readiness and was ever ready and keen to learn new information about her condition. 3. Patient was educated on the causes, treatment modalities and signs and symptoms of uterine fibroids. 4. Patient was encouraged to ask questions. 5. Learning friendly environment such as one with less noise and interference	24/11/21 2:00pm	Goal fully met as evidenced by Patient verbalizing the accurate information about condition and treatment by discharge. Patient recognizing when and how to seek for help	Y.O

		2.Nurse observing patient and family practiced knowledge gained on uterine fibroid	4. Encourage patient to ask questions. 5. Create a learning friendly environment. 6. Inquire feedback about the learning process.	was created to aid in teaching and learning. 6. Feedbacks were sought from the patient. Patient gave feedback that she was grasping the concept very.		to learn new information about any condition by discharge.	

CHAPTER FOUR

IMPLEMENTATION OF PATIENT AND FAMILY CARE

4.0 Introduction

This is the fourth phase of the nursing process signifying the giving of care in relation to defined nursing interventions and goals. The nursing care plan is tested for effectiveness and accuracy.

4.1 Summary of Actual Care Rendered

The summary of the actual nursing care plan is a narrative of the care rendered to patient and family while on the ward until discharge. The nursing care was aimed at ensuring comfort of patient and to promote her recovery without complication. The actual nursing care rendered to Madam S.E. started on 21st November, 2021 and ended on 15th December, 2021. While on admission, the routine action such as oral care, vital signs and administration of medication were done and all important documentation were also carried out.

FIRST DAY OF ADMISSION (21ST NOVEMBER, 2021).

On the 21st November, 2021, around 9am, Madam S.E reported straight to the surgical ward for an elective total hysterectomy. She was accompanied by her eldest daughter and her sister. On arrival, patient and relatives were welcomed and offered a seat at the nurses station. Introduction of myself and other stuffs present to the patient and her relatives was done. Her admission was confirmed by calling her name written on the e- folder card handed to me and she responded. I also entered her card number on the ward computer and further mentioning her name for response. Her admission was stated clearly there by the Surgeon. She was seen by Dr. A. K. who ordered for the following;

1. Full blood count.
2. Intravenous fluids: 1L ringer's lactate.

3. 1L 0.9% sodium chloride for preload.
4. To get a consent form signed.
5. To do serum electrolyte.
6. Pass urethral catheter.
7. To be kept on nil per os.
8. To secure at least 1 unit of whole blood (this was already secured as the client was told about it on the day she was being booked)
9. Last anaesthetic assessment.
10. Hysteroscopy.

Patient was put into a well laid admission bed and made comfortable in bed. Family of Madam S.E were reassured and made comfortable in the waiting area. Assessment (head to toe) of madam S.E. was done which revealed that patient was not in respiratory distress, She was well hydrated with capillary refill being less than two seconds, there was no pedal oedema observed and was conscious. Vital signs was checked and recorded on arrival as follows: temperature: 36.5 degrees Celsius, blood pressure:119/80mmHg, pulse rate: 92 beats per minutes, respiration count: 20cycle per minutes, oxygen saturation (pulse oximetry): 99%, random blood sugar: 6.1mmol/L. intravenous line was secured and blood sample obtained for full blood count, serum electrolytes and blood grouping. Intravenous ringers' lactate 1L at a rate of 250 drops per hour set up as a preload before the surgery. She came with complains of pains at the pelvic region and fear of impending surgical procedure.

Madam S.E was helped to change into appropriate clothing per the ward's protocols. All valuables were obtained and given to her relatives for safekeeping. Madam S.E was educated on the National Health Insurance Schemes. She was also introduced to other patients near her in the ward. Orientation of ward and its annexes were done for client and her relatives and were also informed about the routine ward activities like time of scheduled vital signs checking and also time of visiting. Client was having a blood group of AB Rh positive. Catheter size 20 was successfully inserted and secured with 20mls of distilled water. Client was kept on nil per os after its significance was made known to her.

Client's particulars were entered into the admission and discharge book and the daily ward state, and nurses note was written. Consent form was duly signed after the procedure was adequately explained to the client, including the risks. The anaesthetic assessment was done around 1pm and it declared client as fit for the impending surgery.

Because I was involved in all the proceedings that transpired between the patient, myself and the other nurses, I was interested in caring for Madam S.E. throughout her current ailments. And as patient and family care study forms part of the requirements needed to obtain a license to practice by the Nursing and Midwifery Council of Ghana, I decided to use Madam S.E for my study. I first approached the Head of nurses in the surgical ward about my intention, who subsequently gave me guidelines and approaches to go about the study. I then approached Madam S.E. when she was comfortably resting in bed about my intention to use her as study. I made her aware about what will be expected of her and myself too. I explained to the patient and her relatives the concept of the patient/family care study and assured them of privacy and confidentiality. It was also added that a report will be written after the entire event. I told them that I will visit their home while they are still on admission and also visit them when they are discharged home to continue the care being rendered. I also made it clear to the family that they have the right to withdraw from the arrangement whenever they feel to do so. Madam S. E. and family agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. I decided to choose this patient for the study because I wanted to know more about uterine fibroid and its managements.

At 10:00am per the patient complains of pains at pelvic region, a nursing diagnosis of pain related to pressure on surrounding pelvic structures secondary to growing tumours was formulated and objective was set to relieve patient pains within 48 hours of hospitalization. The following intervention were carried out on the patient to relieve the pain; patient was reassured of competent care, Pain assessment was done using pain rating scale score (0-10), patient perception about pain was assess, vital signs was monitored, patient and family were involved in therapeutic communication to divert patient attention from pain and intravenous paracetamol 1g served to relieve pain.

At 10:10am I went to interact with her, Patient was showing a feeling of apprehension and she was not cooperating. So I asked her to verbalize her fear and worry. She then revealed to me that she was anxious about the impending surgery. Therefore a nursing diagnosis of Anxiety related to unknown outcome of impending surgery was formulated and objective was set to relieve patient from anxiety within 12 hours of hospitalization. Nursing interventions carried out on Madam S. E. were; Patient and family were reassured of positive outcome and the competence of surgical team, patient was educated on hysterectomy and how it was going to be carried out, Patient and family were allowed to ask question to clear any doubts. Some recovering patients in the ward who had gone through various surgeries were introduced to the client to help reduce anxiety but this was also not the client’s first time at the operation room.

AT 2:00pm vital signs were checked and recorded as in appendix and also due prescribed medications were administered and documented. Patient took her bath around 5:45pm.

At 6:00pm, patient vital signs were checked and recorded as in appendix and due prescribed evening medications were also served and documented to ensure proper nursing care.

At 10:00pm, vital signs were checked and recorded as in appendix.

At 10:10pm, objective set up to help patient and relatives relieved of anxiety was evaluated and goal was fully met as patient verbalized that she does not feel anxious again and nurse observed that patient has relaxed facial expression.

Patient slept around 10:30pm and I handed her over to the night shift nurses to continue the care and departed to my house.

SECOND DAY OF ADMISSION/SURGERY DAY (22ND NOVEMBER, 2021).

On the second day of admission at 7:30am, I went to continue my care to Madam S. E., her morning vital signs had already been checked and recorded by the night shift nurses as follows; Temperature 36.4^{0}C, Pulse 80bpm, Respiration 19cpm and Blood pressure 130/90mmHg. There was no changes in Madam S. E. treatment plan during morning rounds by Dr A. K. but rather to continue the treatment. 1000mls of 5% Dextrose in 0.9% sodium chloride was set up on the patient at 8:30am. Madam S. E. was help to change into theatre gown.

Confirmation from theatre came that the patient would undertake the said surgery at 11:50am, therefore patient was prepared for the said surgery as follows;

IMMEDIATE PRE-OPERATIVE MANAGEMENT.

Patient's drainage bag was emptied, recorded and checked for patency. The surgery site was cleaned and covered aseptically. Body ornaments were taken and store per the ward's protocol. Patient was made to pass out faecal matters early in the morning. She was educated on what happens in the first few hours after coming out of the surgery and what would be done for her. Patient was taken into the operation room exactly at 11:50am with vital signs as follows:

temperature – 36.4^{O}C, blood pressure – 130/mmHg, pulse – 82bpm, respiration count – 18cpm, pulse oximetry saturation – 99%. A well laid operational bed was made in anticipation of patient's return form surgery. Right after patient was sent to the theatre, I took the opportunity and asked for permission from my head of department for my first home visit at 12:10pm.

IMMEDIATE POST OPERATIONAL MANAGEMENT.

After the surgery, patient was taken to the theatre's recovery ward before transferring back to the ward. Patient immediate post-operative care was to be monitored and managed before transferring to ward. Patient level of consciousness was assessed by calling her name and pinching her for a response. Vital signs were checked and recorded accurately as shown in the appendix.

Patient was brought back to the surgical ward at around 3:06pm in a fully conscious state, not in respiratory distress, afebrile, not pale, good hydration, with 500lmls of ringer's lactate infusion insitu and flowing. Drainage bag had 460mls of fluid inside. Patient was received into her operation bed with the side rails raised to protect the patient from falls. Some patients teased her about her earlier anxiety episodes. Vital signs were checked and recorded as follows;

Temperature 36.6^{o}C, Pulse 80bpm, Respiration 19cpm, Sp02 98%, BP 125/80mmHg.

Continuous monitoring and observation went on throughout the rest of the day. The post-operative medical/surgical care plan were carried out accurately. Patient and relatives were reassured of competent nursing care.

The treatment plan for Madam S. E. was as follows;

- Keep NPO for 12hours.
- Keep urethral catheter for at least 24hours.
- Intravenous ceftriaxone 2000mg, 12hourly for 48hours.

- Intravenous metronidazole 500mg, 8hourly for 48hours.
- Suppository diclofenac 100mg, 12hourly for 5days.
- Intravenous morphine 5mg, 6hourly for 24hours
- Intravenous paracetamol 1000mg, 8hourly for 2days
- Monitor vital signs closely.

POST OPERATIVE CARE

- Patient was put in the supine position with the head tilted to one side to prevent aspiration.
- Emergency equipment including oxygen apparatus, suction machine and endotracheal tube were placed at the bed side of patient in case of cyanosis or difficulty in breathing.
- Vital signs (temperature, pulse, respiration and blood pressure) were checked 2 hours and 4hourly as condition improved.
- The incisional site was observed for any bleeding which might lead to shock.
- Patient was instructed to hold the abdomen when coughing and sneezing.
- Patient was encouraged to do range of motion exercises to promote healing of wound.
- Patient was educated to avoid touching the incisional site to prevent transfer of infection.
- Post-operative medications like analgesics administered to relief pain immediately after surgery.
- The patient and relatives were reassured that all measures would be put in place to help patient in gaining full goal in terms of her health.

The following nursing problems were identified today at 4:00pm after thorough assessment as Patient had an incisional wound. And the nursing diagnosis was impaired tissue integrity related to surgical incision. An objective was set to ensure no signs of surgical site infection within the period of hospitalization. Nursing interventions carried out were as follows Patient's wound was assessed, a surgical wound with no drainage or odour. The wound characteristics were assessed every day when wound was cared for, Aseptic technique was employed in wound care and patient was educated and encouraged on the need to avoid rubbing and scratching of the wound. Patient was provided with diet rich in nutritional need of the body to promote wound healing. Patient's temperature was assessed routinely, 4hourly every day.

Also another diagnosis was made as Imbalance nutrition, less than body requirements, in relation to not being able to take in food by mouth, secondary to surgery. The objective set was, patient will regain and maintain optimal throughout the period of hospitalization. Patient was reassured, explaining the concept on the need to restrict food temporarily immediate post-surgery and the gradual transitioning to normal solid food. Patient was weighed every day. Fluid intake and outputs were monitored and recorded every 24 hours. Patient's diet from the immediate post-surgery to normal solid food was planned with patient, the nutritionist, relatives and the nurses after patient was cleared from Nil per os, Patient's mouth was cared for twice daily (morning and evening) and rinses her mouth every time patient was about to eat and has finished eating.

At 6:00pm patient vital sign checked and recorded as shown in the appendix patient's personal hygiene was taken care of and she was made comfortable in bed. All prescribed medications were served and recorded in the nurses' notes. There was an incisional wound which was to be dressed three days after surgery as prescribed by the surgeon.

THIRD DAY OF ADMISSION/FIRST POST-OPERATIONAL DAY (23RD NOVEMBER, 2021).

On the said date at 7:30am I went to the ward to continue my care for Madam S. E..6:00am vital signs were already checked and recorded by the night shift nurses as follows; Temperature 36.6^{0}C, pulse 70bpm, Respiration 18Cpm, Sp02 %, Blood Pressure 120/70mmHg. A report from the night shift nurses indicates that patient had a sound sleep. At 7:55am, Doctors came for wards rounds and attended to her. No changes were made in her treatment plan but added the following.

- 0.9% sodium chloride intravenous fluids, 1.0L
- 5% dextrose intravenous fluid, 1.0L
- Intravenous ceftriaxone 2000mg, 12hourly for 24hours.
- Intravenous metronidazole 500mg, 8hourly for 24hours.
- Intravenous paracetamol 1000mg, 8hourly for 1day.

At 8:00am, it was revealed to me by the patient relative that Madam S. E. cannot perform personal hygiene such as bathing and grooming on her own, hence a nursing diagnosis of Self-care deficit (bathing and grooming) related to weakness after surgery was formulated. An objective and nursing intervention set for patient to demonstrate optimal performance of activities of daily livings within 48hours of hospitalization include: patient was assessed using the FIM, patient could not undertake any of the ADL's in the first few hours after the surgery, patient's oral care was done for her in the initial stages, later, patient was assisted till she gained self-dependence. Walkers were used for patient to help in her early ambulation period, patient was fed in initial stages, later, and she was allowed to feed by herself (assisted). Bedpan was served to patient when necessary. Family and significant other were educated and encourage to promote autonomy in patient's performance of ADL's. She was groomed and made comfortable in bed.

At 10:00am, the objective set up to help patient to relieved of pelvic pain within 48 hours were evaluated and goal was fully met as nurse observing patient showing a cheerful Facial expression. Medications were served appropriately and documented to ensure quality nursing care.

At 2:00pm, Vital signs were checked and recorded as shown in the appendix. All prescribed

Goal fully met as patient report

Patient was continually reassured. Planning of diet with patient and the nutritionist continued but patient was still on Nil per os, hence, no oral food was served to the patient, and the patient and relatives understood this regimen.

Patient was assisted to bath at 5:45pm.

At 6:00pm, Routine vital signs were checked and recorded as shown in the appendix. All due medications were administered to the patient and documented in patient folder.

At 10:00pm, patient vital signs were checked and recorded as in appendix. All medications were also served to her and documented. Patient was made comfortable in bed and she slept around 10:25pm. Patient was handed over to the night shift nurses to continue the care and I departed to my house around 10:35pm.

FOURTH DAY OF ADMISSION/ SECOND POST-OPERATIVE DAY (24TH NOVEMBER, 2021).

On the 4th day of admission, Patient has had no complications so far, as expected. Patient could do some of the activities of daily living but with assistance. Patient verbalized that she had a sound sleep throughout the night. 6:00am Vital signs have been checked and recorded already by the night as in appendix. Patient was assisted to care for her personal hygiene and groomed. Wound dressing was done. The wound was clean with no pus and was dressed aseptically. Prescribed drugs were served and recorded. She was made comfortable in bed; relatives were given seats near patient's bed and health education given to them to their understanding and were made to ask questions to clear all misconception. They were answered in simple terms for easy understanding.

At 7:55am during ward rounds by doctor G. the following treatment plan were added.

To start sip and gradually move to semi solid food and then later, solid food.

At 8:00am, nursing diagnosis of Deficient knowledge related to insufficient information about her condition was formulated with objectives set up to help patient and relative gain adequate knowledge on uterine fibroid within 6 hours. Nursing intervention carried out to help Patient and family to gain adequate information about her condition were as follows; Patient's current knowledge base was assessed and she had very little knowledge about uterine fibroids, patient was assessed for readiness and was ever ready and keen to learn new information about her condition.

Patient was educated on the causes, treatment modalities and signs and symptoms of uterine fibroids, she was encouraged to ask questions, Learning friendly environment such as one with less noise and interference was created to aid in teaching and learning.

At 10am, patient vital signs was checked and recorded as in appendix. All due medication were also served and documented in patient folder.

At 2:00pm, an objective set up to help patient and relatives to gain adequate information about uterine fibroid was evaluated and goal was fully met as evidenced by; Patient verbalizing the accurate information about condition and treatment by discharge, Patient recognizing when and how to seek for help to learn new information about any condition by discharge. Patient was started on sips while close monitoring. Patient was made to start semi-solid food around 5pm today. Patient was looking more stable in the evening.

6:00pm vital signs was checked and recorded as in appendix. All due prescribed medications were also served and documented in patient`s folder. Patient was introduced to assisted range of motion exercises.

Madam S. E. was monitored till I handed her over to the night shift nurses at 10:30pm to continue the care.

FIFTH DAY OF ADMISSION/THIRD POST OPERATIVE DAY (25TH NOVEMBER, 2021).

On the said date, I went to continue my care for Madam S. E. and her family at 7:30am. 6:00am vital signs were already checked and recorded as follows Temperature 36.6^{0}C, Pulse 83bpm, Respiration 18Cpm, Sp02 99%and Blood pressure 120/70mmHg.The main goal for today was to initiate patient on solid food and monitor. No wound dressing was done for today. During ward rounds at 7:50am the following were added to the already existing medical-surgical care plan:

- Oral multivitamin 5mg, 1Tablet daily for 5days
- Oral folic acid 5mg daily for 5days. To remove catheter.
- Oral amoxiclav 625mg, 12hourly for 7days
- Oral metronidazole 400mg, 8hourly for days

Patient was continually reassured. Planning of diet with patient and the nutritionist continued but patient was still on Nil per os, hence, no oral food was served to the patient, and the patient and relatives understood this regimen. Routine vital checked and recorded as shown in the appendix.

At 8:00am an evaluation of the objective set on 23rd November, 2021 to help patient demonstrate activities of daily living was done and goal was fully met as evidenced by; patient verbalized that she is no longer feels weak and nurse observing patient performing activities of daily living on her own.

Patient Vital signs were checked and recorded as in appendix at 2:00pm. All prescribed medications were served. Patient was initiated on solid food. Her wounds had no complications yet. Patient was recuperating very well as expected. Urethral catheter was removed successfully without any complications.

Evening Vital signs were monitored and all prescribed medication were served to Madam S. E.to help in her recovery. Patient was monitored till I handed her over to the night shift nurses at 10:45pm to continue the care of her and departed home.

SIXTH DAY OF ADMISSION/ DAY OF DISCHARGE (26TH NOVEMBER, 2021).

On this day patient was very strong and looked cheerful. All basic nursing care was carried out which includes checking and recording vital signs and serving medications. Patient was able to carry out her personal hygiene activities when assisted. On ward rounds, patient was reviewed by the doctor and was discharged.

At 10:00am an evaluation of the objective set on 22 November 2021 to prevent infection of patient wound throughout the period of hospitalization was done and the goal was fully met as evidenced by; Patient verbalized the need to keep incisional site dry and nurse observing strictly to asepsis technique during wound care.

At 10:05am, an evaluation of the objective set on 22 November 2021 to maintain an optimal nutrition was done and goal was fully met as evidenced by; patient verbalized an increase in appetite and nurse observing patient eating more than half of meals served.

Patient was told to come for review on 8/12/2021 at the OPD. Patient was educated on good personal hygiene and environmental hygiene. She was then educated on the need to eat a well-balanced diet to enhance wound healing and adequate water to prevent constipation. Patient relatives were accompanied to settle bills and received her discharge drugs. Patient was discharged home by the doctor on the following medication: oral amoxiclav 625mg, 12hourly for 7days, oral metronidazole 400mg, 8hourly for 7days, oral paracetamol 1000mg, 8hourly for 5days, oral multivitamin 5mg daily for 5days and oral folic acid 5mg daily for 5days. Patient’s wound dressing was done (the wound has not had any complications) and was instructed and encouraged to continue wound care in any accredited health facility. Patient and relatives were educated on the need to adhere to medication regimen, and the need to report to the hospital when she experience any abnormalities. Patient’s belonging were packed and handed over to her relative (L. K.). Madam S. E. thanked all the staff personnel around and said good bye to other patients in her abide. Patient's name was documented in the admission and discharge book as well as daily ward state. I accompanied the Patient to the car park to board a car to her home. About to return from the car park, I reminded her again of the date for the review.

4.2 Preparation of Patient / Family for Discharge and Rehabilitation

Patient’s preparation towards discharge started on the day of admission, (21/11/21) which made preparation effective till discharge (26/11/21). Patient and relatives were told that she was not going to stay on the ward for a long period of time and that, measures were being put in place so that she will be well for her to go home and continue treatment. Patient and relatives were educated on the condition, its causes, signs and symptoms, management and more especially, wound care and infection prevention. She was advised to take in a well-balanced diet to help with wound healing and also to stop lifting heavy objects. She was told to wait for some time before going back to her work. Patient was also educated on personal hygiene like daily bathing, washing hands with soap under running water before eating and after visiting the toilet. She was also educated on the administration of prescribed drugs and to report to the hospital when she had any ill health and not to self-medicate.

4.3 Follow-Ups/Home Visit/Continuity of Care

Home visit is a form of continuity of care using public health care approach to render nursing assistance to a patient after hospitalization, considering the available resource in patient's possession.

FIRST HOME VISIT (22nd NOVEMBER, 2021)

Patient and her family were informed about home visit and its importance, therefore this particular home visit was to get to know the environment of Madam S.E. and factors that could predispose her to post- operative complications, for to be educated on how to prevent them. On the said date at 12:10pm, I went for my first home visit when patient was sent to theatre, following the direction given to me by Madam S.E and her daughter L.K, i arrived at my destination and was warmly welcomed by her other relatives who were at home by then. Patient lives in a compound house built with bricks and roofed with roofing sheets. There are four rooms Madam S.E. occupies one which is a two-bed room apartment, big enough to accommodate herself and the family. It was kept clean, and things were well arranged. There is one bathroom and one toilet facility (W.C) for her side of the apartment. They have electricity and good water supply. Madam S.E.'s apartment had its own water supply and a veranda that has been transformed into a kitchen. There is access to electricity. Even though I only had access to the hall of the apartment, the hall had a good ventilation system with enough windows to allow free passage of air in and out of the room.

The community, Sessiman, is a generally clean community with a well-situated refuse damping site, at least two public toilet facility, enough public tap water, one closely located private hospital and St. Theresa's hospital is some few drive away. The community has one main tarred road that links Nkoranza with Kintampo. There are other untarred roads that links the different parts of the community together. Sessiman has two schools, and in all, can accommodate schooling going age children from Crèche to junior high school level. There are many churches and two counted mosques. In all, the community provided many of the amenities needed to grow, develop and live independently. I told relatives around about my impressions and encouraged them on the need for a good environmental and personal hygiene. I came back to the hospital to continue my care for Madam S. E. at 1:30pm.

SECOND HOME VISIT (6TH DECEMBER, 2021).

This was an informed visit to assess how patient was doing, and to know if she is following medication regimen. Patient was happy to see me and her condition was very good. She had finished taking all discharged drugs. I congratulated her and advised her to report to the hospital if she had any symptoms. I also reminded her of follow up and the need to attend the hospital for the next review schedule. After some time of interaction, I asked for permission to leave. She thanked me for my effort of visiting her.

REVIEW (8TH DECEMBER, 2021).

Patient reported to the outpatient department of St. Theresa's hospital for review on post hysterectomy. She only complained of low intensity pain at the incisional site. Per the prescriber's assessment, patient had had a successful procedure without any complication as at now. The prescriber however educated patient on possible risk that might happen if the health education about wound care and infection prevention are not practiced very well. Suppository diclofenac 100mg, 12hourly for 5days was ordered for patient to use for the management of the incisional pain. Also, oral vitamin C was added to boast up patient's immunity in this time of COVID-19 pandemic. Vital signs checked and recorded as follows:

Temperature: 36.0 degrees Celsius

Pulse: 88beats per minutes

Respiration: 21cycle per minutes

Blood pressure: 124/92mmHg.

Oxygen saturation (pulse oximetry): 98%

THIRD HOME VISIT – 15TH DECEMBER, 2021

I did inform my patient of this visit and she was very much surprised to hear my voice. This visit was my final official home visit to my patient's house since it was meant to terminate and to know the general wellbeing of Madam S. E. Upon arrival, I met some few other family members who had visited Madam S.E. Patient was obviously recuperating very well. No new complains were lodged. Patient had not experienced any side effects or complications from any of the treatment and management modalities employed in the hospital. The family asked some few other questions not pertaining to patient's condition but still in the territories of health, of which simple and clear answers were given. Again, they were show different ways of which to appropriately inquire new information about health-related issues. Formally, I terminated my care with the patient and the family. Madam S.E. was handed over to a community nurse [Y.E] at the Sessiman health center, for further management. Madam S. E. and her family thanked me for my care rendered to them.

Permission was then soughted to leave, of which Madam S. E. and her daughter (L. K.) accompanied me to board a taxi at the road side.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/FAMILY

5.0 Introduction

Evaluation is the assessment of outcome of nursing care rendered to the patient. It is a final stage in nursing processes. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which nursing has accountability (Herdman, 2013). Accountability is evaluation. In evaluation, both the patient and the effectiveness of the nursing care must be continuously evaluated and the care plan modified as needed. Evaluation, the final step of the nursing process, allows the nurse to determine the patient's response to the nursing interventions and the extent to which the objectives have been achieved. The plan of nursing care is the basis for evaluation. The nursing diagnosis, collaborative problems, priorities, nursing interventions and the expected outcomes provide the specific guidelines that dictates the focus of the evaluation. (Smeltzer, et al. 2010).

5.1 Statement of Evaluation

Madam S. E. was admitted to the female surgical ward on 21st November, 2021, on the account of bleeding uterine fibroids, booked for elective total hysterectomy on 22nd November, 2021. In her stay in the hospital, some few health problems were identified and nursing objectives and interventions were planned to help solve the health problems. In evaluating the nursing care rendered to her, both formative and summative approaches were used. The formative evaluation consisted of the findings gathered during the time the nursing interventions were still under implementation. The summative approach was the evaluation done after the interventions to a specific objective have all been completely implemented.

From admission to the discharge of my patient, six health problems were identified, and they are as follows;

1. **Patient and relatives were relieved of anxiety. (21/11/21).**

On 21/11/21 at 10:10am I went to interact with Madam S. E., she was manifesting a feeling of apprehension as she was not cooperating. So I asked her to verbalize her fears and worries. She then informed me that she was anxious due to unknown outcome of impending surgery. Hence a nursing diagnosis of Anxiety related to unknown outcome of impending surgery was made. An objective was therefore set to relieve patient anxiety within 12hours. Nursing interventions carried out were as follows; Patient and family were reassured of positive outcome and the competence of the surgical team, Patient was educated on hysterectomy and how it was going to be carried out, Patient and family were allowed to ask questions to clear any doubts, all questions asked were tactfully answered, patient was introduced to a successful recovered patient who has undergone similar procedure On 21/11/21 at 10:10pm,the summative evaluation was done on the patient which revealed that patient had a very reduced level of anxiety hours before the surgery time, hence, the objective was fully met.

2. **Patient was relieved of pain at the pelvic region. (23/11/21).**

On 21/11/21 at 10:00am Patient complained of pain at the pelvic region, therefore a nursing diagnosis was made as Pain related to pressure on surrounding pelvic structures secondary to growing tumors: An objective was set to relieve patient `s pain within 48 hours. Nursing interventions carried out on the patient were as follows; patient and family were reassured of competent care, pain assessment was done using the pain rating scale score, patient`s perception about the pain was assessed, vital signs were checked and recorded as in appendix, patient and family were involved in therapeutic communication to divert patient attention from pain and prescribed 1g of paracetamol was administered. The formative evaluation was done every four hours, alongside the time of checking vital signs. The summative evaluation was done on 23rd

November, 2021 around 10am, and the objective was found to have been fully met, as patient verbalizing feeling of improved comfort and Nurse observing patient having a cheerful face.

3. Patient showed no sign of surgical site infection. (26/11/21).

On 22/11/21 at 4:00pm, a nursing diagnosis of impaired tissue integrity related to surgical incision was identified in the immediate hours after surgery, after patient was brought back from the surgery/recovery ward around 4:00pm. An objective to help patient's skin integrity to be restored and maintained without any complications within the period of hospitalization. Nursing interventions carried out were as follows; Patient wound was assessed and was free from drainage and odour, patient temperature was checked and recorded routinely, aseptic technique was employed in wound care, patient was educated and encouraged on the need to avoid rubbing and scratching of the wound edges, patient was provided with diet rich in nutritional needs of the body to promote wound healing without any complications. With all this proper interventions put in place, the wound had not developed any complication, has reduced in size and patient had acquired the measures needed for protecting and healing the wound, hence, the objective was fully met. The summative evaluation was done on the 26th of November, 2021, at 10am.

4. Patient regained and maintained optimal nutritional balance. (26/11/21).

On 22/11/21 at 4:00pm, Imbalance nutrition, (less than the body's requirement) related to not able to take in food temporarily, secondary to surgery. After the surgery, the plan was to hold on any form of oral feeding and be gradually introduced to the patient as the recovery margin improves, hence this nursing diagnosis was formulated. An objective was set to help patient regain and maintain optimal nutritional balance, to her body's requirements before discharge after patient returned from surgery to the ward. The summative evaluation which was done on 26th of November, 2021, at 10:05am, day of discharged, revealed that the goal was fully met as evidenced by; a Nurse observed that patient was able to eat more than half of her meal served and patient verbalized an increase in appetite.

5. Patient was able to perform self-care activities. (26/11/21).

On 23/11/21 at 6:00am a nursing diagnosis of Self-care deficit (bathing and grooming) related to weakness after surgery was made. The objective was to help patient to demonstrate optimal performance of activities of daily living within 72 hours of hospitalization. A plan was made taking into consideration the family and their resources to help the patient do activities of daily living after the surgery was done. Most of patient's ADL's were completely done for her in the initial hours of the post-operative stage. Patient was gradually guided to pick up the pace till the time patient was discharge, patient's self-care had never been neglected. Plans to continue the self-care were made, utilizing the resources (family) in the house. On the day of discharge, 26th November, 2021, patient had displayed optimal performance in activities of daily living, hence. Objective fully met.

6. Patient and family gained adequate knowledge on the uterine fibroid. (24/11/21).

On 24/11/21 at 8:00am, a nursing diagnosis of Deficient knowledge related to insufficient information was formulated on Madam S. E.. An objective to help patient and family acquire necessary basic knowledge on uterine fibroids within the period of hospitalization was set. The nursing interventions carried out on the patient were as follows; patient current knowledge on uterine fibroid was assessed, patient was assessed for readiness and was ever ready and keel to learn new information about her condition, patient was educated on the causes, treatment modalities and signs and symptoms of uterine fibroid, patient was encouraged to ask questions, feedbacks were sought from the patient and she was able to provide correct information gained. Objective was found to be fully met on the day of evaluation, (24th November, 2021) as evidenced by patient and family being able to answer simple questions asked about uterine fibroids and general health care.

Other routine nursing care like reassurance, drug administrations were carried out as patient and family members co-operated very well.

5.2 Amendment of Nursing Care Plan.

Due to a careful nursing care and interventions and the cooperation from madam S. E. and her family, all set goals were fully met which contributed to a speedy recovery of Madam S. E.. Therefore the plan was not amended.

5.3 Termination of Care

Termination of care refers to the end of interaction between a nurse, patient and relatives from the time of admission through the time of discharge followed by home visit. My interaction with Madam S. E. started on 21/11/2021. Patient was discharged on 26/11/21. Even though, the care at the hospital was terminated, I paid a visit to the patient in her home with which the necessary care and education was given to the patient and her family. It was during these visits that the patient was handed over to the community health nurse (25/12/21) for continuity of care to the patient. I reemphasized on the health educations that had been given to them already.

Termination of care was not easy but since it was well planned before discharge, they accepted it. There was no separation anxiety as Madam S. E. and her relatives had enough psychological preparation from the day of admission till the last day of therapeutic relationship between myself and Madam S. E. and family members. I thanked them for their co-operation and they were grateful for the care rendered them.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Summary

Madam S.E. is the subject of this care. She was admitted to the female surgical Unit on 21st November, 2021 around 9am for an elective total hysterectomy scheduled on 22nd November, 2021. She was sent to the operation room on 22nd November 2021 around 11:50am and came back to the female surgical ward on the same day around 3:50pm, after a successful surgery.

The following are the summary of medications used on the patient from time of admission to time of discharge:

- Intravenous metronidazole 500mg, 8hourly for 48hours
- Intravenous Ceftriaxone 2000mg, 12hourly × 48hours
- Intravenous Normal Saline 4.0 liters
- Intravenous Ringers Lactate 2liters
- Intravenous fluid 5% dextrose 1.0L
- Injection morphine 5mg, 6houlry for 24hours.
- Intravenous paracetamol 1000mg, 8hourly for 48hours
- Suppository diclofenac 100mg, 12hourly × 5days

All laboratory investigations were carried out and specimen sent to the laboratory. Prescribed drugs were also given and nursing measures were taken to correct any abnormalities.

Patient and relatives were educated on the causes, signs and symptoms and management of uterine fibroid and also the need to come for review schedule. Patient was discharged from female surgical ward on 26th November, 2021 and reported for review on 8th December, 2021.

6.2 Conclusion

This care study has given me the opportunity to know what holistic and total care to a patient really means. It has given me a broader understanding in nursing process and how to render to all patients under my care.

This care study has also given me much knowledge about uterine fibroids in general, signs and symptoms, and management, complications as well as its treatment.

In all, I recommend that the nursing process approach be used in the care of all patients to help in recovery and reduce the higher mortalities we have in our hospitals.

APPENDIX

Vital signs of Madam S.E

Date	**Time**	**Temperature (°C)**	**Pulse (Bpm)**	**Respiration (Cpm)**	**Blood Pressure (mmHg)**
21/112021	09:30am	36.5	92	20	119/80
	2:00pm	36.5	84	23	138/90
	6:00pm	36,2	79	19	135.90
	10:00pm	36.5	79	23	130/70
22/11/2021	6:00am	36.2	88	21	130/70
	11:00am	36.4	82	18	130/90
	6:00pm	35.8	79	21	125/80
23/11/2021	6:00am	36.6	75	20	120/70
	10:00am	36.9	83	24	125/80
	2:00pm	36.2	82	24	130/80
	6:00pm	36.6	80	22	125/80
	10:00pm	35.6	87	20	120/90
24/11/2021	6:00am	36.5	75	18	120/70
	10:00am	36.9	85	22	125/80
	2:00pm	36.5	75	22	128/70
	6:00pm	36.6	75	20	120/80
	10:00pm	36.5	78	23	130/70
25/11/2021	6:00am	36.1	84	20	120/80
	10:00am	36.6	75	22	120/70

	2:00pm	36.7	82	19	120/80
	6:00pm	36.3	78	21	120/80
	10:00pm	36.1	84	18	120/80
26/11/21	6:00am	36.5	88	22	120/80
	10:00am	36.4	86	20	120/80

Vital signs checked after receiving Madam S.E from theatre until she was stable

DATE AND TIME	TEMPERATURE	PULSE	RESPIRATION	BLOOD PRESSURE
22/11/2021 3:06pm	36.6	80	19	125/80
22/11/2021 3:21pm	36.6	75	20	130/90
22/11/2021 3:36pm	36.7	75	22	130/90
22/11/2021 3:51pm	36.1	82	22	130/80
22/11/2021 4:21pm	35.2	84	21	130/80
22//11/2021 4:51pm	35.6	83	21	120/90
22/11/2021	36.3	75	19	120/70

5:51pm				
22/11/2021(7pm)	36.6	78	19	130/80

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