HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT AND FAMILY CARE STUDY ON RIGHT VAGINAL HYDROCELE

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

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PREFACE

Centuries ago, the nursing profession was just caring for the sick. From the day the profession started, it has undergone many changes throughout the years. Starting from the patient centred approach to a more complicated form of care which includes: the family and the community as a whole. Nursing became a profession when Florence Nightingale, in the nineteenth century provided and set a pattern which has become the basis of educating nurses today.

Nursing care has moved from the physical care of patients to a more complex approach which includes the psychological, spiritual and intellectual needs as well as that of their family as a whole (Nursing process). To achieve ultimate goal, the nursing process requires the cooperation of the family, the patient and the community. Also, education is given to help prevent the diseases and to help them to know their right pertaining to their care. The patient and family care study entails rendering holistic care to the patient and family starting from the day of admission till discharge. Individualized nursing care is the area of interest in the study.

The nursing process is a deliberate problem-solving approach for meeting a person's health care and nursing needs. It consists of a sequence of steps in the following order; assessment, diagnosis, objective/outcome criteria, planning, implementation, and evaluation. Assessment is the systematic collection of data to determine the patient's health status and identify any actual or potential health problem. Diagnosis is the identification of actual, potential and collaborative patient problems whereas planning is the development of goals and outcomes, as well as a plan of care designed to assist the patient in resolving the diagnosed problems and achieving the identified goals and desired outcomes. Implementation is the actualization of the plan of care through nursing interventions and evaluation is determination of the

patient's responses to the nursing interventions and the extent to which the outcomes have been achieved.

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

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

The confidentiality of the patient/family was ensured by the use of patient/family members initials instead of full name'. The patient/family care study is a requirement for the award of a license to practice as a Registered General Nurse in Ghana.

The comprehensive care rendered was made possible by the employment of skills and knowledge in such disciplines as psychology, anatomy and physiology of the human system, public health nursing, medical nursing, surgical nursing, pharmacology and nutrition and dietetics.

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INTRODUCTION

Patient and family care study is a report of comprehensive nursing care rendered to patient and their family from the day of admission, discharge and subsequent follow ups and visits in other to help them meet their health needs. For confidentiality purposes, the name of the patient and his family would be replaced by their initials.

MR. I.Z, a 37-year-old was my subject in the study. He came to the hospital on the 3th of December and had his laboratory test done towards his pending surgery of hydrocelectomy which was scheduled on the 5th of December. He was admitted at the Surgical ward of Berekum Holy Family, on the 5th December, 2021 with complaints of groin pain. Diagnostic investigations that were conducted on patient were physical examination and full blood count. Patient spent five days at the ward, within and after which home visit was embarked on. Medications were served and patient was prepared for surgery the next day.

Establishment of rapport and good interpersonal relationship was established with the patient throughout the study. Patient and family were reassured of maximum confidentiality. I made them aware that as a final year student, it is a requirement by the nursing and midwifery council to take a patient, to render individualized nursing care to him until discharge and follow up visit after discharge until he recovers fully as a partial fulfillment for the license to practice as a Registered General Nurse.

On the day of admission, patient presented pain in the groin region as well as scrotal swelling but with the proper interventions, he was discharged with a satisfying outcome at the end.

After discharge, home visit was undertaken to ensure the continuity of care. The first home visit was embarked on the 6th of December, 2021 while patient was still on admission. Second and third home visits were done on the 11th and 21st of December,2021 respectively.

A follow up care was rendered and patient was finally handed over to a community health care nurse to ensure continuity of care.

The study has been arranged in six chapters in line with the generally accepted steps that is, assessment, diagnosis, planning, intervention and evaluation.

1. Chapter one: Assessment of patient/family
2. Chapter two: Analysis of data collected
3. Chapter three: Nursing care plan for patient/family
4. Chapter four: implementation of patient and family care plan
5. Chapter five: Evaluation of care rendered to patient and family
6. Chapter six: Summary and conclusion of care rendered.

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY

1.0 Introduction

Assessment is an important and the first step in the nursing process. it involves collection of data or information concerning the patient's individual physiological, psychological, sociological and spiritual needs. (Toney-Butler, Unison-Pace,2021)

Collection of data is done through observation, examination and interviews with patient, family and at times friends. This is done so that the nurse may understand the individual's feelings, ideas, values and biophysical response very well. With this information, the nurse and the patient work together to identify the patient's strengths and needs so as to develop an effective nursing care plan.

Assessment is done through observation, interviewing of patient and family members or physical examination of patient, review of records, percussion, auscultation, palpation and inspection. This chapter comprises of;

1. Patient particulars.
2. Family's medical history.
3. Patient and family social economic history.
4. Patient developmental history.
5. Patient's lifestyle/hobbies.
6. Patients past medical history.
7. Patients present medical history.
8. Admission of patient.
9. Patient's concept of illness
10. Literature review
11. Validation of data

1.1 Patient Particulars

The particulars of a person are facts or details about him or her which are written down and kept as record. (Mish, 2016).

Mr. I.Z is the client for my study. he is thirty-seven years old man born to Mr. M.Z and Mrs. E.Z on the 15th of May, 1985 with which both parents are alive. He is dark in complexion with a weight of 72kg and about 1.6 meters tall. He is the sixth child of his parents. Mr. I.Z has two sisters and 5 brothers. Mr. I.Z was born in Sunyani- Yawhima in the Bono Region. He lives in a house number YH 9/5. He completed his junior high school at Yawhima SDA basic school which happens to be his highest educational level. He is a divorced man with two kids. Mr. I.Z does farming for a living. He is a catholic and a very devoted one. He speaks Twi, Bosanga and some small English

1.2 Family Medical And Surgical History

Medical history is a record of information about a person's health which include information about allergies, illnesses, surgeries, immunizations and results of physical exams and tests. (NCI Dictionary, 2022).

According to Segen's Medical Dictionary (2012), surgical history is a history of the surgical procedures and complications, if any, that a particular person has had.

According to Mr. I.Z, there is no known hereditary disease such as sickle cell disease, hypertension and diabetes mellitus in both the mother and father's family. There is also no known history of communicable diseases like leprosy and tuberculosis as well as chronic diseases such as asthma and epilepsy. They do not have any food or drug allergy in the family. The family sometimes experience minor illness such as headache, diarrhea and bodily pains which they treat with over-the-counter drugs and sometimes they visit the hospital on an out-patient basis for treatment. It was established by Mr. I.Z that neither of his parents' smokes nor drinks alcohol. He was then advised on the risks and disadvantages of self-medication and was encouraged to always visit the nearest health facility to seek healthcare

1.3 Patient And Family Socio-Economic History

Socio-economic history presents a profile of the patient / family's social and personal world (Park, 2014).

It includes family relationship / social cohesion, support systems, religious activities, sources of medical care / financing (NHIS), parent employment / job, occupational hazards and income levels of the family as well as traditions, norms, values, taboos and cultural practices.

Mr. I.Z is a farmer. He lives with his father and mother, 2 sister and 5 brother siblings and his 2 kids. According to Mr. I.Z. there is a cordial relationship between the family members as a whole. He stated that, most of his hospital bills were catered for by his money and his nuclear family comes in when the money involved is huge. National health insurance scheme is another source of him catering for his hospital bills.

He attends weddings, funerals and other programs that are related to him including family and church programs. It was difficult for him to predict his income from the farming work since the weather and seasons sometimes affects his crops.

He depends on his job and sometimes his family for support when the need arises. His occupation is farming which serves him as a source of income for him and to the family

1.4 Patient's Developmental History.

According to MedicineNet (2021), developmental history is an account of how and when a person meets developmental milestones such as walking and talking.

According to Mrs. E.Z, patient was a full-term baby and was delivered normally per vaginum without any post-partum complications. She added that, Mr., I.Z sat up when he was four (4) months, his teeth erupted when he was 6 months precisely, he had 2 upper and 2 lower milk teeth. According to patient with the confirmation from his mother, his mother added complementary feeding when he was 4 months and started crawling at his 8^{th} month. My patient also said that he was immunized against the six childhood preventive diseases in his childhood age.

My patient is 37 years old and he falls under the fifth psychosocial development theory by Erick Erickson which is intimacy verses isolation which begins from twenty to forty years. According to Erik Erickson, in young adulthood, we begin to share ourselves more intimately with others. We explore relationships leading towards long term commitments with someone other than a family member. Successful completion can lead to comfortable relationships and a sense of commitment, safety, and care within a relationship. Avoiding intimacy fearing commitment and relationships can lead to isolation, loneliness, and sometimes depression.

On observation specifically at the ward, he was not all that relating to the other patients, he was only found at his bed side. When he has a problem, he even waits till somebody approaches him before he voices it out. He was not conversing with others. With this lifestyle my patient is the isolated type.

1.5 Patient's Lifestyle/Hobbies.

As stated by Weller F.B. (2014), Lifestyle is a pattern of daily living that an individual develops.

Hobbies are activities that one does for pleasure when he or she is not working (Hornby, 2015).

According to patient, he normally goes to bed at 9:00pm and wakes up around 5:30am to perform his routine daily personal hygiene (washes his face, brushes his teeth empties his bowels before taking his warm bath in the morning). He makes sure his children are prepared for school on week days. At about 8:00am, he goes to farm and returns home at about 4:00pm He later watches television, takes his bath and goes to bed. He seldom brushes his teeth before bed.

On Sundays, he goes to church around 9:30am with his family and close around 1:00pm. He mostly likes to eat ampesi and vegetable stew in the morning and afternoon and "fufu" and any kind of soup in the evenings. He usually sleeps/rests for two hours during the day and

sleeps for about eight hours during the night. He enjoys watching football with friends during the weekends. Apart from Sundays, all holidays and "resting" days from farm are used to clean up his room. He attends wedding ceremonies, funerals, church picnics and other social activities to relieve stress. He is a father who openly expresses his dissatisfaction about wrong behaviors put up by his children. He sometimes blinks his eyes to tell his children to stop misbehaving. He is a very good person to interact with, he is loving, open, fair, firm, disciplined, respectful and God fearing to mention a few. He dislikes frowning and likes healthy relationships. He is a father and a mother to his children.

1.6 Patients Past Medical History.

According to Mr. I.Z he didn't suffer any childhood illness like measles, whooping cough etc. He has enjoyed good health right from birth he said. However, two years ago, he was hospitalized once at the Sunyani Municipal Hospital with abdominal pain which he was treated and discharged after three days.

1.7 Patients' Present Medical History.

Present medical history is a description that provides detailed information about the chief complaints that led to client's hospitalization (Israel, 2021).

According to patient, he was well until 1st of December, 2021 when a swelling appeared at his groin and failed to disappear on lying down. All attempts at reducing it were unsuccessful and therefore visited Berekum Holy Family Hospital on the 3rd of December, 2021. He was attended to by the medical officer in charge who diagnosed of him of right vaginal hydrocele upon assessment.

1.8 Admission Of Patient

Admission is defined as the act of allowing a patient to stay in the hospital for observation, investigation, treatment and care (Davis, 2020).

On the 3rd of December 2021, Mr. I.Z visited the Out-Patient Department of Berekum Holy Family Hospital after experiencing swelling at his groin which failed to disappear on lying

down and after all attempts. He was diagnosed of right vaginal hydrocele and was scheduled for a planned hydrocelectomy on the 6th of December 2021 but was to report to the surgical ward a day before the surgery.

Mr. I.Z was admitted to the surgical ward of Holy Family Hospital Berekum on the 5th of December 2021 around 12:00 pm per ambulatory accompanied by two student nurses and a sister relative, with the diagnosis of right vaginal hydrocele. They were welcomed, offered a seat and Mr. I.Z was assured of competent nursing care by the present staff nurses and I. His vital signs were then checked and recorded as;

- Temperature – 37.3 ^{o}C
- Pulse – 68bpm
- Respiration – 20cpm
- Blood Pressure – 135/80 mmHg
- SPO2 – 98%

His HAMS card was requested and confirmation of his name, diagnosis and other necessary informations were made accordingly. I then oriented Mr. I.Z to the ward environment such as the nurse's station, washroom and kitchen. He was offered a comfortable bed and was introduced to his room members. He was informed of the ward policies such as visiting hours and ward routines like ward rounds and medication hours. I was instructed by the ward in-charge to go the pharmacy for his IV fluids.

1.9 Patients' Concept Of Illness.

Patient's and family concept of illness is the understanding retained in mind, from experience, reasoning or imagination about patient illness (Park, 2013). He knew little about his condition as he said it was as a result of swelling in his right scrotum. He did not attribute the condition to any spiritual cause.

He believes that the surgical intervention and medication will help him regain his normal health.

1.10 Literature Review

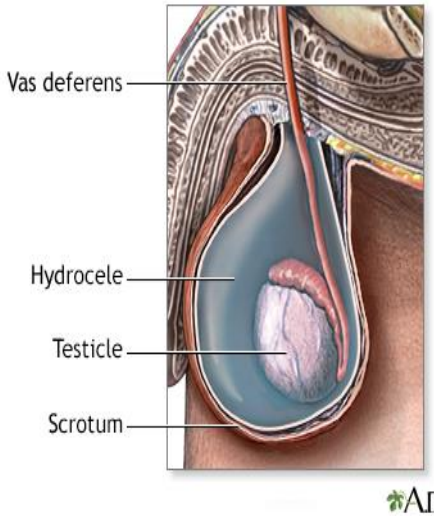
HYDROCELE

DEFINITION

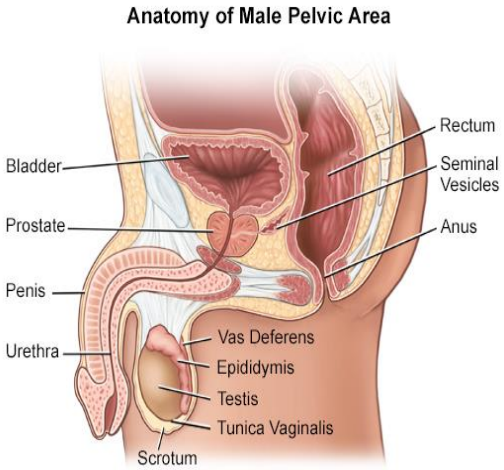
According to Siegel (2019), hydrocele is an accumulation of fluid within the sac that surrounds the testicle, resulting in ballooning and enlargement of the scrotum.

ANATOMY OF THE TESTES

Like the ovaries, to which they are homologous, the testes are components of both the reproductive and endocrine system. Each testis weighs about 2.5grams. the testes produce and store spermatozoa, and are the body's main source of the male hormone testosterone which is responsible for the development of secondary sex characteristics. In the embryo, the testes develop high up in the lumber region of the abdominal cavity. In the last few months of the fetal life, they descend through the abdomen, over the pelvic brim and down the inguinal canal into the scrotum. The testes are contained within the scrotum. each testis is an oval structure about 5cm long and 3cm in diameter. There are three layers of the testis: the tunica vasculosa is the inner layer of connective tissue containing a fine network of capillaries. The tunica albuginea is a fibrous covering, ingrowths of which divide the testis into 200 – 300 lobules. The tunica vaginalis is the outer layer, which is made of peritoneum brought down with the descending testis when it migrated from the lumber region in the fetal life. The tunica vaginalis is a potential space for fluid to accumulate, provided the proximal portion of processus vaginalis remains patent and results in free communication with the peritoneal cavity, leading to hydrocele. (Jayne & Maureen, 2014).



HYDROCELE



NORMAL TESTIS

TYPE OF HYDROCELE

According to Wint and Smith-Garcia (2022), the types of hydroceles include;

1. **NONCOMMUNICATING HYDROCELES**: These types of hydroceles occur when the sac closes but the body does not absorb the fluid. The remaining fluid is typically absorbed into the body within a year.
2. **COMMUNICATING HYDROCELES**: These types of hydroceles occur when the sac surrounding the testicles does not close all the way. This allows the movement of fluid in and out of the sac.
3. **NUCK'S HYDROCELES**: This type of hydrocele is rare. It is found in people without testicles. It occurs in the lining of the pelvic wall and can cause painful swelling in the lymph nodes of the groin. This can be mistaken for ovarian cyst, endometriosis, and a host of other conditions, making diagnosis and treatment difficult.

INCIDENCE

Hydrocele occurs in men except hydrocele of the canal of the nuck which is a cyst related to the round ligament in the female. It occurs at any age but old men are more prone to the condition.

AETIOLOGY OR CAUSES

According to Wint and Smith-Garcia (2022), the aetiology or causes of hydrocele include:

1. Failure of the precessus vaginalis to close.
2. Prematurity
3. Trauma
4. Inflammation
5. Infections e.g., epididymitis
6. Torsion.

PATHOPHYSIOLOGY

During fetal development, the testicle is located below the kidney, within the peritoneal cavity. As the testicle descends through the inguinal canal and into the scrotum, it is accompanied by a saclike extension of the peritoneum otherwise known as precessus vaginalis. After the testicle descends, the precessus vaginalis obliterates in the healthy infant and becomes a fibrous cord with no lumen. The distal tip of the precessus vaginalis remains as a membrane around the testicles, the tunica vaginalis. Normally the inguinal and scrotum should not connect with the abdomen. Neither abdominal organs nor peritoneal fluid should be able to pass into the scrotum or inguinal canal. If the precessus vaginalis does not close, it is referred to as a patent precessus vaginalis.

If the patent precessus vaginalis is smaller in caliber and only large enough to allow fluid to pass, the condition is referred to as communicating hydrocele. If the patent precessus

vaginalis is large allowing ovary, intestine, omentum and other abdominal content to protrude, the condition is referred to as hernia.

SIGNS AND SYMPTOMS

According to Mayo Clinic (2020), the following are signs and symptoms of hydrocele;

1. Swelling of one or both testicles.
2. Discomfort from the heaviness of a swollen scrotum.
3. Sometimes swelling disappears upon lying and reappears upon stand or strains.
4. Pain is not generally prominent but may occur if hydrocele expands quickly.

COMPLICATIONS

According to Paderla (2021), the complications of hydrocele include;

1.Haematoma

2.Wound infections

3.Infertility: a large hydrocele may obstruct the testicular blood supply leading to testicular atrophy and subsequent impairment of fertility

4. Calculi: this may develop as a result of a precipitation of cholesterol in the tunica vaginalis.

5. Pyocele: infection of the fluid present in the hydrocele could lead to purulent collection within the potential spaces between the visceral and parietal tunica vaginalis surrounding the testes.

DIAGNOSTIC INVESTIGATIONS

According to Siegel (2019), diagnostic investigations of hydrocele include;

1. Ultrasonography to provides excellent detail of the testicular parenchyma.
2. Physical examination will show swelling of the scrotum.
3. Urinalysis will show elevated white blood cell count.
4. Signs and symptoms.

5. History from patient.

DIFFERENTIAL DIAGNOSIS

They are specific diagnosis that is done to confirm a diagnosis because there are other conditions that exhibit the same signs and symptoms. Differential diagnosis of hydrocele include;

1. Scrotal trauma
2. Tumors of the spermatic cord,
3. Testicular torsion,
4. Inguinal lymphadenitis
5. Retractile testis.

MEDICAL TREATMENT

According to The following drugs are used for treating hydrocele

1. Antibiotic therapy such as ciprofloxacin and metronidazole are often prescribed for infectious hydrocele.
2. Anti-inflammatory agents such as diclofenac and ibuprofen may also be used in the setting of a reactive hydrocele
3. Analgesics such as paracetamol and pethidine are also given for pain.

SURGICAL TREATMENT

Aspiration and injection of agent has been recommended for non-communicating hydrocele in adults but this therapy is contraindicated in children because most hydrocele in children are associated with patent precessus vaginalis. Sclerosing agent may damage intra-abdominal content and also not likely to correct the underlining pathology.

Hydrocelectomy is recommended when there is continued discomfort, enlarging or waxing and waning in volume, unsightly appearance and secondary infections which are very rare.

NURSING MANAGEMENT

PRE-OPERATIVE MANAGEMENT

PSYCHOLOGICAL PREPARATION

Patient is reassured to win his confidence and cooperation and also relieve him of his fear and anxiety from the impending surgery and its outcome. The nurse re-emphasizes the surgeon's explanation of the nature of the surgery, the purpose and the positive outcome of the surgery and also, if possible, someone who has undergone the same surgery successfully should be introduced to the patient.

OBSERVATION

Patient's vital signs that are, temperature, pulse, respiration and blood pressure are monitored and recorded accurately. Intravenous infusions are also monitored to prevent fluid overload. The flow rate, patency of the tube and air are all monitored. The nurse must also do general observation for pallor and facial expression and must also maintain intake and output chart. The skin is also inspected for any rashes, scar and tribal marks.

NUTRITION

Patient is put on nil per os if general anesthesia would be used until peristalsis occurs after surgery. Intravenous infusions are administered as prescribed by the surgeon to prevent dehydration and also to serve as food supplement.

PERSONAL HYGIENE

Patient is assisted to bath and prepared for theater. Care of the mouth, hair, hands and feet are ensured to prevent infections. Patient's bed linens are kept clean and made sure they are free from creases and crumps. Bed pan is offered and an indwelling catheter is passed prior to surgery to avoid urine and fecal incontinence when under anesthetic influence. Patient is then given the theatre gown to wear.

EXERCISE

Prior to surgery, patient is taught and encouraged to carry out both passive and active exercise. The importance of the exercise is explained and patient is also given the opportunity to practice this exercise.

PREPARATION OF THE OPERATION SITE

The supra-pubic area is shaved up to the anterior surface area of the thigh. The skin is then washed with antiseptic agent such as savlon 1% solution and wiped with spirit to keep the skin dry. It is then covered with sterile towel to prevent infection.

POST- OPERATIVE NURSING MANAGEMENT

POSITION

After surgery, the patient is put in a semi-fowler's position to prevent aspiration of saliva. The patient is taught how to get out of bed. The scrotum is elevated on to a rolled towel and a bandage or scrotal support is applied to prevent swelling of the scrotum

OBSERVATION

Vital signs which include temperature, pulse, respiration and blood pressure are monitored and recorded accurately every fifteen minutes for the first hour, thirty minutes and finally when the condition improves, it is monitored four hourly, the tube observed for patency, air, kinking and swelling of the hand. The incisional site is also observed for any blood for re-enforcement to be done. Observe the mental state of the patient and the level of consciousness by calling him. Any elevation of temperature should be reported since it could be a sign of infection. Also signs and symptoms of infections and fluid overload should be observed. Intake and output chart should also be monitored.

NUTRITION

Patient is encouraged to take in well-balanced diet especially foods which are rich in protein and vitamins after recovery to promote rapid wound healing. The patient's meals are planned

with him and his family and his likes and dislikes taken into consideration. He is advised to rinse his mouth before and after and all nauseating equipment removed from the ward during meal time. Patient will be put on intravenous infusion until peristalsis is present, he would start sips of water, fluid diet, light diet, and finally normal diet if he is able tolerate them.

RELIEF OF PAIN

Patient is encouraged to rest in a calm and comfortable environment to help reduce the pain. Visitors are restricted and prescribed analgesics such as pethidine is administered. Patient is also engaged in diversional therapy such as reading of books and watching television to divert his attention from the pain. Patient is also assisted to change position regularly and the scrotum is also supported to reduce pain. Patient is also instructed to splint the incisional site with his hands when he develops cough or sneezes to lessen pain and to protect the incision.

CARE OF THE WOUND

Patient's wound is dressed aseptically with prescribed lotions to prevent wound infection. The wound is assessed for bleeding, swelling and signs of wound infection. The healing process is also assessed and patient must be advised to avoid touching the wound with his hands. Again, the patient must be taught the signs and symptoms of wound infection so that he can report immediately he sees any of these signs.

PATIENT EDUCATION

Patient is educated to avoid strenuous activities. He is also advised to avoid lifting heavy objects. If possible, he should be taught the various lifting techniques so as to prevent re-occurrence of the hydrocele

1.11 Validation Of Data

Validation of data simply means to establish the soundness, accuracy or legitimacy of the data gathered so that it will be free from errors and misinterpretation (Farlex, 2020). From the

information gathered and the signs and symptoms exhibited by patient together with the history presented by patient, it was directly related to what was found in the literature reviewed. It indicates that Mr. I.Z had hydrocele. Therefore, the data collected on him was valid and free from misinterpretation.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis of data is a systematic examination and evaluation of data or information, by breaking it into its component parts to uncover their interrelationship, thus providing basis for problem solving and decision making (Weller, 2009). Analysis of data is done in the second step of the nursing process. It involves sorting out information gathered on the patient in order to draw conclusion and bring out the exact problem so as to formulate the appropriate intervention. It also entails laboratory investigations and their interpretations as compared to the normal values, causes of the disease and its clinical clinical manifestations, health problems and nursing diagnoses. This chapter contains the following;

1. Comparison of data with standards

2. Patient/Family strengths

3. Health problems

4. Nursing diagnosis

2.1 Comparison Of Data With Standard

This involves comparing information gathered from the client with standard in the literature.

a. Diagnostic investigation/test

According to (Weller B., 2014), diagnoses is the determination of the nature of a disease. Test is defined as an examination or trial.

Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment. The following diagnostic tests were carried out on the client;

1. Full blood count.
2. Blood urea, electrolyte and creatinine.

Table 1: Comparison Of Diagnostic Test Carried Out On Client And Those Listed In The Literature Review.

Diagnostic Investigations Outlined In Literature Review	**Diagnostic Investigations Carried Out on My Patient**
Ultrasonography to elevate the flow of blood.	Ultrasonography test was not done
Physical examination will show swelling of the scrotum.	Examination of the perineum revealed swollen scrotum
Urinalysis will show elevated white blood cell count	Urinalysis test was not done
Signs and symptoms	Signs and symptoms experienced by the patient helped confirm diagnosis
History from patient	History was taken from patient which aided in confirming diagnosis

Even though, most of the diagnostic investigations stated in the literature review were not done on patient, but the diagnosis was confirmed from the history taken and physical examination conducted.

Blood urea, electrolyte and creatinine was done on Mr. I.Z to help determine the functioning of the kidneys.

Table 2: results of diagnostic investigations carried out on patient compared with standards

DATE	SPECIMEN	INVESTIGATION	RESULTS	NORMAL VALUE	INTERPRETATION	REMARKS
5/12/2021	Blood	White blood cell count	2.7×10^3/uL	3.0-8.50×10^3/uL	It was below the normal range making him susceptible to infection	Intravenous metronidazole 500mg tds x 48hours and intravenous ciprofloxacin 400mg bd x 48hours were prescribed
		Hemoglobin level estimation	12.1g/dl	Male-14.5-18g/dl Female-11-16g/dl	It was below the normal range indicating patient was anemic	No treatment given but was asked to get a blood doner for donation as standby

		Red blood cell count	3.92	4.00 – 5.50 10^6/uL	It was below the normal range indicating patient is anemic	Syrup hematocrit 10mls bd x 14days was prescribed
		Differential white blood cell count	Neutrophils-39.8% Lymphocytes-33.8% Eosinophils -11.3% Basophils-0.4% Monocytes–14.7%	25-75% 25 – 60% 1- 10% 0-1% 2-10%	All the values were within the normal range except eosinophils and monocytes which were high indicating infections	Prescribed antibiotics were administered
		Urea, electrolyte and creatinine	Urea - 3.7mmol/L Sodium-139mmol/L Potassium-3.7mmol/L Chloride- 110mmol/L	2.50-8.30mmol/L 139- 145mmol/L 3.5- 5.5mmol/L 90- 110mmol/L	All the values were within the normal range indicating proper functioning of the kidneys	No treatment was given

b. Causes of Patient's Condition

The causes of right vaginal hydrocele include failure of the precessus vaginalis to close, any condition that increases intra-abdominal pressure or inhibits the closure of the precessus vaginalis, inflammation, trauma, infections, such as epididymo-orchitis, prematurity and epispadias, hypospadias, ambigious genitalia and exstrophy of the bladder.

With reference to the literature review, patient's condition was caused by failure of the precessus vaginalis to close

c. Clinical features / signs and symptoms

Comparison of clinical features exhibited by client with those listed in the Literature Review

Table 3: clinical manifestation exhibited by Mr. I.Z compared with those in the literature review

CLINICAL FEATURES IN TEXT BOOK	CLINICAL FEATURES EXHIBITED BY PATIENT
Swelling of one or both testicles.	Patient experienced swelling of the Scrotum
Discomfort from the heaviness of a swollen scrotum.	Patient experienced discomfort whenever he walked
Sometimes swelling disappears upon lying and reappears upon stand or strains.	Patient experienced disappearance of swelling upon lying but reappeared upon standing or straining
Pain is not generally prominent but may occur if hydrocele expands quickly.	Patient experienced pain when the swelling increased in size rapidly

d. TREATMENT GIVEN TO PATIENT

According to Weller, (2014) treatment refers to the mode of dealing with a patient or disease. With reference to the literature review, the following drugs were prescribed for the patient with vaginal hydrocele

The following treatment was given to patient,

1. Injection pethidine 50mg bd x24hours
2. Intravenous metronidazole 400mg tds x 48hours.
3. Intravenous ciprofloxacin 500mg bd x 48hours
4. Injection diclofenac 50mg bd x48hours.
5. Intravenous normal saline 1liter x 24hours.
6. Intravenous dextrose saline 1liter x 24hours
7. Intravenous ringers lactate 1liter x 24hours
8. Tablet ciprofloxacin 500mg bd x 7days
9. Tablet metronidazole 400mg tds x 7days
10. Syrup hematocrit 10mls bd x 14day

Table 4: Treatment Outlined In The Literature Compared With Treatment Given To Mr. I.Z

TREATMENT OUTLINED IN THE LITERATURE	TREATMENT GIVEN TO THE PATIENT
Antibiotic therapy such as ciprofloxacin and metronidazole	Patient was put on metronidazole and ciprofloxacin
Anti-inflammatory agents such as diclofenac and ibuprofen	Patient received diclofenac injection 50mg bd x48hours

Analgesics such as paracetamol and pethidine	Patient was injected with pethidine 50mg bd x24 hours
Aspiration and injection of agent	Aspiration and injection of agent was not done
Hydrocelectomy	Hydrocelectomy was done for Mr. I.Z

Table 5: Pharmacology Of Drugs

DATE	DRUG	STANDARD DOSE AND ROUTE	DOSAGE AND ROUTE OF ADMINISTRATION	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT AND REMEDDIES
5/12/2021	Ringers lactate	Intravenous Adult/ children: doses depend on patient's condition but usually 1.5L to 3L over 24 hours	1 liter x 24hours Intravenously	Caloric fluid and electrolyte balance solution	To restore fluid and electrolyte balance	Patient fluid and electrolyte balance was restored	Fluid overload, metabolic acidosis and oedema. None was observed
5/12/2021	Ciprofloxacin	Adult: 200-500mg of 12 hours Children: 2-30mg 1kg per day in divided doses of 12 hours	500mg bd x 7days Orally	Antibiotics	It kills susceptible bacteria by inhibiting protein synthesis to	Patient's infection was controlled	Headache, nausea, vomiting, rashes, confusion and

					prevent infection		dizziness. None was observed
5/12/2021	Metronidazole	Adult dose/children: 1kg per day in divided doses of 6 hours Intravenous Oral	400mg tds x 7 days Orally	Antibacterial, antiprotozoal and anti-amoebic antibiotic	It kills susceptible bacteria and amoeba by inhibiting protein synthesis to prevent infection	Infection was controlled and patient's condition improved	Headache, abdominal discomfort, nausea and vomiting and rashes. None was observed
6/12/2021	Pethidine	Intramuscular Adult dose: 25-100 mg every 2 to 3 hours	50mg bd x 24 hours Intramuscularly	Opioid narcotic analgesics	To control moderate to severe pain	Patient was relieved of pain	Hypotension, nausea, vomiting, bradycardia and retention of urine None was observed
6/12/2021	Metronidazole	Adult dose/children: 1kg per day in divided doses of 6 hours Intravenous	500mg tid x 24hours Intravenously	Antibiotics, antiprotozoal, and antiameobic	It kills susceptible bacteria and amoebic by inhibiting protein synthesis to prevent	Infection was controlled and patient's condition	Headache, rashes, abdominal discomfort, nausea, and vomiting, None was observed

		Oral		antibiotics	infections	improved	
6/12/2021	Ciprofloxacin	Intravenous Adult: 200-500mg of 12 hours Children: 2-30mg 1kg per day in divided doses of 12 hours	400mg bd x 48hours Intravenously	Antibiotics	It kills susceptible bacteria by inhibiting protein synthesis to prevent infections	Infection was controlled	Headache, rashes, confusion, vomiting, nausea, and dizziness. None was observed
6/12/2021	Normal saline	Intravenous Adult/children: depends on the patient's condition that is fluid and caloric requirement	1liter x 24hours Intravenously	Sodium intravenous infusion (isotonic)	To maintain and restore body fluid and electrolyte balance.	Patient was hydrated, electrolytes level was maintained	Pulmonary oedema, hypotension, nausea, vomiting, retention of urine, confusion None was observed
7/12/2021	Diclofenac	Intramuscular	50mg bd x 48hours Intramuscularly	Antipyretic, anti-inflammatory, analgesics	Inhibits prostaglandins synthesis by decreasing enzymes needed for	Patient was relieved of pain and his temperature was within the	Tachycardia, nausea, skin rash, liver damage, and jaundice None was observed

					biosynthesis	normal range	
7/12/2021	Dextrose saline	Dosage depends on the fluid and caloric requirement. Intravenous	1 liter x 24hours Intravenously	Fluid and electrolyte infusion	Provides supplementary calories and fluid	Patient was hydrated and energy was restored	Confusion, pulmonary oedema, glucosuria and heart failure. None was observed
7/12/2021	Hematocrit	Oral	10mls bd x 14days Orally	Anti-anemic and hematinic	Promote red blood cell production	There was an increase in red blood cell production	Constipation, dark stool, diarrhea and stain teeth None was observed

COMPLICATIONS

With reference to the complications stated under the literature review such as hematoma, wound infection and renal calculi, patient did not develop any of these complications due to the good nursing and medical care rendered to him by the staffs of the hospital.

2.2 Patient And Family Strength

Patient's strength is what the patient is capable of doing for himself during the period of hospitalization and family's strength is what the family can do to support patient to recover faster or die peacefully.

1. Patient ask questions concerning his condition
2. Patient and family expressed that knowing about hydrocele would help in patient's recovery
3. Patient could verbalize the intensity of pain
4. Patient stated that keeping wound clean and dry will prevent wound infection
5. Patient could eat 100 mls of porridge
6. Patient could sleep 3 hours at night and an hour during the day

2.3 Health Problems

The following health problems were identified during interaction with patient and family

PRE-OPERATIONAL PROBLEMS

1. Patient was anxious
2. Patient and family had little knowledge on the condition

POST OPERATIONAL PROBLEMS

1. Patient had incisional pain.
2. Patient was prone to wound infection
3. Patient had loss of appetite
4. Patient had insomnia

2.4 Nursing Diagnosis

A nursing diagnosis according to NANDA International (2016), is a clinical judgment concerning a human response to health conditions/ life processes, or vulnerability for that response, by an individual, family, group or community. It is a clear and definite statement of the patient's health status that can be influenced by nursing interventions. It is derived from a validated, critically analyzed and interpreted data collected during assessment. Conclusions are drawn regarding the patient's needs, problems, concerns or human responses. The nursing diagnosis, once identified provides a central focus as a reminder of the stages that is based on the nursing process. The plan of care is designed, implemented and evaluated, hence making it possible to give comprehensive health care to the problems.

This is done by identifying, validating and responding to specific health problems. The nursing diagnosis also provides an efficient method of communicating the patient's health problems. The following nursing diagnosis were formulated for patient and family

1. Knowledge deficit related to lack of information on his condition. (5/12/2021)
2. Anxiety related to unknown outcome of impending surgery. (5/12/2021)
3. Incisional pain related to surgical incision. (6/12/2021)
4. Risk for wound infection as evidenced by interruption in skin integrity. (6/12/2021)
5. Altered nutritional pattern (less than body requirement) related to anorexia. (7/12/2021)
6. Altered sleeping pattern (insomnia) related to change in environment. (7/12/2021)

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

This is a written plan which provides a baseline that the health team can use in planning for the patient and family. The nursing care plan includes nursing diagnosis, objective and outcome criteria, nursing orders, intervention and evaluation. It is also a tool to guide the process of planned nursing actions. It serves as a means of communication among nursing personnel and brings about continuity of nursing care. It is the third step in nursing process.

3.1 Objectives And Outcome Criteria

The following objectives and outcome criteria were set for Mr. I.Z.

1. Patient and family would gain knowledge about his condition within 6hours as evidenced by;

a. patient and family asking questions and seeking clarification in relation to the condition

b. nurse observing that patient and relatives practice what was taught

2. Patient and family would be relieved of anxiety within 4hours as evidenced by;

a. Nurse observing patient and family chatting happily with other patients on the ward

b. Patient and family verbalizing a reduction in anxiety

3. Patient's pain would reduce within 48hours as evidenced by;

a. Nurse observing that patient has a cheerful facial expression

b. Patient verbalizing the absence of pain.

4. Patient's wound would not be infected within his period of hospitalization as evidenced by;

a. Patient verbalizing that his wound is looking dry and clean.

b. Nurse observing a progression in wound healing process.

5. Patient would regain normal nutritional status within 48hours as evidenced by;

a. Nurse observing that patient is able to eat at least half of his food served

b. Patient verbalizing that he was able to eat more than half of meal served

6. Patient would be able to sleep within 24hours as evidenced by;

a. Nurse observing that patient was able to sleep uninterrupted for 2hours during the day and 8hours during the night.

b. Patient verbalizing that he was able to sleep throughout the night without any interruption

Table 6: Nursing care plan for Mr. I.Z

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
5/12/2021 at 3:30pm	Knowledge deficit related to lack of information on the condition	Patient and family will gain knowledge about his condition within 6hours as evidenced by; a. patient and family asking questions and seeking clarification in	1.Reassure patient and family that everything about his condition will be made known to them 2.Create a conducive environment 3.Establish good interpersonal relationship with family and patient	1.Patient and his family were reassured that everything about his condition will be made known to them for them to have a better understanding on the condition 2.A conducive environment was created to ensure patient and family's comfort 3. rapport was established to make them feel at home and cooperate effectively	5/12/2021 at 9:30pm	Goal fully met as they were able to answer questions in relation to the condition	Y.C

		relation to the condition b. patient and family verbalizing knowledge regarding management of individuals with hydrocele	4.Educate them on the condition 5.Allow them to ask question	4.Patient and family were educated on the causes, signs and symptoms, management and prevention of the condition based on their level of knowledge 5.Patient and family were allowed to ask questions about the disease condition and their questions were answered accurately			

Table 6: Nursing Care Plan For Mr. I.Z Continued

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
5/12/2021 at 5:00pm	anxiety related to unknown outcome of impending surgery	Patient and family will be relieved of anxiety within 4hours as evidenced by; 1.Nurse observing patient and family chatting with other members on the	1.Reassure patient and family of the positive outcome of surgery 2.Orientate patient and family to the ward environment 3.Clarify any misconceptions 4.Introduce patient to	1. Patient and family were reassured of the positive outcome of surgery 2.Patient and family were orientated to the ward and its environment like the bathroom, toilet, dressing room and nurses' station to help reduce their fears 3.All misconceptions patient and family had been clarified 4.Patient was introduced to two	5/12/2021 at 9:00pm	Goal fully met as nurse observed patient and family chatting with other patients on the ward and they verbalized a reduction in anxiety	Y.C

		ward 2.Patient and family verbalizing a reduction in anxiety	successful recovered patients who had similar surgeries 5.Allow them to ask question	patients who had undergone surgery successfully and were doing well 5.They were allowed to ask questions to clarify any misconception they may have about the condition.			

Table 6: Nursing Care Plan For Mr. I.Z Continued

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
6/12/2021 at 1:30pm	incisional pain related to surgical incision	Patient's pain will reduce within 48hours as evidenced by; 1.Nurse observing that patient has a cheerful facial expression 2.Patient verbalizing the	1. Reassure patient 2.Observe the area around wound 3.Assit patient to change positions regularly	1. Patient was reassured that appropriate measures would be put in place to relieve him of his pain. This was done to gain his cooperation 2.The area around the wound was observed for tension, bleeding and discharges as well as oedema to prevent complication 3.Patient was assisted to change his position regularly; he was in a sitting up position and his scrotum	8/12/2021 at 1:30pm	Goal fully met as nurse observed that patient had a cheerful facial expression and he verbalized the absence of pain	Y.C

		absence of pain	4.Engage patient in diversional therapy 5.Ensure complete bed rest 6.Serve prescribed analgesics	supported to reduce pain 4.Patient was engaged in diversional therapy such as reading books and watching television to divert his attention from the pain 5.Patient was encouraged to rest in a quiet and calm environment to help reduce the pain 6.Prescribed injection pethidine 50mg bd x 24hours was served to relieve patient of pain			

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
6/12/2021 at 2:30pm	Risk for wound infection related to interruption of skin integrity	Patient's wound will not be infected within his period of hospitalization as evidenced by; a. Patient verbalizing that his wound is looking dry and clean	1.Reassure patient and family 2.Assess wound for discharges 3.Dress wound aseptically 4.Teach patient strict infection prevention technique	1.Patient and family were reassured that measures would be put in place to prevent wound infection 2.Patient's wound was assessed for the presence of pus, odor and redness around the skin 3.Patient's wound was dressed with prescribed lotions and sterilized gauze after which it was secured with a plaster 4.Patient was taught not to touch the wound with his hand and also	9/12/2021 at 2:30pm	Goals fully met as nurse observed a progression in wound healing process and patient verbalizing that his wound is looking dry and clean.	

		b. nurse observing a progression in wound healing process progression in wound healing process	5.Serve well balanced diet	prevent water from entering the wound since such practices can cause wound infection 5.Patient was served with well-balanced diet and he was encouraged to eat in order to promote rapid wound healing			

Table 6: Nursing Care Plan For Mr. I.Z Continued

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
7/12/2021 at 12:00pm	Altered nutritional pattern (less than body requirement) related to anorexia	Patient will regain normal nutritional status within 48hours as evidenced by; 1.Nurse observing that patient is able to eat at least half of his food	1.Reassure patient 2.Maintain oral hygiene twice daily 3.Plan diet with patient and family	1.Patient was reassured that measures would be put in place to enhance and stimulate his appetite 2.Patient was assisted to clean his mouth morning and evening with tooth brush and paste and rinse his mouth with water before and after each meal to enhance his appetite 3.The diet was planned with patient and family, and his like and dislikes taken into consideration in order to prepare his favorite meal	9/12/2021 at 12:00pm	Goal fully met as nurse observed that patient was able to eat at least half of his meal served and also patient verbalizing that he was able to eat more than half of meal	

		served 2. patient verbalizing that he was able to eat more than half of meal served	4.Serve food in a clean environment 5.Monitor patient's weight daily 6.Encourage patient to take in more fruits	4.The ward environment was made clean and pleasant by putting away bed pans, vomitus bowls and any other unpleasant odor to enhance appetite 5.Patient body weight was checked daily to know whether there has been an increase in weight 6.Patient was encouraged to take in more fruits like oranges and bananas to aid in wound healing		served	

Table 6: Nursing Care Plan For Mr. I.Z Continued

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
7/12/2021 At 12:00pm	Altered sleeping pattern (insomnia) related to hospitalization	Patient will be able to sleep within 24hours as evidenced by a. Nurse observing that patient was able to sleep for 2 hours during the day and 8hours during the night	1.Reassure patient 2.Provide adequate ventilation 3.Carry out procedures at once	1Patient was reassured that he would be able to have his normal pattern of sleep since measures are being put in place to ensure uninterrupted sleep. 2. Adequate ventilation was provided by opening nearby windows and putting on the fans to allow fresh air into the room to enhance sleep. 3.All nursing procedures such as	8/12/2021 at 12:00pm	Goal fully met as nurse observed that patient was able to sleep for 2hours during the day and 8hours during the night and also verbalized that he was able to sleep	

		patient verbalizing that he was able to sleep throughout the night without any interruption	4.Ensure quite environment 5.Give warm bath and serve warm beverages	checking of vital signs, wound dressing and medications were done at once to enhance sleep 4.Quite environment was maintained by restricting visitors and reducing the volume of radio and television set and also asking staffs to speak undertone 5.Warm beverage of milo was served after he has been given a warm bath		throughout the night without any interruption	

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

This chapter form the fourth part of the patient and family care study. Implementation is the actualization of the nursing care plan through nursing intervention (Smeltzer and Bare, 2010). This chapter presents the actual nursing care rendered to the client and family throughout the hospitalization period. It covers;

1. Summary of the actual nursing cares.
2. The preparation of the patient / family for discharge and rehabilitation.
3. Follow up / home visit / continuity of care.

4.1 Summary Of The Actual Nursing Care

This involves the actual implementation of the nursing orders in the nursing care plan. The nursing care giving to patient and family started on the 5th of December 2021 and ended on the 9th of December 2021. The management aimed at making patient comfortable, promoting his early recovery and prevention of complications. For the purpose of organization, the summary of the actual nursing is presented on daily basis as follows;

FIRST DAY OF ADMISSION (05/12/2021)

On the 3rd of December 2021, Mr. I.Z visited the Out-Patient Department of Berekum Holy Family Hospital after experiencing sharp inguinal pain from swelling at his groin which fails to disappear on lying down and after all attempts. He was diagnosed of right vaginal hydrocele and was scheduled for a planned hydrocelectomy on the 6th of December 2021 but was to report to the surgical ward a day before the surgery.

Mr. I.Z was admitted to the surgical ward of Holy Family Hospital Berekum on the 5th of December 2021 around 12:00 pm per ambulatory accompanied by two student nurse and a sister relative, with the diagnosis of right vaginal hydrocele. They were welcomed, offered a

seat and Mr. I.Z was assured of competent nursing care by the present staff nurses and I. His vital signs were then checked and recorded as;

- Temperature – 37.3 ºC
- Pulse – 68bpm
- Respiration – 20cpm
- Blood Pressure – 135/80 mmHg
- SPO2 – 98%

His HAMS card was requested and confirmation of his name, diagnosis and other necessary informations were made accordingly. I then oriented Mr. I.Z to the ward environment such as the nurse's station, washroom and kitchen. He was offered a comfortable bed and was introduced to his room members. He was informed of the ward policies such as visiting hours and ward routines like ward rounds and medication hours. I was instructed by the ward in-charge to go the pharmacy for his IV fluids. At 2:00 pm vital signs were checked and recorded as shown in appendix.

At 3:30 pm, during conversation with patient, I noticed that patient had little knowledge on his condition due to the questions he's been asking. Therefore, a nursing diagnosis of knowledge deficit related to lack of information on the condition was formulated and an objective was set to enhance patients' knowledge about his condition within 6hours. The following interventions were made: Patient was reassured that everything about his condition will be made known to him to have a better understanding on the condition, A conducive environment was created to ensure patient's comfort, rapport was established to make them feel at home and cooperate effectively, Patient was educated on the causes, signs and symptoms, management and prevention of the condition based on their level of knowledge, Patient was allowed to ask questions about the disease condition and their questions were answered accurately.

At 5:00 pm, During visiting hours, I realized patient and family were anxious due to unknown outcome of impending surgery. Therefore, a nursing diagnosis of anxiety related to unknown outcome of impending surgery was formulated and an objective was set to relieve patient and family from anxiety within 4hours. The following interventions were made: Patient and family were reassured of positive outcome of surgery, Patient and family were orientated to the ward and its environment to help reduce their fears, all misconceptions patient and family had been clarified, Patient was introduced to two patients who had undergone surgery successfully and were doing well, they were allowed to ask questions to clarify any misconception they may have about the condition.

At 6:00 pm, vital signs were checked and recorded as shown in appendix.

In the evening, at 9:00 pm, an evaluation was done on the objective set to relieve patient of anxiety within 4 hours. Goal was fully met as I observed patient and family chatting with other patients on the ward and they verbalizing the reduction in anxiety.

At 9:30 pm, an evaluation was done on the objective set to enhance the knowledge of patient and family on condition within 6 hours. Goal was fully met as I noticed patient and family were able to answer questions related to the condition.

At 10:00pm, vital signs were checked and recorded as follows:

- Temperature –37.1^{o}C
- Pulse –82bpm
- Respiration –21cpm
- Blood Pressure –110/60mmHg
- SPO2 – 99%

DAY OF SURGERY (06/12/2021)

On the second day of admission, at 7:00am I went to the ward to continue with my nursing care for Mr. I.Z. He woke up at 5:30am and performed his daily personal hygiene according to night nurses who handed over to me. His morning vital signs had already been checked at 6:00am and recorded. The night nurses reported to me that IV Ringers lactate had been served. Mr. I.Z was prepared and sent to the theatre at around 8:20am.

Preoperative vital signs were checked and recorded as

Temperature	36.9^{o}C
BP	110/70mmHg
Respiration	20cpm
Pulse	89bpm
SPO2	99%

I then informed the ward in charge and sort permission to embark on my first home visit for which I was granted the permission to proceed and wished me safe journey as well. I had already made pre arrangement with patient relatives. Around 8:35 am, I left the ward prepared for the journey. My car left Berekum for Sunyani around 8:50 am and got to patient's house with the help of his siblings around 9:40 am.

I boarded a car back to Berekum after achieving my purposes for the visit.

At 12:40pm, Patient was received from the recovery room in a conscious and alert state. Incisional site was inspected for any bleeding and swelling. Mr. I.Z was made comfortable in bed. Post-operative vital signs were checked and recorded as

Temperature	36.4^{o}C
BP	100/60mmHg
Respiration	24cpm
Pulse	92bpm

SPO2 99%

At 1:30 pm, Patient complained of pain at the incisional site. Nursing diagnosis of incisional pain related to surgical intervention was then formulated. Objectives were set to relieve patient of incisional pain within 48 hours which included; He was reassured those appropriate measures would be put in place to relieve him of his pain. This was done to gain his cooperation. The area around the wound was observed for tension, bleeding and discharge as well as any oedema to prevent complication. He was assisted to change his position regularly and the scrotum supported to reduce pain. He was also engaged in diversional therapy such as watching videos to divert his attention from the pain. Patient was also encouraged to rest in a quiet and calm environment to help reduce pain and prescribed injection pethidine 50mg bd x 24hours was served to relieve patient from pain. At 2:00 pm vital signs were checked and recorded as shown in appendix.

At 2:30 pm, I noticed that patient's wound was prone to infection due to interruption of skin integrity. Therefore, a nursing diagnosis of risk for wound infection as evidenced by interruption in skin integrity was formulated and an objective was set to prevent wound infection within his period of hospitalization. The following interventions were carried out; patient and family were reassured that measures would be put in place to prevent wound infection, His wound was assessed for the presence of pus, odor and redness around the skin, The wound was dressed aseptically with prescribed lotions and sterilized gauze after which it was secured with plaster, Patient was advised not touch the wound with his hand and also prevent water from entering the wound since such practices can cause wound infection, He was also served with well-balanced diet and was encouraged to eat to promote rapid wound healing. He was given intravenous metronidazole 400mg tds x 48hours.

At 6 pm, vital signs were checked and recorded as follow;

- Temperature –37.1^{o}C

- Pulse –84bpm
- Respiration –20cpm
- Blood Pressure –100/60mmHg

Patient was served with rice and kontomire stew as supper. After consuming his supper, his due medications were initiated as intravenous ciprofloxacin 500mg bd x 48hours and metronidazole 400mg tds x 48hours and injection pethidine 50mg bd x 24hours and diclofenac 50mg bd x 48hours.

At 10 pm, his vital signs were checked and recorded as follows;

- Temperature –36.7^{o}C
- Pulse –87bpm
- Respiration –22cpm
- Blood Pressure –115/80mmHg
- SPO2 – 99%

His bed linen was straightened and was then encouraged to have some rest. Mr. I.Z then decided to sleep after been on phone for entertainment for about 15 minutes.

1ST DAY POST OPERATIVE (07/12/2021)

On the 7th of December 2021, patient had insomnia which was confirmed by the night nurse's report. He woke up around 2:00am and could not sleep again until 4:20 am.

Mr. I.Z got out of bed to perform his daily personal hygiene after 6:00 am vital signs were checked and recorded as shown in appendix. Intravenous medications of ciprofloxacin 500mg bd x 48hours and metronidazole 400mg tds x 48hours were administered and intravenous fluid insitu was dripping well after the injection of pethidine. His bed linen was changed when he got out of bed to brush his teeth and bath. He took breakfast of porridge and bread. During ward rounds, we were asked to continue with treatment.

At 10 am, his vital signs were checked and recorded at recorded as follows

- Temperature –37.1^{o}C
- Pulse –84bpm
- Respiration –20cpm
- Blood Pressure –100/60mmHg
- SPO2 – 99%

In the afternoon at 12:00 pm, patient complained of loss of appetite and as a result could not consume his lunch of rice and stew. Therefore, a nursing diagnosis of altered nutritional pattern (less than body requirement) related to anorexia was formulated and an objective was set to regain patients' nutritional status within 48 hours. The following interventions were made; patient and family were reassured that measures would be put in place to enhance and stimulate appetite, patient was assisted to clean his mouth morning and evening with toothbrush and paste and rinse his mouth with water before and after each meal to enhance his appetite, the diet was planned with family and patient, and his like and dislikes were taken into consideration in order to prepare his favorite meal, the ward environment was made clean and pleasant by putting away bed pans, vomitus bowls and any other unpleasant odour to enhance appetite, patient body weight was checked daily to know whether there has been an increase in weight and patient was encouraged to take in more fruits like oranges and banana to aid in wound healing.

Patient also complained of finding it difficult to take a nap at 12:00 pm. His drug of metronidazole 400mg tds x 7days was administered. A nursing diagnosis of disturbed sleep pattern (insomnia) related to change in environment was formulated. An objective was set to relieve patient of insomnia within 24 hours. The following nursing interventions were carried out; Patient and family were reassured that he would have his normal pattern of sleep since measures are being put in place to ensure uninterrupted sleep. Adequate ventilation was provided by opening nearby windows and putting on the fans to allow fresh air into the room

to enhance sleep. All nursing procedures such as checking of vital signs and serving of medications were performed at a go to enhance sleep. Quite environment was maintained by restricting visitors and reducing the volumes of radio and television set and also asking staffs to speak undertone. Warm beverage of milo with milk was served after he has been given a warm bath. Vital signs were checked and recorded as shown in appendix.

SECOND DAY POST OPERATIVE (08/12/2021)

According to the night nurse's report, patient had a sound sleep. He woke up around 5:50am for the serving of medications and checking of vital signs. At 6:00 am vital signs were checked and recorded as shown in appendix. He got out of bed after listening to the current national news on radio and watching football highlights on his phone to perform his daily personal hygiene activities. Patient's general condition as stated by the night nurse's report was satisfactory. He was able to maintain his personal hygiene such as bathing and mouth care. His bed linen was changed after which he was served with milo with milk and bread as breakfast. He was served his drugs of intravenous metronidazole 400mg bd x 48hours and ciprofloxacin 500mg tds x 48hours and injection diclofenac 50mg bd x 48hours.

During ward rounds, tablets ciprofloxacin 500mg bd x 7days, metronidazole 400mg tds x 7days and Syrup hematocrit 10mls bd x 14days were prescribed and we were asked to discontinue the intravenous infusion and the drugs he had completed.

During ward rounds, Doctor on duty informed the patient of a possible discharge the following day if the condition continued to improve. He for very happy at this news.

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

- Temperature – 37.1^{o}C
- Pulse – 80 bpm
- Respiration – 21 cpm
- Blood Pressure –110/70mmHg

- SPO2 – 98%

In the afternoon he was served banku and light soup as lunch, his vital signs were checked and he joined other patients in the ward and engaged in conversation with them.

At 12:00 pm, an evaluation was done on the objective set on 7th December 2021 at 12:00 pm to relieve patient of insomnia within 24 hours. Goal was fully met as I observed that patient was able to sleep for 2 hours during the day and 8hours during the night and he verbalizing that he was able to sleep throughout the night without any interruption.

At 1:30 pm, an evaluation was done on the objective set on 6th December 2021 at 1:30 pm to relieve patient of incisional pain within 48hours. Goal was fully met as I observed patient having a cheerful facial expression and verbalizing the absence of pain.

Vital signs were checked and recorded as shown in appendix at 2:00pm.

Patient took his supper of kenkey and light soup at 6:00pm. Vital signs were checked and recorded and his medications of tablets ciprofloxacin 500mg bd x7days, metronidazole 400mg tds x 7days and syrup hematocrit 10mls bd x 14days were administered. His bed linens were then straightened to make him comfortable in bed.

At 10:00pm, vital signs were checked and recorded as;

Temperature – 36.8ºC

Pulse – 87 bpm

Respiration – 22 cpm

Blood pressure – 120/75 mmHg

SPO2 – 98%

THIRD DAY POST OPERATIVE (09/12/2021)

Patient was very happy and had maintained his personal hygiene needs. He took his breakfast of porridge and bread and due medications of tablets ciprofloxacin 500mg bd x 7days,

metronidazole 400mg tds x 7days and syrup hematocrit 10mls bd x 14days were served. His 6:00 am vital signs were checked and recorded as follows

- Temperature – 37.2
- Pulse – 84bpm
- Respiration – 22cpm
- Blood pressure – 120/70 mmHg
- SPO2 – 99%

During ward rounds, he was discharged by the doctor and was asked to do wound dressing at the Yawhima Health Centre and come for review on the 16th of December 2021.

After the ward rounds, his folder was sent to the account office and all his bills were paid. He was assisted to pack his belongings and they were educated on how to take the remaining drugs at home. His name was discharged from the admission and discharge book and on the daily ward state.

At 12:00 pm, evaluation was made on the objective set on 7th December 2021 at 12:00 pm to regain normalcy of patient's nutritional status within 48 hours. Goal was fully met as I observed patient been able to eat at least half of his food served and regaining normal body weight after hospitalization.

At 2:30 pm, evaluation was made on the objective set on 6th December 2021 at 2:30 pm to prevent patient's wound from infection within his period of hospitalization. Goal was fully met as I noticed that patient's wound looked dry and clean and also in a progressive wound healing process.

An evaluation was also made on the objective set on 7th December 2021 at 9:35 am for patients' wound to show signs of healing within his period of hospitalization. Goal was fully met as I noticed that patient's wound looked dry and clean and was also healed by first intention.

I accompanied them to board a car and I promised to visit them.

The bed linen was removed and sent to the laundry and his bed was disinfected with 0.5% bleach solution and made ready for the next use.

4.2 Preparation Of Patient And Family Towards Discharge And Rehabilitation

The preparation of patient and family towards discharge and rehabilitation was important in order to ensure adequate continuity of care as well as involve patient and family in the care at home. The preparation started on the day of admission and continued until the day of discharge. It was made known to them that the hospitalization was temporal and that he would be discharged to go home and this depends on their cooperation with the health personnel.

The main objective was to give patient and family insight into some of the causes of hydrocele which include failure of the precessus vaginalis to close, prematurity, trauma, inflammation etc., it's management and complications as well as how to prevent it. Prior to discharge, patient and family were educated on the need to seek medical attention promptly at the nearest hospital and to avoid over the counter drugs to prevent complication. The importance of review was explained to them and they were asked to report even if patient had no complaint. Emphasis was made on the intake of well-balanced diet like rice with vegetable stew and fish to aid in wound healing and also raise the hemoglobin level. They were also encouraged to take in more fruits such as banana, orange and pineapple to prevent constipation and also the need to wash hands before and after meals and after visiting the toilet.

He was discharged on the 9th of December 2021 and was asked to come for review on the 16th of December 2021. He was educated on how to take his drugs at home and also the family members were advised to make sure that Mr. I.Z keeps the wound clean and visit the

Yawhima Health Centre for wound dressing as ordered by the doctor to promote wound healing.

The discharge date was recorded in the admission and discharge book and his name was recorded on the daily ward state. The folder was taken to the revenue department for assessment and the bills were paid by his guardian since he was not a member of the national health insurance scheme. Patient was assisted to pack his belongings and was again reminded of the review date. They were advised to register with the national health insurance scheme so that they can receive free medical treatment whenever they are sick.

Patient and family expressed their sincere gratitude to the nurses as well as other staffs and bid goodbye to the other patients. They were then escorted to the station to board a car home His bed linens were taken to the laundry and the mattress and pillow were sent outside for airing after the bed has been disinfected and prepared for the next admission

4.3 Follow-Up/ Home Visit/Continuity Of Care

Home visit is a friendly but purposeful visit to patient and family in their home with the aim of preventing diseases, promote and maintain health. It is one of the most vital roles in the efficient care of patient both on admission and after discharge. It also aids in the observation of how patient and family are coping in their natural habitat and where necessary inputs are made to ensure patient adjust at home and the care is continued.

FIRST HOME VISIT (6TH DECEMBER 2021)

The first home visit was made on the 6th of December 2021 when Mr. I.Z was still on admission. My boarded vehicle took off from Berekum to Sunyani around 8:50 am and got to Mr. I.Z house with the help of his relatives around 9:40 am. The purpose of this visit was to verify the information given by Mr. I.Z, to know how his home situation relates to his health status and to assess the actual home situation on which health education will be based. I had a pre-arrangement with patient's family. Patient stays at Yawhima suburb of Sunyani.

He lives in a house with number YH 9/5. On arrival to the house, I made a quick observation on the environment after I had been given a seat and a glass of water. The house was built with cement blocks, roofed with aluminum sheets and painted white and wine and was also fenced. It is a rented three-bedroom apartment with kitchen, bathroom and toilet and has access to electricity and pipe borne water which is an extension from the main house. Refuse generated in the house is kept in a bin covered with lid which is disposed of at the community refused dump every morning. The environment was well swept but was a bit bushy so I advised them to weed the surrounding to prevent harboring mosquitoes. I also advised them to always keep the environment clean and also cover their foods to prevent transmission of diseases. Mr. I.Z room was clean and things well organized but I realized that he was not sleeping in mosquito net so I educated them on the importance of sleeping in mosquito nets. I was told that the nearest health facility in the area is a private hospital which is about one and half kilometers from patient house.

Patient's family was reassured that Mr. I.Z would be discharged within a few days. They were allowed to ask questions which appropriate answers were given. I sought permission and was accompanied to the station to board a car back

SECOND HOME VISIT (11TH DECEMBER 2021)

The second home visit was made on the 11th of December 2021, two days after Mr. I.Z has been discharged. The aim was to know how he was faring after discharge and how he was adhering to medications given and to remind them of the review date which will be on the 16th of December 2021. I was welcomed by patient and relatives and given a seat. Mr. I.Z was very cheerful and according to him, he complied with all the advice and education given to him in the hospital. His wound was inspected and it was dry and clean and all the stitches had been removed. He complained of itching at the incision site and I explained to him that it

was part of the healing process. He told me he was taking his drugs as prescribed and on inspection, I realized that he had completed almost all the drugs given to them.

The environment had been weeded so I congratulated them for that. I emphasized on all the education given to them on discharge and also reminded them about the date for review and its importance. The family members were allowed to ask questions which were answered appropriately. Termination of the care was explained to them that the care would be terminated on the third home visit. I informed them that I will be accompanied by the community health nurse during the third home visit to hand them over to her for continuity of care.

DAY OF REVIEW (16th DECEMBER, 2O21)

On 16th December, 2021, Mr. I.Z. visited the Out Patient Department (OPD) of Berekum Holy Family Hospital. His HAMS card was activated at the records department. His vital signs were checked and recorded as:

Temperature	36.6^{o}C
Pulse	82bpm
Respiration	20cpm
Blood pressure	120/80mmHg

After the vital signs were taken, we then proceeded to the Surgical Out Patient Department which is consulting room 3 where we were received by Dr. E.N.D

There were no complaints on the day of review. He was also looking healthy as compared to the period of hospitalization. I then escorted him to the main hospital gate and exchanged goodbyes.

THIRD HOME VISIT (21th DECEMBER 2021)

The third home visit was made on the 21st of December 2021, five days after the review date. The purpose of the visit was to terminate the care and to hand over patient and family to the

community health nurse from the Yawhima Health Centre. We were welcomed and offered seats. I introduced the community health nurse to them. Patient's condition had improved and no complain was presented.

I emphasized on all the education given to them, congratulated them and advised them to report to the hospital if any problem arises. Patient and family were then handed over to the community health nurse for continuity of care

I then thanked them for their cooperation and understanding during our interaction. We were accompanied to the station

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/FAMILY

5.0 Introduction

This chapter of the study deals with how the goals and objectives set in the care plan were achieved. It also emphasizes on the changes that were made to achieve partially met and unmet goals and the termination of care rendered to my client and her family.

5.1 Statement Of Evaluation

Goals and objectives were set during the care of the patient and family to help check the effectiveness of the nursing implementation. During evaluation, the various goals and objective which were set for patient and family were met and the extent to which they were met are stated on daily basis.

PATIENT WAS EDUCATED ON CONDITION (5/12/2021)

The need to educate patient and family became necessary on the 5th of December 2021, at 3:30 pm, as they had little knowledge on his condition. Nursing diagnosis of knowledge deficit related to lack of information. An objective was set to help them gain adequate knowledge on the condition within 6hours. Nursing interventions such as patient and his family were reassured that everything about his condition will be made known to them for them to have a better understanding on the condition, a conducive environment was created to ensure patient and family's comfort, rapport was established to make them feel at home and cooperate effectively, patient and family were educated on the causes, signs and symptoms, management and prevention of the condition based on their level of knowledge, patient and family were allowed to ask questions about the disease condition and their questions were answered accurately were carried out.

At 9:30 pm on 5th of December 2021, Goal was fully met as they were able to answer questions in relation to the condition.

PATIENT WAS RELIEVED OF ANXIETY (5/12/2021)

On the 5th of December 2021, at 5:00 pm, patient was anxious due to unknown outcome of impending surgery. Nursing diagnosis of anxiety related to unknown outcome of impending surgery for formulated. An objective was set to relieve patient of anxiety within 4 hours. Nursing interventions such as patient and family were reassured of the positive outcome of surgery, patient and family were orientated to the ward and its environment like the bathroom, toilet, dressing room and nurses' station to help reduce their fears, all misconceptions patient and family had been clarified, patient was introduced to two patients who had undergone surgery successfully and were doing well, they were allowed to ask questions to clarify any misconception they may have about the condition were carried out. At 9:00 pm, goal was fully met as I observed patient and family chatting with other patients in the ward and they verbalized a reduction in anxiety.

PATIENT WAS RELIEVED OF INCISIONAL PAIN (8/12/2021)

On the 6th of December 2021 at 1:30pm, patient had incisional pain as a result of surgical intervention. Nursing diagnosis of incisional pain related to surgical incision was formulated. An objective was set to reduce patient pain within 48hours. Nursing interventions such as reassuring patient that appropriate measures would be put in place to relieve him of his pain, the area around the wound was observed for tension, bleeding and discharges as well as oedema to prevent complications, assisting patient to change his position regularly; he was in a sitting up position and his scrotum supported to reduce pain, engaging patient in diversional therapy such as reading books and watching television to divert his attention from the pain, encouraging patient to rest in a quiet and calm environment to help reduce the pain, injection of pethidine 50mg bd x 24hours was served to relieve patient of pain were implemented.

At 1:30 pm on the 8th of December 2021 goal was fully met as I observed that patient had a cheerful facial expression and also, he verbalizing the absence of pain.

PATIENT WOUND WAS NOT INFECTED (9/12/2021)

On the 6th of December 2021, at 2:30 pm, patient's wound was prone to infection due to interruption of skin integrity. Therefore, a nursing diagnosis of risk for wound infection related interruption in skin integrity was formulated. An objective was set to prevent wound infection during his period of hospitalization. Nursing interventions Patient and family were reassured that measures would be put in place to prevent wound infection, patient's wound was assessed for the presence of pus, odor, and redness around the skin, patient's wound was dressed with prescribed lotions and sterilized gauze after which it was secured with a plaster, patient was taught not to touch the wound with his hand and also prevent water from entering the wound since such practices can cause wound infection, patient was served with well-balanced diet and he was encouraged to eat in order to promote rapid wound healing were implemented.

Goal was fully met on 9th December 2021 as I observed a progression in wound healing process and patient verbalizing that his wound is looking dry and clean.

PATIENT REGAINED NORMAL NUTRITIONAL STATUS (9/12/2021)

On 7th December, 2021 at 12:00pm, patient had problem with his appetite. An objective was set that patient will maintain his normal nutritional status within 48hours. Nursing interventions such as patient was reassured that measures would be put in place to enhance and stimulate his appetite, patient was assisted to clean his mouth morning and evening with tooth brush and paste and rinse his mouth with water before and after each meal to enhance his appetite, the diet was planned with patient and family, and his like and dislikes taken into consideration in order to prepare his favorite meal, the ward environment was made clean and

pleasant by putting away bed pans, vomitus bowls and any other unpleasant odour to enhance appetite, patient body weight was checked daily to know whether there has been an increase in weight, Patient was encouraged to take in more fruits like oranges and bananas to aid in wound healing were implemented.

Goal was fully met on the 9th of December 2021 as I observed that patient was able to eat at least half of the food served and also patient verbalizing that he was able to eat more than half of meal served.

PATIENT REGAINED HIS NORMAL SLEEP PATTERN (8/12/2021)

On the 7th December, 2021, patient reported that he had difficulty sleeping the previous night. A nursing diagnosis of disturbed sleep pattern related to change in normal environment was formulated and an objective was set to help patient regain his normal sleep pattern that is 2 hours during the day and 8 hours at night within his period of hospitalization. The following interventions were carried out on the patient to achieve the set objective; Patient was reassured that he would be able to have his normal pattern of sleep since measures are being put in place to ensure uninterrupted sleep, adequate ventilation was provided by opening nearby windows and putting on the fans to allow fresh air into the room to enhance sleep, all nursing procedures such as checking of vital signs, wound dressing and medications were done at once to enhance sleep, quite environment was maintained by restricting visitors and reducing the volume of radio and television set and also asking staffs to speak undertone, warm beverage of milo was served after he has been given a warm bath

On the 8th December, 2021, at 12:00pm, the objective was evaluated and goal was fully met as I observed patient sleep 8hours at night and 2hours during the day uninterrupted and patient verbalizing was able to sleep throughout the night without interruption

5.2 Amendment Of Nursing Care Plan

Despite the numerous problems identified, with the individualized comprehensive nursing care and support from others members of the health team and cooperation of Mr. I.Z and family, all of the goals set were fully on the allocated time. The care plan was therefore not amended.

5.3 Termination Of Care

Termination of care is a break in the therapeutic relationship between the nurse, patient and the family. Interaction with patient and family started from the day of admission and continued till 21st of December 2021 as objectives set were achieved on my last home visit

It was made clear to patient and family from the beginning that the interaction was a temporal one and it would last for a short period of time. On my last home visit, patient's condition had improved, health education given were re-emphasized. They were advised to visit the Yawhima Health Center whenever they are sick.

The care was terminated finally after they had been handed over to the community health nurse from the Yawhima Health Centre for continuity of care.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation (Weller, 2014). This is the final aspect of the patient and family care study. It deals with the summation of all medical and nursing care rendered to the patient and his family as well as the conclusion.

6.1 Summary

Mr. I.Z a thirty-seven-year-old man was admitted to the surgical ward of Berekum Holy Family Hospital on the 5th of December 2021 with a diagnosis of Right Vaginal Hydrocele for which hydrocelectomy was performed.

On admission, some of the signs and symptoms exhibited by patient were scrotal swelling and inguinal pain. Nursing problems were identified with diagnosis formulated and interventions rendered. Some of the problems identified during patient hospitalization include; anxiety, incision pain, and anorexia. Nursing interventions were implemented and all goals were fully met due to effective nursing management. Routine nursing activities like changing of patient's bed linen, regular checking of vital signs and serving of medications were some of the procedures that were rendered to the patient on admission. The following drugs were given to Mr. I.Z

1. Injection pethidine 50mg bd x24hours
2. Intravenous metronidazole 400mg tds x 48hours.
3. Intravenous ciprofloxacin 500mg bd x 48hours
4. Injection diclofenac 50mg bd x48hours.
5. Intravenous normal saline 1liter x 24hours.
6. Intravenous dextrose saline 1liter x 24hours

7. Intravenous ringers lactate 1liter x 24hours
8. Tablet ciprofloxacin 500mg bd x 7days
9. Tablet metronidazole 400mg tds x 7days
10. Syrup hematocrit 10mls bd x 14day

Patient was discharged on the 9th of December 2021 during ward rounds by the doctor on duty after thorough examination. He was asked to report for review on the 16th of December 2021**.** Patient and family were educated on the causes, prevention and treatment of hydrocele, good nutrition, maintenance of good personal and environmental hygiene and the need to conform to drug regimen. The need to come for hospital for review was emphasized. Three home visits were made before and after patient's discharge, first, second and the third home visit in order to monitor his condition and to find out what might have contributed to the illness. He came for review on the 16th of December 2021 after discharge and was finally handed over to the community health nurse during the third home visit.

6.2 Conclusion / Recommendation

The patient and family care study has helped me acquire in-depth knowledge into the disease condition (Right Vaginal Hydrocele). It has helped me to give comprehensive nursing care that has to be given to individual patients. The study has equally assisted me to transfer the knowledge I have acquired from the three-year nursing course into practice.

Again, it has helped me institute good interpersonal relationship skills with patient and family which enhance patient's recovery.

Lastly, I suggest that all things being equal, all patients should be given such special and individualized care so as to help reduce the re-occurrence of disease conditions and mortality rate of patients admitted to the hospitals.

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APPENDIX

Table 7: vital signs of Mr. I.Z

Date	Time	Temperature ^{o}C	Pulse (Bpm)	Respiration (Cpm)	Blood pressure (mmHg)
5/12/2021	12:00pm	37.3	68	20	135/80
	2:00pm	36.9	78	22	115/75
	6:00pm	36.7	80	19	125/80
	10:00pm	37.1	82	21	110/60
6/12/2021	6:00am	37.3	76	20	135/80
	8:20am	36.9	89	20	110/70
	10:00pm	Patient wax sent to the theatre at this time			
	12:40pm	36.4	92	24	100/60
	2:00pm	36.7	88	21	110/70
	6:00pm	37.1	84	20	100/60
	10:00pm	36.5	87	22	115/80
7/12/2021	6:00am	36.7	87	19	125/85
	10:00am	37.1	84	20	100/60
	2:00pm	36.8	81	22	110/75
	6:00pm	37.0	78	24	120/80

	10:00pm	37.2	80	21	125/80
8/12/2021	6:00am	36.8	78	21	120/75
	10:00am	37.1	80	21	110/70
	2:00pm	37.2	84	19	130/80
	6:00pm	37.0	78	21	130/80
	10:00pm	36.8	87	22	120/75
9/12/2021	6:00am	37.2	84	22	120/70

SIGNATORIES

1. **The Student Nurse**

   Name: Yeboah Christian

   Signature: .....

   Date: 07/10/2022

2. **Nurse In-Charge of Surgical Ward, Holy Family Hospital, Berekum**

   Name: Elizabeth Obeng Pomaa

   Signature: .....

   Date: 07/10/2022

3. **The Supervisor, Holy Family Nursing and Midwifery Training College, Berekum**

   Name: Ms. Rita Agyei Boakye

   Signature: .....

   Date: 07/10/2022

4. **The Principal, Holy Family Nursing and Midwifery Training College, Berekum**

   Name: Monica Nkrumah

   Signature: .....

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