HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT / FAMILY CARE STUDY ON RIGHT INGUINO-SCROTAL HERNIA

(RISH)

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

The patient and family care study is a detailed written account or report of the comprehensive individualized nursing care rendered to a particular patient and family within a specific period of time. This includes the study of the diagnosis, treatment and the actual nursing care rendered to the patient to meet his/her physical, psychological, social and spiritual needs. It involves the interaction between the patient, his/her family, the community in which he/she stays and the health team.

It forms part of the final assessment of the student nurse at the end of the three year training program for a license to practice as a Registered General Nurse awarded by the Nursing and Midwifery Council of Ghana.

It presents the student the opportunity to put into practice the knowledge he or she acquires during training to give effective nursing care to a patient with reference to the patient's condition.

The care also helps the student nurse to acquire more knowledge about the signs and symptoms, diagnosis, causes and treatment of a specific disease condition managed by the student.

The study serves as a reference paper for other student nurses and qualified health personnel who may be interested in its content. The patient's initials were used to maintain confidentially.

ACKNOWLEDGEMENT

I am mostly indebted to my father in heaven for all that he showered on me for the successful completion of this work; may his name be praised now and forever. I am grateful to my patient, Mr. N.O. and his family members for their incredible co-operation. I am much thankful to them for all the information they provided towards the progress of this study. The next big thanks also go to my supervisor Madam Dzigbede Bridget and the entire tutors of Holy Family Nursing and Midwifery Training College- Berekum, especially Mr. Ibrahim Alhassan for their guidance, time and support in the course of writing this care study.

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I would also like to express my gratitude to all nurses and doctors of the Holy Family Hospital-Berekum especially all the staff of the surgical ward that helped me in multiple ways to make this study a success; I say thank you.

How can I forget to also acknowledge the authors and publishers whose works were used as literature in this study.

Finally, I am grateful to all my course mates for their support during the writing of this care study.

INTRODUCTION

The patient and family care study is an aspect of nursing which deals with the comprehensive Nursing care to a patient and family from the day of admission to the termination of care.

Mr. N.O the patient for the study was born on the 14th August 1975 at Koraso Katanka in Berekum in the Bono Region of Ghana. He is 46 years. His parents are Mr. K.F and Mrs. A.B. He is about 1.6m tall and weighs about 69 kilograms.

Mr. N.O, a 47-year-old man was admitted to the surgical ward through the Out Patient Department of Holy Family Hospital, Berekum on the 4th of November, 2021 at 05:00pm with the diagnosis of right inguino-scrotal hernia. On admission, he came in a conscious state. Patient was orientated to the ward. Patient was also educated in maintaining her personal hygiene, rest and sleep, nutrition, and exercises. Patient underwent successful surgery on 6th of November 2021 and was discharged on the 8th of November 2021.

Throughout his stay at the hospital, six (6) health problems were identified during the preoperative and post-operative period. Nursing diagnosis were made, Objectives were set and interventions carried out to address all these problems.

On the 15th of November, 2021 patient reported for review as scheduled. It was to find out if patient was adhering to the advice and all the education given to improve his health and standard of living. Three home visits were embarked on. The first home visit was done while patient was still on admission on 7th November, 2021, second home visit was on the 12th November, 2021 and third home visit was on the 24th November, 2021. The care of Mr. N.O and his family care were terminated on the 24th November, 2021, during the third home visit when patient had fully recovered.

The study was terminated with three home visits and it is arranged under the following sub headings:

a. Assessment of patient and family
b. Analysis of data
c. Planning of the patient/family care
d. Implementing of patient/family care plan
e. Evaluating of the care rendered to the patient/family
f. Summary and conclusion.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

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

1.1 Patient's Particulars

Collins English Dictionary (2018), defines patient particulars as facts or details about the patient which are written down and kept as a record. It includes patient name, address, age, sex, marital status, occupation and religious preference and next of kin.

Mr. N.O was born on the 14th August 1975 at Koraso Katanka in Berekum in the Bono Region of Ghana. He is 46 years. His parents are Mr. K.F and Mrs. A.B. He is about 1.6m tall and weighs about 69 kilograms. He is dark in complexion and has no physical impairments. He is the eighth born among the ten siblings of his parents. He is married to Mrs. B.C. with six (6) children of which four are males and two females. Mr. N.O and family currently lives at Koraso Katanka Suburb in Berekum, Plot number 99 Block C. Mr. N.O is an Akan. He speaks Twi

only. He is a farmer. He is a Christian and worships at Apostle Continuation Church at Koraso Katanka. He started his education at the age of five and completed Junior High School at Koraso Katanka and also continued second cycle school at Berekun senior high. His next of kin is Miss A.O his daughter, who lives at Koraso Katanka House number K.K 28. His folder number number is 24507/17.

1.2 Family Medical History

During the interaction with Mr. N.O he said, there is no history of hereditary disease like hypertension, sickle cell and diabetes, mental illness or any communicable disease like whooping cough or leprosy etc. runs through the family. At times some minor illness like malaria and headache which is either treated with herbal medicine or by buying over the counter drugs and that easily treat the problem. Both of patient's grandparents are deceased. Their deaths were believed to be of natural cause (due to old age). He said his parents are currently in good health but mostly comes to hospital for check-up due to aging. Mr. N.O's wife, children and siblings are also currently in good health. There are also no known allergies in the family.

1.3 Patient and Family Socio-Economic History.

Mr. N.O's family lives harmoniously with each other as well as the people in the community and supports each other in times of need. Mr. N.O said his parents, wife and children are registered members of National Health Insurance Scheme (NHIS) which enable them to seek health care since it helps cut down the cost of hospital bills. Mr. N.O is a farmer and earns about thousand seven hundred cedis in a month and her wife is also a trader. Patient and wife also save some of money for unforeseen circumstances. Patient and wife were educated on occupational hazard. His income together with his wife's own is what they use to provide the needs of their family. Mr. N.O's family members are Christians and they engage themselves in church activities like cleaning of the church premises, song ministration etc. at Apostle

Continuation Church at Koraso Kantaka. Mr. N.O said there is no known family member who has the habit of drinking alcohol excessively or smoking of tobacco or marijuana. According to Mr. N. O, it is a taboo in the community to steal another person's farm items and go to farm on Friday.

1.4 Patient's Developmental History

Development is the process of growth and differentiation (Weller, 2014). Growth is the progressive development of a living thing, especially the process by which the body reaches its point of complete physical development. Maturation refers to the process of aging. That is the physical growth and development of the body, brain and nervous system. Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development. (weller, 2014). Maturation is the process of becoming completely developed mentally or emotionally (walter, 2013). According to Mr. N.O, he was born at term on the 14th August 1985 at Holy Family Hospital, Berekum through spontaneous vaginal delivery with no complications. Mr. N.O said according to his mother, he was immunized against the vaccine preventable diseases e.g. Tuberculosis, Measles, etc. Mr. N.O said according to his mother, he had a normal developmental milestone. At four months, Mr. N.O could sit alone without support, he started to crawl at seven month and walk at the eleventh month.

He began to speak at the age of one. Mr. N.O said according to his mother, he started schooling when he was five years old at Koraso Katanka Government School, where he had his pre-school education as well as his primary and junior high education, which earned him the opportunity into Berekum Senior School. His aim after completion of Senior High school was to be a Police man but due to financial constraint's he couldn't make it. Mr. N.O said he started experiencing secondary sexual characteristics at twelve years. Mr. N.O engaged in farming after secondary school, since there was no money for him to continue his education

and got married. Erikson outlined 8 stages of psychosocial theory of development and Mr. N.O falls under seventh stage, which is Generativity versus Stagnation 40-65 (middle adulthood).The development in this stage is around generativity and stagnation or self-absorption .When people feel a sense of care and responsibility, it's called generativity. They look out for those around and also feel the need to pass along what they have learnt to the younger generation. But if they don't act as a mentor in a capacity they may feel bitter and unhappy. This leads to restlessness and isolation from friend family and society.

1.5 Patient's Lifestyle and Hobbies

Mr. N.O said he usually wakes up at about 5:30am, he prays and maintain his personal hygiene, by washing his face with cold water and uses toothbrush and pepsodent paste which protect him from bad breath, makes his teeth whiter. He stimulates his appetite and makes his mouth moist and gloomy to perform his daily chores. He said he performs his personal hygiene twice daily (bathing and oral care), he baths with cold water with sponge and soap which makes him active and free his bowels mostly three times daily but for bladder not specific. By 6:30am, he leaves the house to his farm because that is the only source of income to support his family, he said he goes to farm for all the days of the week except Friday and Sunday which Friday is a taboo day and mostly goes to church on Sunday and rest after church.

He mostly takes his breakfast at 8:00 am which is mostly koko and bread and his lunch around 1:30pm, which is mostly rice and stew or banku and soup and then leaves the farm place at 5: 00pm for the house and mostly takes his supper around 6:00pm He said he always cooked his lunch in the farm but for his supper is what his wife prepares at home. According to Mr. N.O, he does not have a specific food of dislike. He said after work and eating, he chats with his family members and goes to bed around 9:00pm. He said the games he likes best is Oware and Odame and watches television at his leisure times. He drinks alcohol occasionally but mostly enjoys soft drink, he said his favourite food is fufu and palmnut soup. Mr. N.O said he mostly

participate and support in social activities like funeral weddings, church, community picnics and engages fully in community organized programs. Mr. N.O said he has no distinguished intimate friends, because he is very sociable and friendly to everyone that he comes across, he said, what he dislikes is cheating others, Mr. N.O has a cordial relation with his family and is able to verbalize his feelings appropriately and he is an extrovert. Patient is caring, kind, respectful and humble,

1.6 Past Medical History

According to Mr. N.O he had not been seriously sick before, he had never experienced any medical condition examples; Hypertension, diabetes, tuberculosis etc

He said, he has not been admitted to any health facility before until this current heniorraphy but sometimes suffers minor ailments like headache and general body weakness because of the kind of occupation, which he visits his local chemical shops to buy orthodox drugs or sometimes use herbal medicines.I therefore advise him on the adverse effect of buying drugs or herbal medicine without Physicians prescriptions. There are no difficulties in accessing health care because he is a registered member of the national health insurance scheme. He has not been going for medical check-ups, because he thinks it is not necessary since he is not sick. He said he does not yet have a known allergy to either food or drug. Mr. N.O said he was once involved in a home accident where he one fell on a slip floor and got his right leg injured and also occupational hazard where he cut his thumb finger with cutlass. But was managed at home and healed very well and as such he is not suffering from any disability.

1.7 The Patients Present Medical History

According to Mr. N.O, he has been well until 2 years ago where he noticed a mass in his scrotum. The mass has progressively increased in size over the period, and it involves the right scrotum associated with pain and sometimes difficulty in walking. He reported to the outpatient

department (OPD) of Holy Family Hospital Berekum for medical attention on 2nd November, 2021.

The doctor on duty attending to him after examination diagnosed of him Right Inguino-scrotal Hernia (RISH). He was scheduled to come to the Surgical ward on 4th November, 2021 for the surgery to be conducted on 6th November, 2021.

1.8 The Admission of Patient.

On 4th November, 2021, at 5:00pm, Mr. N.O in a fully conscious state came to the surgical ward ambulatory accompanied by his wife for planned surgery. Patient and relative were welcomed into the ward at the Nurse's station, offered seats and his folder (24507/17) was collected. Patient's name was confirmed from the folder by mentioning it. Patient was given a comfortable simple unoccupied bed. His vital signs were checked and recorded as follows;

Temperature - 36.2 °C,

Pulse - 86bpm

Respiration - 23bpm,

Blood pressure - 130/90 mmHg,

SPO2 - 97%

Patient came with diagnosis of Right Inguinoi Scrotal Hernia and was Scheduled for Surgery on 6th November, 2021. All necessary information was documented in the admission and discharge book. On assessment, it was noticed that patient and relative were anxious, patient and relative were reassured. Patient and relative were orientated to the ward and its annexes such as the nurses' station, kitchen, treatment room and the washrooms. Ward policies such as visiting hours and mode of payment of bills were explained to my patient and relative. He was told of the ward routine such as medications, checking of vital signs and meal times. He was

introduced to the other patients in the cubicle. Patient was asked to bring items like pail, bowl, cup and toiletries like soap and toilet rolls and other items which will be needed by him. Intravenous line for administration of prescribed infusions was secured. The following laboratory investigation had already been requested by the physician and made available on admission.

- Full blood count
- Blood for grouping and cross matching
- Blood for renal function test and electrolytes.

In addition to that, the following treatment was prescribed by the doctor to prepare the patient for surgery (Herniorrophy)

- Intravenous dextrose 5% 2L x 48 hours
- Intravenous normal Saline 2L x 48 hours
- Intravenous Ringers Lactate 1.5L x 48 hours
- Intravenous Amoksiclav 1.2g tds for 48 hours
- Intravenous ciprofloxacillin 400mg bd x48 hours
- Intravenous Metronidazole 500mg tds for 48 hours
- Intramuscular Pethidine 50mg qid x 24 hour
- Suppository Diclofenac 100mg bd x 48 hours

His prescribed drugs were collected from the pharmacy and stat doses were given Intravenous infusions were given to rehydrate him and to provide nutrients to him while he was on no oral feed. Introduction of myself to patient again as a Final Year student of the Holy Family Nursing

and Midwifery Training College, Berekum who would like to use Mr. N.O. in writing of care study. Mr. N.O and relative were informed that, the care study was recommended by the nursing and midwifery council of Ghana in order for a nursing student to be awarded a license to practice as a registered nurse. Patient and relative were reassured that all information taken from them will be kept confidential. Client was chosen in writing because of my desire to gain more knowledge on the condition (right inguino-scrotal hernia). Fortunately, Patient and family responded positively to the request as his wife said, she believes his husband will be cured of his illness looking at how he is being cared for. They were thanked for their acceptance. Patient and family were made to understand that, hospitalization is temporal and patient will be discharged home once his condition resolves. Patient was reassured; he signed the consent form for operation after the procedure had been explained to him. He was educated on condition, pre and post- operation care and was encouraged to ask questions and answers were given to his understanding which made the patient relaxed, patient valuables were in put in a locker He was told to relax in bed. This was done to reduce his level on anxiety. The reason why I took Mr. N.O as my client for the care study is, I wanted to have more knowledge about Hernia and render individualize care

1.10 Patient's Concept of His Illness

According to Mr. N.O, he believes his illness is not as a result of any spiritual doing, but could be as a result of his occupation like lifting of heavy objects and that with the care being rendered to him and God on his side, all will be well. He also said he is expecting a very good result from the surgical treatment rendered to him.

1.11 Literature Review on Hernia

DEFINITION

Hernia is the protrusion of a tissue, structure or part of an organ through the muscle tissue or the membrane by which it is normally contained. The hernia has three parts: the orifice through

which it herniates, the hernia sac, and its contents. The term hernia can also be used for such. protrusion in any part of the internal organ through the structure enclosing them. (Weller,2014).

TYPES OF HERNIA

According to (Smeltzer, Bare, Hinkle and Cheever, 2010) the types of hernia are:

- Inguinal hernia
- Femoral hernia
- Umbilical hernia
- Incisional hernia
- Hiatus hernia
- Richter's hernia

INGUINAL HERNIA

This is most common type in which the abdominal content passes down the spermatic cord in men and around ligament in females into the groin. It is more common in males because of the space allowed for the descent of the testis. This hernia can become extremely large and frequently descend into the scrotum. It is higher among infants and younger persons.

a. **Direct Inguinal Hernia:** It is when the abdominal content escapes through the posterior inguinal ring into the groin.

b. **Indirect Inguinal Hernia:** It is the hernia that occurs when the contents escapes through the inguinal ring and follow the spermatic cord.

FEMORAL HERNIA

This occurs when there is a protrusion through the femoral ring into the femoral canal. It usually begins as a plague of fat in the femoral canal that enlarges and gradually pulls the peritoneal and almost the urinary bladder into the sack and it becomes a look. There is a high incidence of incarceration and strangulation in this type. It is more common in females than in males. (Hinkle & Cheever, 2014)

UMBILICAL HER`NIA

According to (Hinkle & Cheever, 2014) this occurs when the umbilical opens fails to close after birth or when the muscles become weak. There are two types;

i. **Congenital umbilical hernia:** is due to abnormality of the muscles structure of the cord

ii**. Acquire umbilical hernia:** is due to increase abdominal pressure which occurs in obese persons, due to deficit of the umbilicus that persisted from birth.

INCISIONAL HERNIA

This is a type of hernia that occurs when the defect is the result of an incompletely healed surgical wound. These can be the most frustrating and difficult to treat, as the repair utilizes already attenuated tissue. It is also a result of inadequate healing of the incisional site due to post-operative problems such as infection, inadequate nutrition, obesity and other factors.

HIATUS HERNIA

This is the protrusion of the upper portion of the stomach through a weakened esophageal hiatus in the diaphragm into the thoracic cavity. It is also called Oesophageal or diaphragmatic hernia. (Hinkle & Cheever, 2014)

RICHTER'S HERNIA

This is a type of hernia in which a portion of the bowel is held in the abdominal muscles wall. It occurs in older people.(Hinkle & Cheever, 2014)

PARTS OF ABDOMINAL HERNIA

According to Hinkle &Cheever, 2014 a hernia has the following parts:

The sac: It’s an out pouch of the peritoneum; the neck of the sac may be broad, permitting internal organ to slip in and out of the sac. The neck may also be narrow and surrounded by a dense fibrous tissue.

The content: An abdominal hernia sac may contain a loop of small intestines, caecum, omentum, appendix, ovary or occasionally the bladder.

The ring: The hernia ring is of a muscular or fibrous tissue that forms on opening into the sac.

CLASSIFICATION

Hernia can be classified according to the severity of the protrusion. These include; According to Smeltzer, S.C and Bare, B.G (2014)

- **Reducible hernia:** is one that the organ be easily pushed back into it original cavity. It can be done manually.
- **Irreducible hernia:** is one that cannot be reduced by placing back either manipulation or by any manual method; it is by only surgical means.
- **Incarcerated hernia**: is when the hernia becomes both irreducible and obstructed, this condition eventually leads to obstructed blood flow to or from the viscose.
- Inguinal, umbilical and femoral hernia is more likely to become strangulated than other hernia because their sacs have smaller necks and tend to be surrounded by rigid rings of tissues. With time, adhesion may develop between the hernia sac and its content, and result in an irreducible or incarcerated hernia

INCIDENCE

Inguinal hernia affects men whiles femoral and umbilical hernia affect women.

Inguinal hernias account for 75% of abdominal wall hernias, with a life risk of 27% in men and 3% in women (Smeltzer, S.C and Bare, B.G, 2014).

AETIOLOGY

The causes of hernia include the following;

- Congenital malformation: When there is a defective muscle wall of the abdomen at birth.

- Acquired: Muscular weakness may result as a result of trauma or aging.
- When people suffer severe infection of the peritoneal muscles.
- Post-surgical incision

PRE-DISPOSING FACTORS

According to Smeltzer, S.C and Bare, B.G (2014), increase intra-abdominal pressure such as;

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

PATHOPHYSIOLOGY

According to Smeltzer, S.C and Bare, B.G (2014) the most, hernia develops in the abdomen, when a weakness in the abdominal wall evolves into a localized hole or "defect" through which adipose tissue or abdominal organ covered with peritoneum may protrude.

Hernia may or may present either with pain at the site, a visible or palpable lump or in some cases by more vague symptoms resulting from pressure on an organ which has become ‘stuck’ in the hernia, sometimes leading to organ dysfunction. Fatty tissue usually enters a hernia first, but it may be followed by or accompanied by an organ.

Most of the time, hernia develop when pressure into the compartment of a residing organ is increased and the boundary is weak or weakened.

Weakening of containing membranes or muscle is usually congenital and increase with age but it may be on the bases of other illnesses, stretching of muscles during pregnancy, losing weight in obese people or because of scar from previous surgery. Many conditions chronically increase intra-abdominal pressure example pregnancy; benign prostates hypertrophy and hence abdominal hernia are very frequent.

Increasing intracranial pressure can cause part of the brain to herniate through narrowed portion of the cranial cavity. Increased pressure on the intervertebral disc, as produced by heavy lifting or lifting with improper technique increases the risk of herniation.

CLINICAL MANIFESTATION

According to Smeltzer, S.C and Bare, B.G (2014), and this clinical manifestation of hernia include:

- Groin swelling which may or may not disappear when patient lies down. It may at first appear straining but as it gets bigger it appear when the patient stands up and descend into the scrotum.
- Pain is felt by the patient when there is swelling. Severe pain indicates strangulation.
- The skin over the swelling becomes rough due to friction with clothing or from the two skin surface.
- Vomiting.
- Increased pulserateis other symptoms that may be exhibited.

DIAGNOSTIC INVESTIGATIONS

According to Smeltzer, S.C and Bare, B.G (2014), the diagnostic investigations for hernia are:

- Blood for white blood cell count may reveal an elevation of the leukocyte level.
- Blood for renal function test and electrolytes.
- Abdominal or pelvic x-ray reveals the protrusion of the viscous outside its normal cavity.

- Physical examination reveals the presences of swelling which on the vomiting or straining and disappears when the patient lies supine.

COMPLICATIONS

According to Smeltzer, S.C and Bare, B.G (2014), the complications that can arise from hernia include the following:

Irreducibility: The hernia contents cannot be completely return to the abdomen. It is often due to adhesion between the sack and the contents. Loops of bowel may also adhere a mass too bulky to return through the narrowed hernia orifice.

Strangulation: Blood supply to the hernia sack is obstructed by constriction at the neck of the sack that prevents blood supply to the bowel.

Fistula formation: Abscess forms, the sack later ruptures on the skin to form a fistula.

Gangrene and perforation: If the constriction is not relieved immediately, the bowel becomes gangrenous and then perforates.

Intestinal obstruction: Strangulated internal hernia is the commonest cause of intestinal obstruction.

SPECIFIC MEDICAL AND SURGICAL TREATMENT

MEDICAL TREATMENT

According to Smeltzer, S.C and Bare, B.G (2014), the medical treatment of Hernia are;

- Although hernia is a surgical condition, other treatment can also be carried out if for any reason the surgery cannot be done.
- The patient can reduce the hernia by lying down with the foot end of the bed raised.
- Also the patient can lie in a warm tab and then push the mass backwards the abdominal cavity gently.

- Again, a pad made of material is placed over the opening through which the hernia protrudes and is held in place with a belt. This pad (truss) may be used to reduce the hernia.
- Again, in obstructed cases narcotic analgesics eg. pethidine can be given intramuscularly to reduce the pain. Cold compresses can also apply at the site frequently.
- Antibiotics are given to prevent or stop any susceptible bacterial infection before or after surgical treatment.
- Analgesic such as pethidine to relieve pain.
- Anti-inflammatory analgesics such as acetaminophen, tablet Ibuprofen, diclofenac is given to counter inflammation and help relieve pain.
- Intravenous fluids are given before and after surgical treatment because of nil per ors and as nutritional therapy.
- Heamatinics to stimulate red blood cell production, to replenish lost blood in the body system

SPECIFIC SURGICAL TREATMENT

The surgical treatment of hernia are; Herniotomy, Herniorrhaphy and Hernioplasty according to Smeltzer, S.C and Bare, B.G (2014).

Herniotomy

This is the removal of the hernia sac. This operation involves opening the hernia sac and reducing its content into the abdominal cavity. The sac is then tied off and excised.

Herniorrhaphy

This is the removal of the sac and repair of the weakened abdominal wall with a non-absorbable suture. It is the preferred surgical treatment for infants, adult and elderly patient.

Hernioplasty: This is plastic repair of the weakened abdominal wall after reducing the hernia using synthetic sutures such as wire, steel mesh etc.

NURSING MANAGEMENT

According to Smeltzer, S.C and Bare, B.G (2014), managing and preparing a patient with hernia for surgery requires the following

- **Psychological care:**

Client and relatives are reassured that, he is in the hands of competent health staff who will help in managing his condition. This helped to relief patient and relatives from their fears and anxiety, relaxed the patient and established a good rapport. The surgical procedure is explained to client to help allay his fears.

- **Rest and sleep:**

These are ensured to enhance recovery process, conserve energy and reduce metabolic activities.

Bed is made which was comfortable to patient. Brighter light on the ward was switched off. Nearby windows are opened to facilitate adequate ventilation. Visitors are not allowed to enter the ward.

- **Observation:**

The patient vital signs (temperature, pulse, respiration and blood pressure) are monitored fifteen minutes, half hourly, hourly, two hourly and gradually to four hours as patient condition improves. These will help to assess the improvement or retrogression in patient condition to prevent shock. Signs and symptoms, possible complications are observed on the client so that any problem that is identified can be solved to enhance patient comfort and

recovery. Intravenous fluid in-situ is also observed to ensure that it is dripping according to the prescribed rate. Also the nurse observes that the infusion catheter is not kinked.

Patient level of consciousness is also assessed by calling his name, pinching him.

The patient responds to these determine his level of consciousness.

The patient mental orientation is also assessed for, to know if he is oriented to place, time and person. The desired and side effects of drugs administered are assessed for any abnormalities.

Intake and output chart is monitored to assess the fluid and electrolyte status of the client.

Nutrition:

- All prescribed intravenous fluid are administered and observed for dripping rate to correct fluid and electrolyte imbalance.
- After surgery, patient is served with fluid diet (water, Lipton etc), light diet (light soup, rice and stew etc) and balanced nourishing diet rich in protein to repair worn out tissue.
- Carbohydrate to provide energy and vitamins to help improve immune system gradually as condition improves.

Drugs / Medication:

- The patient drug is served as prescribed by the physician with regards to the seven R's. Side effects of the drug are monitored for example rashes, itching etc.

Elimination:

- This include the urinary and bowel output. The client is served with bedpan on request.
- The outputs are observed for colour, amount, odour and other findings recorded in the nurse's note and the output portion of the intake and output chart.
- Catheter care is done every two days to prevent infections e.g. Cystitis

Personal Hygiene:

- Patient is bed bathed and assisted bathroom bath as condition improved. This helped to promote sleep, remove dirt, promote circulation and relax patient. Care of patient hair by washing with soap and water to prevent lice infestation and ring worm.
- Client is assisted to care for his mouth using toothbrush and paste; this also helped to prevent dental carries, halitosis.
- The finger and toe and nails are soaked in a bowl of water to make them soft and then cut them short to prevent them from harbouring microbes.
- The pressure areas are treated to prevent bedsore by applying Vaseline. The patient position is changed every four hours to prevent pressure sores.
- Soiled or dirty linen is removed promptly to enhance patient's comfort.

Positioning:

- Client is made to assume the supine position to enhance his comfort in bed.

Exercise:

- This help to promote circulation, prevent thrombosis, embolism, hypostatic pneumonia, joint stiffness and muscle wasting. Examples of exercises recommended for patient include;
- Client is made to sit up in bed, walk around his bed and gradually walk around the ward
- Client is made to do range of motion exercises e.g. Extension, flexion, abduction etc.

Education:

- Patient knowledge of the condition is assessed for so that education can go on, building on what client already knows.
- The client is educated on the definition, causes, signs and symptoms, complications, preventive measures, diet and review.

- The client is made to ask questions and all answers given in simple terms. Client is made to give feedback on the education given.

1.12 Validation of Data

Data validation is a method of checking for the accuracy and quality of your data. It also includes the process of ensuring that data entered fall within the accepted boundaries (Alley, 2019). All the data collected from client was cross checked in the literature review for confirmation. The patient's medical history was confirmed by some of the signs and symptoms he manifested. The information obtained regarding patient's home environment was verified during home visits. The clinical features presented and diagnostic investigations conducted on him confirmed that he was suffering from Inguinal hernia. When the data collected from were compared with the literature review, it was vivid that Mr.N.O. was suffering from Right Inguinio Scrotal Hernia.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis refers to the act of determining the component part of a substance (Weller, 2014). Data is a collection of facts (Weller, 2014). Analysis of data is the second stage of the nursing process, and it involves grouping the information collected at the assessment phase in simpler components. This allows an individual to come out with a conclusion about the patient health needs. The patient and family strengths are also identified and this forms a guide to arrive at a nursing diagnosis and to give appropriate care to the patient.

2.1 Comparison of Data with Standards

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

a. Diagnostic Investigation/Tests

Diagnosis is the determination of the nature of a disease (Weller, 2014). Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment (Weller, 2014). The Literature points out; Physical examination revealing warmth redness and swelling, Full blood count, Culture and sensitivity test to detect the present organism and the antibiotic they are most sensitive to (in case of wound), Liver function test to rule out any involvement of the liver, Blood urea electrolyte and creatinine to assess liver function.

The following diagnostic investigation was done on the patient.

- Full blood count

- Blood for grouping and cross matching
- Blood for renal function test and electrolytes

Table one below shows the comparison of diagnostic tests carried out on client and those listed in literature review.

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

Diagnosed Test outlined in literature review	**Diagnostic Test carried out on Mr. N.O**
Blood for white blood cell count may reveal an elevation of the leukocyte level.	Full Blood Count was done
Blood for renal function test and electrolytes	This was conducted.
Abdominal or pelvic x-ray	This was not conducted
Physical examination for clinical signs	This was conducted which help in confirmation of the diagnosis.

From table 1 above, some diagnostic investigations were carried for patient as stated in the literature, which included blood sample for full blood count, Blood for renal function test and Physical examination to confirm the diagnosis. Blood for renal function test and serum electrolyte was done to know the renal function and serum electrolyte of (sodium, potassium etc). Abdominal or pelvic x- ray was not conducted because patient diagnosis was fully confirmed with physical examination and its clinical signs. Blood grouping and cross matching was done to confirm patient blood group, which help to prevent any adverse reaction in case of haemo transfusion.

Details of the test carried out on the patient have been presented in table 2

TABLE2: DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	RESULTS	NORMAL RANGE	INTERPRETATION	REMARKS
04/11/2021	Blood	**FULL BLOOD COUNT(FBC)**				
		Red blood cell count	5.27 [10^6/uL]	4.50-5.50 [10^6/uL]	Normal	No treatment was given
		Haemoglobin level estimated	13.9 [g/dL]	Female: 11-16g/dL Male: 12-18g/dL	Normal	No treatment was given
		Differential white blood cell count	9.27 [10^3/uL]	2.6 - 8.50[10^3/uL]	Increased circulating white blood cell in the blood indicating	To combat infection, prescribed antibiotics, intravenous flagyl 500mg

		Neutrophil Lymphocytes Monocytes Esinophils Basophils	69.7% 13.8% 15.7% 0.5% 0.3%	40-70 % 20-50 % 2-10 % 1-6 % 0-1 %	infection	tds x 48 hours and intravenous ciprofloxacin 400mg tds x 48 hours were given.
04/11/2021	BLOOD	**RENAL FUNCTION TEST AND ELECTROLYTES**				
		Urea Creatinine	8.08mmol/L 50mmol/L	2.50-8.30mmol/L 62-106mmol/L	Normal Below normal	No treatment given No treatment given

04/11/2021	BLOOD	Sodium Potassium Chloride	125mmol/L 4.2mmol/L 91mmolL	135-145mmol/L 3.5-5.5mmol/L 94-110mmolL	Below normal Normal Below normal	Prescribed infusion; normal saline 2L for 48 hours intravenously
04/11/2021	BLOOD	Grouping and cross matching	Blood group O positive	A(+ or -), AB(+ or -),B(+ or -) and O(+or -)	Client belonged to blood group O with Rhesus Positive,(O+)	Client was not transfused.

CAUSES

With reference to the Literature Review, Hernia could develop from so many risk factors. From the physical examination conducted, laboratory investigation and history taking from patient, his cause of hernia could be attributed to constant increased intraabdominal pressure caused by his work as he frequently bend down to weed. He also engages himself in timber work which involves lifting heavy objects.

TABLE 3: Clinical Features Exhibited By Patient Compare To Those In The Literature

CLINICAL FEATURES INDICATED IN THE LITERATURE	**CLINICAL FEATURES EXHIBITED BY PATIENT**
1. Groin swelling which may or may not disappear when patient lies down.	1. Patient experienced groin swelling which did not disappear when patient lied down.
2. Pain felt by patient when there is swelling.	2. Patient complained of pain around swollen groin
3. Roughed skin over swelling	3. Was not present
4. Vomiting	4. Patient was not vomiting.
5. Increasing pulse	5. Was present

As compared with the signs and symptoms outlined in the literature review shown in table 3 above, client did exhibit some of the signs and symptoms mentioned and others he did not.

Treatment for Patient

According to Weller (2014), Treatment is the mode of dealing with a patient or disease.

Patient underwent surgery known as Herniorrhaphy on 6th November,2021 and the following medications were prescribed for him:

Pre-Operative Drugs

1. IV Dextrose5% 2.0 liters x48 hours
2. IV Normal Saline 2.0 liters × 48 hours
3. IV Ringers Lactate 1.5 liters × 48 hours

Post-Operative Drugs

1. IV Metronidazole 500mg tds × 48hours
2. IV Amoxiclav 1.2g tds x 48 hours
3. Pethidine 50mg qid × 24 hours
4. IV Ciprofloxacin 400mg bid x 48hours
5. Suppository Diclofenac 100mg bid × 48 hours

Discharge Drugs

1. Tablets Ciprofloxacin 500mg bd × 5 days
2. Tablets Metronidazole 400mg tid x 5days
3. Tablets Zincovit dly x 30 days
4. Suppository Diclofenac 100mg bd × 3 days

Table 4: Comparison of treatment outlined in literature review with those given to patient.

Treatment Outlined in Literature Review	Treatment Given to Patient
Analgesic	Pethidine 50mg qid × 48 hours was given Suppository diclofenac 100mg x 48hours was given.
Antibiotics	Antibiotics such as amoxiclav was given
Intravenous fluid	Patient was given IV Dextrose5% 2.0 liters x48 hours IV Normal Saline 2.0 liters × 48 hours IV Ringers Lactate 1.5 liters × 48 hours
Heamatinics	Tablets Zincovite dly x 30 days

From the above table, the treatments given to patient were in line with the literature. Sedatives were not given because patient was calm. Analgesics Pethidine was given to patient since patient felt pain at the incision site. Antibiotics were also given to prevent infection after surgery. Surgical intervention; **Herniorophy** was performed.

TABLE 5. PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. N.O.

Date	**Drug**	**Dosage/Route of Administration (Literature)**	**Dosage/Route of Administration (Client)**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/Remedies**
04/11/21	IV Dextrose 5%	Amount to be given depends on patient's condition.	Dosage: 2.0 litres for 2 days Route: Intravenous	Intravenous fluid and electrolyte	Restores normal fluid and electrolyte balance	Patient was provided with the needed body fluid and electrolyte	Patient did not show any side effect.
04/11/2021	Normal Saline	Dose: Amount to be given depends on patient's condition. Route: Intravenously	04/11/2021 Dose: 2 litres for 48 hours Route: intravenously	Intravenous fluid and electrolyte	To replace deficiency of water, sodium and chloride ions in the body.	Client did not show any sign of water or sodium deficiency.	Large doses may result in sodium accumulation causing edema and loss of potassium. Patient did not show any of the above.

TABLE 5. PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. N.O.

Date	**Drug**	**Dosage/Route of Administration (Literature)**	**Dosage/Route of Administration (Client)**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/Remedies**
04/11/2021	Ringer's Lactate Infusion.	Amount to be given depends on patient's condition Route: intravenously	Dosage: 1.5litres for 2days Route: IV	Intravenous fluid and electrolyte	Restores normal fluid and electrolyte balance especially bicarbonates	Patient was provided with the needed body fluid and electrolyte	Fluid over load may lead to metabolic alkalosis. Patient did not show this side effect.
06/11/2021 And 08/11/2021	Metronidazole (flagyl)	Adult: 500mg tds Child: 7.5mg/kg Route: oral and intravenous	**06/11/2021** Dosage:500mg tds x 48hrs Route: IV **08/11/2021** Dosage:400mg	Bactericidal, amoebicidal and trichomocidal	Known to disrupt DNA and inhibit nucleic acid synthesis. It is effective	The wound shows no sign of infection.	Headache, ataxia, confusion, depression, restlessness, abdominal cramps, dysuria, fatigue. None was observed.

			tds x 5days Route: orally		against dividing and non-dividing cells.		

TABLE 5. PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. N.O.

Date	**Drug**	**Dosage/Route of Administration (Literature)**	**Dosage/Route of Administration (Client)**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/Remedies**
06/11/2021 and 08/11/2021	Ciprofloxacin	Adult: 100-500mg intravenously and orally. Children: 15mg/kg Route: oral and intravenous	**06/11/2021** Dosage: 400mg bd x48hrs Route: IV **08/11/2021** Dosage: 500mg bd x5 Route: orally	Broad spectrum antibiotic (Quinolone)	They are bactericidal agent and act by interfering bacterial cell synthesis	Infection subsided as patient condition improved	Headache, dizziness, fatigue, insomnia. Client did not show any of these.
06/11/2021	Amoskiclav (amoxicillin + Clavunate)	Adult: 1.2g tds **Route:** intravenous,	**Dosage:** 1.2g tds x 48 hrs **Route:** IV	Antibiotics(broad spectrum beta-lactams)	They are used in treatment of infection (they inhibit Peptidoglyc-an	Patient infection was combated and	Nausea, vomiting, diarrhea, constipation, Gas,Tooth discolouration,

					synthesis)	further infection was prevented.	unusual tiredness or weakness but patient did not experience any of these.
06/11/2021	Pethidine.	Adult: 50-100mg Child:1.0-2.2mg/kg every 3 to 4 hours **Route:** oral, intramuscular subcutaneous 3-4 hourly Prn	**Dosage :** 50mg qid x 24hrs **Route**: IM	An opoid narcotic analgesic	Relieves pain by inhabiting the reuptake of norepinephrine and serotonemia	Patient was relieved of his incisional pain after surgery	Somnolence, tremors, dizziness, nausea, bradycardia, muscle twitching at site of injection. Client did not show any of these.
06/11/2021	Diclofenac	Adult: 75-150mg daily. Child: 12.5-25mg/kg dly in divided doses	**06/11/2021** Dosage: 100mg bd x 48hrs Route; Rectal **08/11/2021**	Non-steroidal anti-inflammatory agent. Analgesic and	Relief inflammati-on, pain and fever	Patient was relieved of pain	Depression, dizziness, drowziness, insomnia, irritability, migraine, head, blurred vision, fluid retention.

		Route: IM, IV, Oral, Topical	Dosage: 100mg bd x 3 days Route: Rectal	anti-pyretic			Patient did not experience any of these.

TABLE 5. PHARMACOLOGY OF DRUGS ADMINISTERED TO MR. N.O.

Date	**Drug**	**Dosage/Route of Administration (Literature)**	**Dosage/Route of Administration (Client)**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/Remedies**
08/11/2021	Tab. Zincovite	One tablet daily or as directed by the physician Route: Oral	Dosage: 1 tablet daily x 30 days Route: Orally	Haematinic.	To stimulate red blood cell production.	Patient red blood cells were restored to normal.	Nausea, constipation, diarrhoea. None was observed.

Complications

With reference to the complications listed in the literature review, client came in with right inguinal scrotal hernia and was operated upon and had no complication after the surgery.

2.2 Patient's / Family Strength.

According to Mish (2016), patient/family strength refers to the resources they have to help to solve their problems. The strength of the patient and family involves what can be done on their part to facilitate the work of health care providers in providing holistic care to promote recovery. Through interaction with Mr. N.O and family, the following strengths were observed;

1. Patient and family were able to express their anxiety.

2. Patient was able tolerate intravenous fluid set up during the preoperative day and was able to eat 1/3 of food served during post-operative days on admission.

3. Patient could take I hour nap in the afternoon.

4. Patient was able to express the intensity of pain.

5. Patient was able to tolerate extra sheet and cloth that he was covered with.

6. Patient kept wound dry and did not wet the wound.

2.3 Patient Health Problems

Health problem according to Hornby (2017), is an unmet health need to which the patient responds in a variety of ways. To give effective nursing care, health problems must be identified through observation and interactions. These problems include actual and potential health problems. The following health problems were identified during interaction with Mr. N.O patient and family.

Pre-Operative

1. Patient and family were anxious. (04/11/21)
2. Patient has changes in his eaten pattern to meet treatment regimen. (05/11/21)
3. Patient has difficulty in sleeping at night. (05/11/21)

Post -Operative

4. Patient had pain at the incisional site. (06/11/21)
5. Patient had low body temperature. (06/11/21)
6. Patient had wound. (07/11/21)

2.4 Nursing Diagnosis

According to (Hinkle & Cheever, 2014), nursing diagnosis is the organization, analysis, synthesis and summarization of data collected and determines the patient's need for care. The following diagnoses were made based on the problems identified.

1. Anxiety related to unknown outcome of impending surgery. (04/11/21)
2. Risk for nutritional imbalance (less than body requirement) related to changes in patient's eating pattern (NPO) to meet treatment regimen. (05/11/21)
3. Insomnia related to change of environment. (05/11/21)

4. Acute pain related to surgical incision. (06/11/21)
5. Hypothermia (35.1^{o}C) related to ineffective metabolic activities. (06/11/21)
6. Risk of infection related to incisional wound. (07/11/21)

CHAPTER THREE

PLANNING FOR PATIENT / FAMILY CARE

3.0 INTRODUCTION

Planning is stage of nursing process in which the nurse and patient/family together consider the goals to achieve in meeting the patient's/family identified or potential problems in daily life and to produce an individual care plan (Weller, 2014). Planning is the third step which involves prioritization of patient's problems, setting of objectives and outcome criteria and outlining the methods of solving those problems. It also includes a statement of specification used to achieve goals specified and documentation of the care plan. It also aims towards designing measures or interventions required to prevent, reduce or eliminate the patient's health problems that were identified during the analysis.

3.1 OBJECTIVES OF CARE/ OUTCOME CRITERIA

Objectives are what the nurse and patient want to achieve in terms of observable patient responses rather than nursing activities (Smeltzer, Bare, Hinkle & Cheever, 2010).

Based on the health problems identified on client, the following objectives were set for patient and family care during the period of hospitalization to help solve their health problems.

1. Patient and family would be relieved from anxiety within 48 hours as evidence by:
    a. Patient and family verbalizing they are relieved from the anxiety.
    b. Nurse visualizing that patient and family are showing a cheerful facial expression.

2. Patient would maintain a normal nutritional status before and after the surgery as evidence by:
    a. Patient tolerating all intravenous fluid set up.
    b. Patient verbalizing knowledge on fluid needs.
3. Patient would be able to sleep at least 6-8 hours within the period of hospitalization as evidence by:
    a. Patient verbalizing that he has been able to sleep.
    b. Nurse observing that patient is not having interrupting sleeping pattern.
4. Patient would be relieved of pain within 48 hours as evidence by:
    a. Patient verbalizing that he is relieved of pain.
    b. Nurse observed patient to be calm and has a relaxed facial expression.
5. Patient would have body temperature range (36.2-37.2^{0}C) and feel warm in bed within 2 hours as evidence by:
    a. Nurse recording normal values of patient's temperature between 36.2 - 37.2^{0}C.
    b. Patient verbalizing that he feels warm in bed.
6. Patient wound not get infected through the period of hospitalization as evidence by:
    a. Nurse observing patient has an intact skin at the incisional site.
    b. Nurse using aseptic technique in patients wound dressing.

TABLE 6: NURSING CARE PLAN FOR MR. N.O AND FAMILY

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
04/11/21 6:00pm	Anxiety related to unknown outcome of impending surgery.	Patient and family would be relieved from anxiety within 48 hours as evidenced by; A. Patient and family verbalizing they are relieved from the anxiety. B. The nurse visualizing that patient and family	1. Reassure patient and relatives. 2. Explain the important of surgery to client and relatives.	1. Patient and relatives were reassured that competent nursing staff will handle his condition so that no complication would arise after the surgery. This was done to allay their fears and anxiety. 2. Patient and relatives were told that the surgery will help reduce the pain, eliminate the swelling, so that he could live his normal life. This helped them to gain more confidence in the health staff.	06/11/21 6:00pm	Goal fully met as patient and family verbalized relieved of anxiety and nurse visualized that patient and family are showing a cheerful facial expression.	K.F

		are showing a cheerful facial expression.	3. Introduce other patients who have undergone the same surgery and are recovering well to the patient. 4. Engage Patient in diversional therapy. 5 Encourage the patient to express his fear and concerns 6. Explain procedure to the patient	3. Other patient who was successfully recovering from herniorrhaphy was introduced to patients and was made to converse with them. This helped to allay his fears. 4. Patient was engaged in conversations which divert his attention. 5. Patient was encouraged to express his fear and concern 6 Procedures concerning the surgery was explained to the patient which			

				helped cleared patient preoccupied fears.			

TABLE 6: NURSING CARE PLAN FOR MR. N.O AND FAMILY

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/11/21 7:00pm	Risk for nutritional imbalance (less than body requirement) related to changes in patient's eaten pattern (NPO) to meet treatment regimen.	Patient would maintain a normal nutritional status before and after the surgery as evidence by: a. Patient tolerating all intravenous fluid set up. b. Patient verbalizing knowledge on fluid needs	1. Reassure patient. 2. Serve prescribed IV Fluids 3. Monitor IV fluids	1. Patient was reassured that he will he regain his sense of appetite to meet his nutritional needs and also explained to patient and relatives the need of the change in patient eaten pattern to meet treatment regimen 2. Prescribed IV Fluids were served 3. Client IV fluids was monitored	08/11/21 9:00am	Goal fully met as patient tolerated all IVF set up and verbalized the importance of fluids therapy.	K.F

			4.Observe circulation overload 5. Assist patient to perform oral hygiene to boost patient appetite after surgery. 6.Check vital signs 7. Monitor intake and output	4. Client was observed carefully to avoid fluid overload. 5. Patient was assisted to perform mouth wash for each meal which help boost his appetite 6. Patient's vital signs was checked and recorded. 7. Client's intake and output was monitored by measuring any fluids patient took and urine output.			

TABLE 6: NURSING CARE PLAN FOR MR. N.O AND FAMILY

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/11/21 8:05pm	Insomnia related to change of environment.	Patient would be able to sleep at least 6-8 hours within the period of hospitalization as evidence by: A. Nurse observing that patient is not having interrupted sleep pattern.	1. Reassure the patient. 2. Reduce noise on the ward. 3. Restrict visitors during rest and sleeping time.	1. Patient was reassured that all effort will be done to ensure sound sleep. 2. Television and radio set were turned down to reduce the noise and visitors with high heel were restricted. 3. Patient and family were educated on the importance of rest and sleep so that they visit her on visiting hours only.	08/11/21 8:05am	Goal fully met as patient verbalized he was able to sleep about 6-8 hours without interrupted sleep within his period of hospitalization	K.F

		B. Patient verbalizing that he has been able to sleep.	4. Serve warm beverages. 5. Ensure complete bed rest. 6. Ensure patient take a warm bath before sleeping.	4. Warm milo was served in the evening to induce sleep. 5. Comfortable bed was made free from creases and cramps and supported with pillow to help induce. 6. Patient was given warm assisted bathroom bath to induce sleep.			

TABLE 6: NURSING CARE PLAN FOR MR. N.O AND FAMILY

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/11/21 3:40pm	Acute pain related to surgical incision.	Patient would be relieved of pain within 48 hours as evidenced by A. Patient verbalizing that he is relieved of pain. B. Nurse observing patient have a pain level rated less than 2 on the pain rating scale of 0-10.	1. Reassure the patient. 2. Assess the degree of pain, frequency, nature and duration. 3. Put patients in a comfortable position. 4. Engage patient in diversional therapy.	1. Patient was reassured of competent nursing care to help relive him of his pain 2. Pain was assessed using the scale of 0-10; pain was severe in the afternoon and in night. 3. Patient was put in a comfortable position which was not contraindicated to his condition. 4. Patient was engaged in diversional therapy listening to radio and conversation to divert his attention.	08/11/21 11:00am	Goal fully met as patient verbalized that he has no pain and nurse observed patient have a pain level rated less than 2 on the pain rating scale of 0-10.	K. F

			5. Engage patient in relaxing technique. 6. Restrict visitors. 7. Administer prescribed analgesic.	5. Patient was also engaged in relaxing techniques by patient having slow, deep breathing for at least five minutes at a time to reduce muscle tension and intensity of pain. 6. Visitors were restricted which helped patient focused on the relaxation. 7. Prescribed analgesic was administered such as inj. Pethidine and sup. Diclofenac which help in relieving of the pain.			

TABLE 6: NURSING CARE PLAN FOR MR. N.O AND FAMILY

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/11/21 4:30pm	Hypothermia (35.1^{o}C) related to in effective metabolic activities.	Patient would have a normal body temperature (36.2-37.2^{0}C) and feel warm in bed within 2 hours as evidence by; A. Nurse recording patient's temperature between (36.2-37.2^{0}C) B. Patient verbalizing that he feels warm in	1. Reassure patient. 2. Check patient's vital signs. 3. Cover patient with blanket and close all	1. Patient was reassured that all measures would be put in place to bring his temperature to a normal range. This was done to allay fears and anxiety. 2. Patient's vital signs (temperature, pulse, respiration and blood pressure) especially the temperature was checked every 15 minutes. This helped in correcting the deviation from the normal. 3. Patient was covered with blanket and all windows were closed and fan was switched off which made patient warm	06/11/21 6:30pm	Goal fully met as Patient's temperature increased to 36.2^{o}C from thermometer reading and patient body not feeling cold to touch.	K.F

		bed and not cold to touch.	windows and switch off fans. 4. Serve patient with warm beverages. 5. Assist patient to change into cloth that will keep him warm. 6. Serve prescribed medications.	in bed and increased his body temperature. 4. Patient was not served with a warm prepared tea because he was still in the immediate post op phase. 5. Patient was assisted to change from light cloths to cloth that could keep the patient warm. 6. Patient was served with suppository Diclofenac.			

TABLE 6: NURSING CARE PLAN FOR MR. N.O AND FAMILY

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
07/11/21 5:00pm	Risk for surgical infection related to incisional wound.	Patient wound would not get infected within the period of hospitalization as evidence by: a. Patient having an intact skin at the incisional site.	1. Reassure patient and relatives. 2. Educate patient on factors that delay wound healing.	1. Patient and relatives were reassured that the incisional wound would heal with time. This was done to relief them of anxiety. 2. Patient was educate on factors that delay wound healing process, by not wetting the site with water, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material.	08/11/21 10:00am	Goal fully met as patient had an intact skin at the incisional site and nurse observed patient show no signs of infections.	**K.F**

		b. Nurse observing patient show no signs of infections.	3. Assist patient to position well. 4. Dress wound aseptically. 5. Encourage client to eat high protein diet and food rich in vitamins. 6. Serve all prescribed antibiotics.	3. Patient was assisted to assume the supine position in order to observe the incisional site 4. Incisional wound was dressed aseptically. This was done to promote the healing process of the wound. 5. Patient was encouraged to eat high protein foods like beans and vitamin foods like kontomire, orange. These helped in the healing process of the wound. 6. Patient was served prescribed Amoxiclav, metronidazole and ciprofloxacin prevent wound infection.			

CHAPTER FOUR

IMPLEMENTING PATIENT AND FAMILY CARE

4.0 Introduction

According to Mish (2016), Implementation is making something that has been officially decided start to happen or be used. Implementation is the fourth step of the nursing process. It refers to carrying out of proposed plan of care. The nurse takes responsibility including the family and other health team members. While implementing care, the nurse should assess the patient's response to the nursing care and make alteration when necessary.

This chapter entails the summary of nursing care rendered to Mr. N.O and his family from the day of his admission to the day of discharge based on the problems identified. It also covers the preparation towards discharge, home visits and follow-up care made to ensure continuity of nursing care.

4.1 Summary of Actual Nursing Care Rendered To Patient/ Family.

The actual nursing care rendered to patient and his family started on the day of admission, 4th November, 2021 to the time care was terminated. The management of patient and his family was planned to meet their physiological, emotional, spiritual and physical needs.

First Day on Admission (4th November, 2021)

On 4th November, 2021, at 5:00pm, Mr. N.O in a fully conscious state came to the surgical ward ambulatory accompanied by his wife for planned surgery. Patient and relative were welcomed into the ward at the Nurse's station, offered seats and his folder (24507/17) was collected. Patient's name was confirmed from the folder by mentioning it. Patient was given a comfortable simple unoccupied bed. His vital signs were checked and recorded as follows;

Temperature - 36.2 °C,

Pulse - 86bpm

Respiration - 23bpm,

Blood pressure - 130/90 mmHg,

SPO2 - 97%

Patient came with diagnosis of Right Inguinoi Scrotal Hernia and was scheduled for Surgery on 6th November, 2021. All necessary information was documented in the admission and discharge book. On assessment, it was noticed that patient and relative were anxious, patient and relative were reassured. Patient and relative were orientated to the ward and its annexes such as the nurses' station, kitchen, treatment room and the washrooms. Ward policies such as visiting hours and mode of payment of bills were explained to my patient and relative. He was told of the ward routine such as medications, checking of vital signs and meal times. He was introduced to the other patients in the cubicle. Patient was asked to bring items like pail, bowl, cup and toiletries like soap and toilet rolls and other items which will be needed by him. Intravenous line for administration of prescribed infusions was secured. The following laboratory investigation had already been requested by the physician and made available on admission.

- Full blood count
- Blood for grouping and cross matching
- Blood for renal function test and electrolytes.

In addition to that, the following treatment was prescribed by the doctor to prepare the patient for surgery (Herniorrophy)

- Intravenous dextrose5% 2L x 48 hours
- Intravenous normal Saline 2L x 48 hours
- Intravenous Ringers Lactate 1.5L x 48 hours
- Intravenous Amoksiclav 1.2g tds for 48 hours
- Intravenous ciprofloxacillin 400mg bd x48 hours
- Intravenous Metronidazole 500mg tds for 48 hours
- Intramuscular Pethidine 50mg qid x 24 hour
- Suppository Diclofenac 100mg bd x 48 hours

His prescribed drugs were collected from the pharmacy and stat doses were given Intravenous infusions were given to rehydrate him and to provide nutrients to him while he was on no oral feed. Introduction of myself to patient again as a Final Year student of the Holy Family Nursing and Midwifery Training College, Berekum who would like to use Mr. N.O. in writing of care study. Mr. N.O and relative were informed that, the care study was recommended by the nursing and midwifery council of Ghana in order for a nursing student to be awarded a license to practice as a registered nurse. Patient and relative were reassured that all information taken from them will be kept confidential. Client was chosen in writing because of my desire to gain more knowledge on the condition (right inguino-scrotal hernia). Fortunately, Patient and family responded positively to the request as his wife said, she believes his husband will be cured of his illness looking at how he is being cared for. They were thanked for their acceptance. Patient and family were made to understand that, hospitalization is temporal and patient will be discharged home once his condition resolves.

At 6:00pm, patient and family were anxious due to unknown outcome of impending surgery; an objective was set to relieve patient and family of anxiety within 48hours. The nursing interventions carried out include: Patient and relatives were reassured that competent nursing staff will handle his condition so that no complication would arise after the surgery. This was done to allay their fears and anxiety. Patient and relatives were told that the surgery will help reduce the pain, eliminate the swelling, so that he could live his normal life. This helped them to gain more confidence in the health staff. Other patient who was successfully recovering from herniorrhaphy was introduced to patients and was made to converse with them. This helped to allay his fears. Patient was engaged in conversations which divert his attention. Patient was encouraged to express his fear and concern. Procedures concerning the surgery was explained to the patient which helped cleared patient preoccupied fears.

Vital signs were checked and recorded and due medications and IVFs were served at 10:00pm and all nursing procedures carried on Mr. N.O throughout the night were documented by the night nurses.

Second Day on Admission (5th November, 2021)

On the second day of admission Mr. N.O woke up around 5:30 am. He performed his personal hygiene.

Vital signs and due medications were served at 6:00am. Patient took his breakfast which was porridge with bread.

During the ward rounds the surgical team met patient and told him the surgery will be done the following day.

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

Patient was informed that, he would be allowed to take anything by mouth after his supper. The rationale behind this was explained to the patient and he accepted to comply to that.

At 10:00am, vital signs were checked and recorded as shown in appendix. Routine nursing care was rendered to patient throughout the afternoon. Patient was served fufu with light soup as lunch.

In the evening vital signs were checked and recorded as shown in appendix. Due medications were also served.

At 7:05pm on 5th November, 2021, patient was having insomnia due to change of environment. An objective was set to help him achieve adequate sleep within the period of hospitalization. The nursing interventions carried out on him include Patient was reassured that all effort will be done to ensure sound sleep. Television and radio set were turned down to reduce the noise and visitors with high heel were restricted. Patient and family were educated on the importance of rest and sleep so that they visit her on visiting hours only. Warm milo was served in the evening to induce sleep. Comfortable bed was made free from creases and cramps and supported with pillow to help induce. All nursing cares were organized to prevent interrupting with patients rest periods Patient was given warm assisted bathroom bath to induce sleep.

Patient took milo drink without bread as his supper. According to patent he had eaten fufu in the afternoon so he couldn't take any heavy food this evening as well.

At 8:05pm, Patient was informed that there would be a change in his eaten pattern to meet treatment regimen as he would not be allowed to eat again. A nursing diagnosis of Risk for nutritional imbalance (less than body requirement) related to changes in patient's eaten pattern (NPO) to meet treatment regimen was made.

Goal was set to enable patient maintain a normal nutritional status before and after the surgery.

Patient was reassured that he will he regain his sense of appetite to meet his nutritional needs and also explained to patient and relatives the need of the change in patient eaten pattern to meet treatment regimen. Prescribed IV Fluids were served. Client IV fluids was monitored. Client was observed carefully to avoid fluid overload. Patient was assisted to perform mouth wash for each meal which help boost his appetite. Patient's vital signs was checked and recorded. Client's intake and output was monitored by measuring any fluids patient took and urine output.

At 10:00pm, vital signs were checked and recorded and due medications and IVFs were served and all nursing procedures carried on Mr. N.O throughout the night were documented by the night nurses. Patient went to bed around 10:30am.

Day of Surgery (6TH NOVEMBER, 2021)

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

Temperature - 36.2^{o}C

Pulse - 87bpm

Respiration - 21cpm

SP02 - 96%

BP = 120/60mmHg.

Patient and relatives was reassured of competent health care and was still encourage not be anxious check list has been done, incisional site has been shave and cleaned already.

At 11:20am patient was already in theatre gown with Intravenous Ringers Lactate 500 mls set up (30 drops/min). Operation bed was made to receive patient from theatre.

Immediate post-operative care

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

At 3:10pm patient was brought from the theatre, on arrival to the surgical ward, Patient level of consciousness was assessed by calling his name and pinching him for a response. On assessment, client had clean wound dressing indicating no sign of bleeding. Client was admitted to the ward fully conscious, with 300mls of Dextrose Saline, and was received on already operation bed prepared. Doctor's treatment plan include: Monitoring of vital signs frequently (every 15 minutes for 4 times, every 30 minutes twice and then 4 hourly and to start sips of fluids the next day.

Vital sign were checked and recorded accurately until he was stable.

Patient complained of pain at the incisional site after the successful surgery at 3:40pm of which an objective was set to relieve patient of pain within 48hours. Nursing interventions carried out include reassuring client and family that patient will be relieved of pain within 48hrs. Patient was reassured of competent nursing care to help relive him of his pain .Pain was assessed using the scale of 0-10; pain was severe in the afternoon and in night, Patient was put in a comfortable position which was not contraindicated to his condition, Patient was engaged in diversional therapy listening to radio and conversation to divert his attention. Patient was also engaged in relaxing techniques by patient having slow, deep breathing for at least five minutes at a time to reduce muscle tension and intensity of pain. Visitors were restricted which helped patient

focused on the relaxation. Prescribed analgesic was administered such as inj. Pethidine and sup. Diclofenac which help in relieving of the pain.

At 4:30pm patient had a lower temperature (35.1^0C). A nursing diagnosis of Hypothermia (35.1^oC) related to in effective metabolic activities was made. Patient would have a normal body temperature ($36.2\text{-}37.2^0$C) and feel warm in bed within 2 hours was the objective set.

Patient was reassured that all measures would be put in place to bring his temperature to a normal range. This was done to allay fears and anxiety. Patient's vital signs (temperature, pulse, respiration and blood pressure) especially the temperature was checked every 15 minutes. This helped in correcting the deviation from the normal. Patient was covered with blanket and all windows were closed and fan was switched off which made patient warm in bed and increased his body temperature. Patient was assisted to change from light cloths to cloth that could keep the warm.

The incisional site was observed for any bleeding which might lead to shock. Client was instructed to hold the abdomen when coughing, sneezing to prevent herniation immediately after surgery. Client was encouraged to do range of motion exercises to promote healing of wound. Client was educated to avoid touching the incisional site to prevent transfer of infection. The client and relatives were reassured that all measures would be put in place to help in gaining full goal in terms of his health. This was done to relief them of anxiety and to gain their co-operation. Client and relatives were told about the visiting hours and oriented to the ward.

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

At the same time (6:00pm), I evaluated the objective that was set to help relieve patient of anxiety and goal was fully met as patient and family verbalized relieved of anxiety and nurse visualized that patient and family are showing a cheerful facial expression.

At 6:30pm, the goal set to help patient regain normal body temperature was evaluated. The goal was fully met as patient temperature increase to 36.2^{o}C from thermometer reading and patient body not feeling cold to touch.

Vital signs were checked and recorded and due medications were served at 10:00pm and all nursing procedures carried on Mr. N.O throughout the night were documented by the night nurses

First Post-Operative Day (7TH NOVEMBER, 2021)

On this day of admission, patient woke up around 5:50am showing a cheerful face and verbalized that he had sound sleep. Patient was assisted to care for his personal hygiene and groomed. Patient vital signs was checked and recorded at 6:00am as

T – 36.5^{o}C,

P – 78bpm,

R– 28cpm,

BP– 120/70mmHg.

All due medication was served as prescribed. Patient was served with his Lipton tea as breakfast. Doctors during ward rounds inspected patient incisional site and ordered for continuation of treatment. Patient and relatives were reassured that the incisional wound would heal with time. This was done to relief them of anxiety.

Routine nursing care was rendered to patient throughout the afternoon.

At 2:00pm patient vital signs was be checked and recorded and prescribed medication was served.

At 5:00 pm patient with an incisional wound after the successful surgery and was at risk of surgical infection, objective was set that patient wound will not get infected within the period of hospitalization intervention implemented were: Patient and relatives were reassured that the incisional wound would heal with time. This was done to relief them of anxiety. Patient was educate on factors that delay wound healing process, by not wetting the site with water, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material. Patient was assisted to assume the supine position in order to observe the incisional site. Incisional wound was dressed aseptically. This was done to promote the healing process of the wound. Patient was encouraged to eat high protein foods like beans and vitamin foods like kontomire, orange. These helped in the healing process of the wound. Patient was served prescribed Amoxiclav, metronidazole and ciprofloxacin prevent wound infection

Patient and family were informed of intention to visit their house in Koraso Katanka a Suburb in Berekum, Plot number 99 Block C. I was given direction to the house.

Patient took his bath and went to sleep around 8:00pm.Vital signs were checked and recorded and due medications were served at 10:00pm and all nursing procedures carried on Mr. N.O throughout the night were documented by the night nurses.

Second Post-Operative Day (8TH NOVEMBER, 2021) Day of Discharge

On the fifth day of his admission in the ward, Mr. N.O woke up at 5:55am looked strong and very cheerful and verbalized that he had a sound sleep hence evaluation for the objective to relieve pain was made. He maintained his personal hygiene. Client had no complains. His vital signs checked at 6:00am were recorded in the nurse's notes as follows:

- Temperature 36.1 degree Celsius
- Pulse 84 beat per minute
- Respiration 20cycle per minute
- Blood pressure 120/80mmHg

Patient was served with white porridge and milk as breakfast of which patient was able to eat very well. Through conversation with patient, he made it known he will be glad if he was discharged so he can go supervise some job to be done for him.

At 8:05am, I evaluated the set objective to relieve patient of insomnia and goal was fully a s patient verbalize he was able to sleep about 6-8 hours without interruption during the per iod of hospitalization.

At 9:00am, objective set on the 5th November 2021 to help maintain the patient's nutrition al status was evaluated. Goal was fully met as patient tolerated all IVF set up and verbali zed the importance of fluids therapy.

At 10:00am, the objective set to prevent the patient's wound from getting infected was evaluated and goal was fully met patient had an intact skin at the incisional site and nurse observed patient show no signs of infections.

At 10:45am, during ward rounds, patient was seen by the doctor and was discharged. Patient was to come for review on the 15th November, 2021 and to be coming for alternate dressing at the OPD dressing unit. Patient and family were reminded of the causes and prevention of his condition, and were reminded on the education given earlier as patient was warned against bending lifting or doing any strenuous activity after surgery.

At 11:00am, because patient has been discharged I couldn't wait till 3:40pm to evaluate the objective that was set on 6th November, 2021 to relieve patient of incisional pain. The goal was

therefore evaluated and goal was fully met as patient was relieved of pain as patient verbalized that he has no pain and nurse observed patient have a pain level rated less than 2 on the pain rating scale of 0-10.

Patient was educated to delay sexual activities after surgery. The need to observe personal hygiene and also continue the factors to complete the wound healing process and to report signs of complications as well as the need to adhere strictly to his treatment regimen. Since patient is a registered member of the National Health Insurance scheme, patient was asked to pay one hundred and twenty Ghana cedis as his hospital user fee as per the hospital's policy and other medications and treatment which is not covered by the NHIS. Patient's HAMS number was then sent to the Nurses' station and patient was fully discharged in the admission and discharge book Mr. N.O was discharged on the following medications:

5. Tablets Ciprofloxacin 500mg bd × 5 days
6. Tablets Metronidazole 400mg tid x 5days
7. Tablets Zincovit dly x 30 days
8. Suppository Diclofenac 100mg bd × 3 days.

Drug was collected from pharmacy. Patient and family were educated on the medications they are sending home with emphasis on the dosage, side effects, time and the need to follow strictly the orders giving by the doctor and the need to complete treatment as prescribed.

Around 11:40am patient and wife were ready to go home after packing their belongings and patient had finished dressing up. Mr. N.O was again advised on the need to return for review on the said date and alternate wound dressing. Mr. N.O was advised on the need to ensure all his family members report to the hospital early whenever they are not feeling well. They expressed their gratitude to all staff and bid farewell to the remaining patients on the ward. They were escorted to the hospital where they took a tricycle home at 12:25pm. They were

bade goodbye. Bed accessories that needed to be disinfected were removed and sent to the sluice room for decontamination. The bed was also cleaned, decontaminated and laid nicely awaiting new admission immediately after patient and family had left.

4.2 Preparation Of Patient / Family For Discharge And Rehabilitation

Preparation towards discharge started on the day of admission until the day of discharge. Client and family were reassured that client will be discharged home once his condition has resolved. The primary aim was to enable them participate actively in his care for speedy recovery and also to give his insight of his condition. Emphasis was made on the need to visit hospital immediately with any illness that may occur, so as to promote early detection and treatment in order to avoid complication. They were educated on the following:

Personal Hygyiene

The client and family were educated to maintain good personal and environmental `hygiene, he was advised to wash clothes frequently, proper disposal of refuse, weeding around the environment; he should ensure good drainage systems because choked and stagnant water can result in breeding of mosquitoes. Patient was encouraged to bath and brushed his teeth twice daily and to keep finger nails short, in order not to harbor micro-organisms. Patient and family were encouraged to adhere to the various education in order to maintain and promote a good environment and health in the house respectively.

Diet

Mr. N.O and his family were educated on the importance of a well-balanced diet to help promote good health and wound healing. He was encouraged to take enough fruits and adequate proteins as well as enough fluids, roughages in order to improve the immune system and promote adequate healing of the wound and help him to free his bowel free.

Drugs And Review

Patient and family were educated to avoid self – medication, thus buying over the counter drugs without prescription by qualified prescriber. These drugs may have adverse effects on their health and may even cause harm than good.

The client was advised to continue the treatment regimen as prescribed to prevent relapse of the disease condition and emphasis was laid on the side and adverse effect of the medications given to Mr. N.O and was also reminded on the need to come for the review on the said date which was 15th November, 2021 for his recovery status to be assessed.

Prevention Of Condition

Patients and family were educated on the need to seek early treatment in case of any relapse before it becomes chronic. Emphasis was made on the need to prevent lifting of heavy objects, Client and relatives were educated on the condition, its causes, signs and symptoms, management and prevention. The need for wound dressing was stress on. He was advised to take in a lot of roughage diet to help in easy bowel movement and also to stop lifting heavy objects. He was told to wait for sometimes before going back to his work. This will help him to fully recover before starting to work.

Patient preparation towards discharge started on the day of admission, which made preparation effective till discharge.

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 client with consideration of available resource to solve patient problems.

First Home Visit (7TH NOVEMBER, 2021)

First home visit was made to the client's house on the 7th November, 2021 prior to his discharge. The main aim was basically to verify any information given to me and also assess his environment and identify health problems and also to identify any nearest health care center.

I got to Koraso Katanka by car at 5:40pm and was warmly welcomed by Mr. N.O son who was in the house that day. The house is a self-contained with three bed room, a hall, toilet and bath in each room, a hall and a kitchen, painted blue, made of blocks and roofed with aluminum sheets. They have a good source of water which is pipe borne. The environment was seen to be clean on assessment of which the family was congratulated and encouraged to maintain a healthy environment. They had electricity in their rooms. Enquiry was made if they were all using mosquito net and Mr. N.O son confirmed they were all using mosquito net of which they were congratulated. The family stores water in a barrel with cover in front of their room. They had modernized kitchen so after washing their cooking utensils, they were placed in the cabinet. Education was given on the need to cover the washed utensils with clean napkins. The community had a common place where they all dump refuse. All my expectations were met as all information gathered correspond with what patient had gave me and assessment of the environment was also done. Patient's relatives were informed about my next home visit which will take place after client is discharge. After spending over an hour with Mr. N.O's house, permission was sought to leave and it was granted. I left for the community lorry station and board a car back to Berekum.

Second Home Visit (12TH NOVEMBER, 2021)

On the 12th of November, 2021, second home visit to client's house was made. The purpose was to find out how client and family were coping with the treatment regimen and the

education given after discharge as well as to remind them of the review date. The tricycle took off at Berekum at 2:30pm got to Koraso Nkantanka around 2:50pm. Client's wife met me at the lorry station and escorted me to the house. The family cheerfully welcomed me. After making myself comfortable, assessment of the general health status of Mr. N.O was done and he was found to be in good health and as expected, Patient incisional site was inspected and was clean and infection free. He was taking his medication as required. Patient was told that although he was doing very well but there was the need to come for review at the said date. I inform patient that, he will be handed over to a community health nurse any time I come for the next visit.

Day of Review (15TH NOVEMBER, 2021)

On the said date of review, client and his wife were met at the outpatient department (OPD) of the Holy Family Hospital Berekum. After exchanging pleasantries, client was helped to collect his HAMS number which was handed over to the nurse in charge and their vital signs were checked and recorded as

Temperature 36.5 C,

Pulse 80bpm,

Respiration 19cpm,

Blood pressure 110/70mmHg

Patient was seen by doctor on duty at the OPD. After thorough examination, the doctor expressed satisfaction with client's condition and advised him to take good care of himself. Client had no complaints and he was not given any new medication. The patient was instructed to the dressing unit for the sutures to be removed. The family was escorted to the

road side in front of the hospital to take a car home. They were informed that the care will be terminated during the next visit and they were bid good bye.

Third Home Visit (24TH NOVEMBER, 2021)

Client was visited on the said date for the last home visit. The reason for the visit was to see how client was doing and to terminate the care being rendered to client and family. After being welcomed, interaction with both client and family commenced.

There were no complaints and they expressed their joy over client's recovery. Emphasis on health education and the need to avoid self – medication and to report promptly when patient is sick were made. Patient was told he would be handed over to Client was handed to the community health nurse at Koraso health center. Client and family appreciated the effort and expressed their heartfelt gratitude throughout the period of his sickness to handing his over to the community health nurse who does his outreach service in the community.

The family was also encouraged to give the community health nurse their full cooperation and support.

They were then thanked for their maximum support and cooperation and informed them that, this day will be the last visit since his condition has resolved. They expressed their gratitude to me. We all exchanged good bye and I returned home.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

According to (Weller, 2014), evaluation is the structural interpretation and giving of meaning to predict or actual impacts of proposals or results. It is the final stage of nursing process. Evaluation in nursing care seeks to measure the effectiveness of assessment, diagnoses and implementation. Patient's health status is compared to goals of health care to determine goals achieved. It involves the members of the health team, patient and his family. Unachieved goals of nursing care plan are amended and care is terminated afterwards with conclusions made on the care rendered.

5.1 Statement of Evaluation

During the admission and hospitalization of Mr. N.O problems were identified and objectives were set for them. Below are the outcomes of the objectives set for the identified problems.

1. Patient and Family were relieved of anxiety

At 6:00pm on 4th November, 2021, patient and family were anxious due to unknown outcome of impending surgery; an objective was set to relieve patient and family of anxiety within 48hours. The nursing interventions carried out include Patient and relatives' anxiety level was assessed and were reassured that competent nursing staff will handle his condition so that no complication would arise after the surgery. This was done to allay their fears and anxiety. Patient and relatives were told that the surgery will help reduce the pain, eliminate the swelling, so that he could live his normal life. This helped them to gain more confidence in the health staff. Other patient who was successfully recovering from herniorrhaphy was introduced to patients and was made to converse with them. This helped to allay his fears. Patient was

engaged in conversations which divert his attention. Patient was encouraged to express his fear and concern. Procedures concerning the surgery was explained to the patient which helped cleared patient preoccupied fears.

At 6:00pm on 6th November, 2021 the objective set was evaluated and goal was fully met as patient and family verbalized relieved of anxiety and nurse visualized that patient and family are showing a cheerful facial expression.

2. Patient nutritional needs was met.

At 8:05pm on the 5th November, 2021, Patient had changes in his eaten pattern to meet treatment regimen. A nursing diagnosis of Risk for nutritional imbalance (less than body requirement) related to changes in patient's eaten pattern (NPO) to meet treatment regimen was made.

Goal was set to enable patient maintain a normal nutritional status before and after the surgery.

Patient was reassured that he will he regain his sense of appetite to meet his nutritional needs and also explained to patient and relatives the need of the change in patient eaten pattern to meet treatment regimen. Prescribed IV Fluids were served. Client IV fluids was monitored. Client was observed carefully to avoid fluid overload. Patient was assisted to perform mouth wash for each meal which help boost his appetite. Patient's vital signs was checked and recorded. Client's intake and output was monitored by measuring any fluids patient took and urine output.

On the 8th November, 2021 at 9:00am the goal was evaluated and goal was fully met as patient tolerated all IVF set up and verbalized the importance of fluids therapy.

3. Patient regained his normal sleep pattern.

At 7:05pm on 5th November, 2021, patient was having insomnia due to change of environment. An objective was set to help him achieve adequate sleep within the period of hospitalization. The nursing interventions carried out on him include Patient was reassured that all effort will be done to ensure sound sleep. Television and radio set were turned down to reduce the noise and visitors with high heel were restricted. Patient and family were educated on the importance of rest and sleep so that they visit her on visiting hours only. Warm milo was served in the evening to induce sleep. Comfortable bed was made free from creases and cramps and supported with pillow to help induce. All nursing cares were organized to prevent interrupting with patients rest periods Patient was given warm assisted bathroom bath to induce sleep.

The set objective was evaluated on 8th November, 2021 at 8:05am and goal was fully met as patient verbalized he was able to sleep about 6-8 hours without interrupted sleep within his period of hospitalization.

4. Patient was relieved of pain

Patient complained of pain at the incisional site after the successful surgery at 3:40pm on 6th November, 2021 of which an objective was set to relieve patient of pain within 48hours. Nursing interventions carried out include reassuring client and family that patient will be relieved of pain within 48hrs. Patient was reassured of competent nursing care to help relive him of his pain .Pain was assessed using the scale of 0-10; pain was severe in the afternoon and in night, Patient was put in a comfortable position which was not contraindicated to his condition, Patient was engaged in diversional therapy listening to radio and conversation to divert his attention. Patient was also engaged in relaxing techniques by patient having slow, deep breathing for at least five minutes at a time to reduce muscle tension and intensity of pain.

Visitors were restricted which helped patient focused on the relaxation. Prescribed analgesic was administered such as inj. Pethidine and sup. Diclofenac which help in relieving of the pain.

Goal was fully met as evaluated on the 8th November, 2021 at 11:00am as patient was relieved of pain as patient verbalized that he has no pain and nurse observed patient have a pain level rated less than 2 on the pain rating scale of 0-10.

5. Patient had a normal body temperature

On the 6th November, 2021 at 4:30pm patient had a lower temperature (35.1^0C).

A nursing diagnosis of Hypothermia (35.1^oC) related to in effective metabolic activities was made. Patient would have a normal body temperature ($36.2\text{-}37.2^0$C) and feel warm in bed within 2 hours was the objective set.

Patient was reassured that all measures would be put in place to bring his temperature to a normal range. This was done to allay fears and anxiety. Patient's vital signs (temperature, pulse, respiration and blood pressure) especially the temperature was checked every 15 minutes. This helped in correcting the deviation from the normal. Patient was covered with blanket and all windows were closed and fan was switched off which made patient warm in bed and increased his body temperature. Patient was assisted to change from light cloths to cloth that could keep the warm.

At 6:30pm on the same day (6th November, 2021) goal was evaluated. The goal was fully met as patient temperature increase to 36.2^oC from thermometer reading and patient body not feeling cold to touch.

6. Patient incisional wound was not infected

On the 7th November, 2021 at 5:00 pm patient with an incisional wound after the successful surgery and was at risk of surgical infection, objective was set that patient wound will not get

infected within the period of hospitalization intervention implemented were: Patient and relatives were reassured that the incisional wound would heal with time. This was done to relief them of anxiety. Patient was educate on factors that delay wound healing process, by not wetting the site with water, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material. Patient was assisted to assume the supine position in order to observe the incisional site. Incisional wound was dressed aseptically. This was done to promote the healing process of the wound. Patient was encouraged to eat high protein foods like beans and vitamin foods like kontomire, orange. These helped in the healing process of the wound. Patient was served prescribed Amoxiclav, metronidazole and ciprofloxacin prevent wound infection

Goal was fully met as evaluated on the 8th November, 2021 at 10:00am as patient had an intact skin at the incisional site and nurse observed patient show no signs of infections.

5.2.Amendment Of Nursing Care Plan For Partially met Or Unmet Outcome Criteria

Due to well- planned nursing care which was effectively implemented, the cooperation of the patient and family and also effective medical given, all objective set were fully met which contributed to speedy recovery of the patient. Therefore there was no amendment of nursing care plan or unmet goal.

5.3 Termination of Care

Termination of care is the official ending of care and the relationship between the patient, relatives and the nurse. Since separation can sometimes bring about anxiety and depression due to its accompanied psychological pain, the patient and family members were given a gradual psychological preparation from the day of admission to the day of discharge.

Mr N.O and his family were informed on the day of admission(4th November, 2021) that the care rendered to them will be for a short period that is through the period of hospitalization till discharge, and then his follow up visit after which a community health nurse will continue the care. They were also made known that hospitalization was just a temporal measure to improve the patient‘s condition

Client was visited on my last home visit which was 24th November, 2021. The reason for the visit was to see how client was doing and to terminate the care being rendered to client and family. After being welcomed, interaction with both client and family commenced.

There were no complaints and they expressed their joy over client’s recovery. Emphasis on health education and the need to avoid self – medication and to report promptly when patient is sick were made. Patient was told he would be handed over to Client was handed to the community health nurse at Koraso health center. Client and family appreciated the effort and expressed their heartfelt gratitude throughout the period of his sickness to handing his over to the community health nurse who does his outreach service in the community.

The family was also encouraged to give the community health nurse their full cooperation and support.

They were then thanked for their maximum support and cooperation and informed them that, this day will be the last visit since his condition has resolved. They expressed their gratitude to me. We all exchanged good bye and I returned home.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This is the last chapter for the patient and family care study and it entails the summation and conclusion of all care rendered to patient and family throughout the period of hospitalization and after discharge.

6.1 Summary

Mr. N.O the patient for the study was born on the 14th August 1975 at Koraso Katanka in Berekum in the Bono Region of Ghana. He is 46 years. His parents are Mr. K.F and Mrs. A.B. He is about 1.6m tall and weighs about 69 kilograms.

Mr. N.O, a 47-year-old man was admitted to the surgical ward through the Out Patient Department of Holy Family Hospital, Berekum on the 4th of November, 2021 at 05:00pm with the diagnosis of right inguino-scrotal hernia. On admission, he came in a conscious state. Patient was orientated to the ward. Patient was also educated in maintaining her personal hygiene, rest and sleep, nutrition, and exercises. Patient underwent successful surgery on 6th of November 2021 and was discharged on the 8th of November 2021.

Throughout his stay at the hospital, six (6) health problems were identified during the preoperative and post-operative period. Nursing diagnosis were made, Objectives were set and interventions carried out to address all these problems.

On the 15th of November, 2021 patient reported for review as scheduled. It was to find out if patient was adhering to the advice and all the education given to improve his health and standard of living. Three home visits were embarked on. The first home visit was done while patient was still on admission on 7th November, 2021, second home visit was on the 12th

November, 2021 and third home visit was on the 24th November, 2021. The care of Mr. N.O and his family care were terminated on the 24th November, 2021, during the third home visit when patient had fully recovered.

6.2 Conclusion

According to (Mish, 2016), conclusion is a final decision reached by reasoning.

The care rendered to Mr. N.O has made me gain more Knowledge on the condition Hernia in general with regards to the predisposing factors, cause, clinical features, medical management, nursing management and prevention and complications. This has study equipped me with skills on how to render total individual care. It has also helped me improve on my interpersonal relationship with other members of the health team, the patient and family. Through this study, I have been able to put into practice actual and holistic nursing care.

This study has also correct the misconception of clients who seek health service Holy Family Hospital that nurses do not attend to clients well as client and family said they now feel all they have been hearing is not true. Client and family also said the feel honored to have an individualized care been rendered to them which has motivated them to seek health care when the need arises.

Finally I will recommend that, the idea and principle behind the adoption of the nursing process which is the core approach to the writing of patient and family care study should be embraced by all nurses to ensure total patient care.

APPENDIX

Vital signs of patient

Date	**Time**	**Temperature (°C)**	**Pulse (Bpm)**	**Respiration (Cpm)**	**Blood Pressure (mmHg)**
04/11/2021	5:00pm	36.2	86	23	130/90
	6:00pm	36.7	82	23	120/90
	10:00pm	36.5	79	21	120/90
05/11/2021	6:00am	36.2	87	21	120/60
	10:00am	36.7	85	22	120/70
	2:00pm	36.5	78	28	130/80
	6:00pm	36.8	81	24	110/80
	10:00pm	36.6	84	22	120/70
6/11/2021	6:00am	36.2	87	21	120/60
	10:00am	36.7	72	22	120/90
	2:00pm	36.8	79	20	120/80

	6:00pm	36.0	76	22	110/80
	10:00pm	36.9	70	22	120/80
07/11/2021	6:00am	36.5	78	28	120/70
	10:00am	36.9	83	24	120/80
	2:00pm	36.2	82	24	120/80
	6:00pm	36.6	83	21	120/80
	10:00pm	35.6	87	20	120/90
08/11/2021	6:00am	36.1	84	20	120/70
	10:00am	36.9	85	22	120/70
15/11/2021	8:50am	36.5	80	19	110/70

BIBLIOGRAPHY

Bickley, L. S., & Szilagyi, P. G. (2009). Bates' guide to physical examination and history taking (10th ed.). Philadelphia: Walters Kluver Health/Lippincort Williams & Wilkins.

British Medical Association., & Royal Pharmaceutical Society of Great Britain. (2007). BNF 74.

Delaune, S. C., & Ladner, P. K. (2010). Fundamental of nursing standard and practice (4th ed.). New Jersey: Delmar Cengage Learning.

Herdman, H. T., & Kamitsuru, S. (2014). NANDA Internation, Inc. nursing diagnosis: definitions and classifications: 2015-2017 (10th ed.). Chichester: Wiley Blackwell.

Hinkle, J. L., & Cheever, K. H. (2014). Brunner & Suddarth's textbook of medical-surgical nursing (13th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Hornby, A. (2006). Oxford advanced learner's dictionary of current english (7th ed.). (M. Ashby, C. McIntosh, J. Turnbull, & S. Wehmeier, Eds.) New York: Oxford University Press.

Kumar, P., & Clark, M. (Eds.). (2017). Kumar & Clarks Clinical Medicine (9th ed.). Philadelphia: Elsevier.

McIntosh, C. (Ed.). (2013). Cambridge advanced learner's dictionary (4th ed.). Edinburgh: Cambridge University Press.

MediLexicon. (2009). Medical Abbreviations Dictionary: Database of over 200,000 medical, biotech, pharma and healthcare acronyms abbreviations. Retrieved September 18,

2018, from Stedman’s Medical Dictionary: https://www.medilexicon.com/dictionary/41172

Merriam Webster's College Thesaurus. (1988). Springfield, Messachusetts, U.S.A: Merriam-Webster, Incorporated.

Ministry of Health. (2014). Standard treatment guidelines (7th ed.). Ghana: Ministry of Health.

Wagh, A., & Grant, A. (2014). Ross and Wilson Anatomy and Physiology in Health and Illness (12th ed.). Edinburgh ; New York: Churchill Livingstone Elsevier.

Weller, B. F. (2014). Bailliere's nurses' dictionary: for nurses and healthcare workers (25th ed.). London: Elsevier Health Sciences.

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