HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM ON

A PATIENT / FAMILY CARE STUDY ON EPIGASTRIC HERNIA

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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

Patient and family care study is a report primarily about the care rendered to a patient and family with the aid of the nursing process. The care lasts for a period of time from the time of meeting the patient on the ward till discharge through home visit till care is terminated. This study helps in broadening the knowledge of the student nurse on the nursing process which serves to provide a systematic methodology of nursing practice. It also helps the student nurse unify, standardize and direct nursing practice. The study also helps the student nurse to be abreast of the necessary care given to patients, emphasizing health promotion, maintenance and restoration or enhancing a peaceful death, depending on the patient's condition.

The study again, is an academic exercise that forms part of the requirement for an award of Certificate by the Nurses' and Midwives' Council of Ghana to practice as a Registered General Nurse. During the study, a student nurse is required to give comprehensive details of a particular patient and family which include assessment of the patient and family to enable the student to set goals and objectives for proper implementation. Due to the comprehensive care plan given, the student nurse becomes equipped with information on the patient's condition.

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This report would not have been possible without the help of the Almighty God, who granted me strength, wisdom and knowledge. I wish to express my sincere gratitude first and foremost to God Almighty.

A special note of appreciation goes to Madam A.A. and family for their support and cooperation in providing all the needed information for writing this care study. I am also grateful to all the doctors and nurses of Presbyterian Hospital, Dormaa Ahenkro (female ward), who gathered and assisted me in writing this care study.

My appreciation also goes to Madam Bridget Dzigbede, my supervisor and the entire faculty and staff of the Holy Family Nursing And Midwifery Training Collage, Berekum for their guidance and support, advice and for giving me the insight and time to take up this study. Again, I am grateful to my family and colleagues of the noble profession and all whose criticisms, encouragement and support helped me to complete my care study successfully.

Finally, I wish to also acknowledge the authors and publishers of whose literature I used as references in writing my care study.

INTRODUCTION

Patient and family care study is a study made on a particular client and family with a specific disease condition. This is done to improve upon the nursing skills and care rendered to a particular client by drawing a comprehensive care that will help client attain optimal health. This study deals with the nursing care rendered to Madam A.A. a 66-year-old woman who stays with her elder daughter at Dormaa Ahenkro in the Bono region of Ghana.

Madam A.A. was admitted to Medical/Surgical Ward through the Out Patient Department on 29th November 2021 at Dormaa Presbyterian hospital. He was admitted with a diagnosis of Epigastric Hernia by Dr. S.

On arrival, Madam A.A. reported with the history of swelling at the Epigastric region, pain at the affected area, and a feeling of pulling sensation. The nursing process approach was used to plan a comprehensive nursing care and necessary nursing, medical, surgical interventions were carried out to meet the identified health problems. Patient spent six days on the ward and was discharge on 4th December, 2021.

During evaluation, goals set were fully met without complications. Madam A.A. was discharged on 4th December, 2021 when she had fully recovered. Madam A.A. was booked for review by Dr. S. on 10th December 2021 and 31st December, 2021. After the review by the Doctor, Madam A.A. was declared fit.

Home visits were made to ensure continuity of care. During the third home visit, on 2nd January 2022, care was terminated when A.A. condition had improved greatly.

The whole care study is divided into six chapters according to the nursing process approach and organized as follows;

Chapter one deals with assessment of patient/family. This includes patient particulars, family medical and socio-economic history, patient developmental history, and patient's life style

and hobbies, past and present medical history, admission of patient, patient concept of illness, literature review on the disease condition and validation of data.

Chapter two involves data analysis in which data collected is compared with the standard in the literature review, tables of laboratory investigations, treatment, clinical manifestation, pharmacology of drug, complication, client and family strength, health problems identified and nursing diagnoses.

Chapter three entails planning for client and family care, in this chapter care plan was drawn and interventions carried out.

Chapter four deal with implementation of patient and family care, summary of actual nursing care given to client, preparation of patient and family towards discharge and rehabilitation and follow-up home visit.

Chapter five evaluates care rendered to patient and family, amendment of nursing care, termination of care.

Chapter six also involves summary and conclusion of the nursing care rendered to Madam A.A. and family from time of admission to when she was discharged

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY

1.0 Introduction

Assessment of the patient is the first step in the nursing process and the beginning of nursing care to the patient and family. It gives detail information about the patient, family and her community in general.

The information entails the following; patient's particulars, family medical history, socio-economic history, patient's developmental history, patient's lifestyle and hobbies, patient's past medical history, patient's present medical history, patient's and family concept of illness, and literature review of patient's condition (right inguinal hernia) and validation of data. It also entails data gathering and the admission process to the termination of care.

1.1 Patients Particulars

Madam A.A. is the name of the patient. She was born on 22nd June 1955 to Madam T.A and Mr K.A. both from Dormaa Ahenkro in Bono Region. She is 66 years of age and dark in complexion. She is 147cm tall and weighs 54kg. She is the second born of 6 siblings. She stays with her children in her husband's house at Dormaa house number DO/45. Madam A.A. is a Ghanaian by nationality and speaks Bono. She was married to late Mr K.A and has two sons and two daughters. She is a Christian and worships at Roman Catholic Church and she is a member of the women fellowship. She is a farmer and has no formal educational background.

1.2 Family's Medical History

According to Madam A. A. her grandparents are deceased of which they died of old age. Her parents and siblings are alive and healthy. With the exception of his father who has been diagnosed of Hypertension and is being managed on antihypertensive drugs. There is no identified hereditary disorder like diabetes mellitus, asthma, sickle cell, epilepsy nor any

mental disorders in the family. However, the relatives present during his history taking said that, periodically, they do suffer some ailments like malaria, headache, fever and abdominal pains which are treated by self-medication (using both over-the-counter drugs) but if symptoms persist, they report to the hospital. This is the second time she is being hospitalized. The first instance was as a result of Anaemia secondary to Lower Gastrointestinal Bleeding (LGIb) and malaria which where managed with blood transfusion, haematinics (fesolate and folic acid) and antimalarial medications. The source of medical treatment for Madam A.A's family are both orthodox. There are no known allergies in the family.

1.3 Socio-Economic History

Madam A.A. is a farmer but did not tell the actual annual income she earns. According to her, she gets financial support from her children and one stays with her at in the Dormaa Ahenkro. Three of the children are living outside Ghana. She is a beneficiary of the National health insurance scheme so her laboratory investigations test and medicines and other hospital bills were catered for by the scheme. Madam A.A. lived in a well-built cemented 7 bed room house. She occupies a hall and one of the 7 bedrooms. The house is located at ABB in Dormaa Ahenkro, it was built by herself and her late husband K.A. They are able to afford three square meals a day, they also enjoy good water supply and electricity. With careful analysis and observations about my patient/family standard of living through interview they can be classified among the middle socio economic class.

1.4 Patient's Developmental History

Madam A.A could not express a comprehensive history of her development, according to her, she was born at a full term (nine month) and was born through spontaneous vaginal delivery by traditional birth attendant (TBA) in Dormaa Ahenkro in the year 1955. Even though she does not remember any immunization experience, she was told that, she started walking at

age one, and started bubbling mama and dada at five months. She started her menarche at the age of sixteen (16). She developed her secondary sexual characteristics such as enlargement of breast, growth of pubic hair, widening of the hip and rounding of the body at age 13. Madam A.A had her menopause at the age of 54. This information was collected to determine if she was able to pass through the various stages of development successfully.

1.5 Patient's Lifestyle and Hobby

Lifestyle is defined as the pattern of daily living that an individual develops (Weller, 2014). Madam A.A. who is sociable and easily gets well with other people she come across in life, always starts her day with the usual tradition of washing face and brushing her teeth with brush and toothpaste by 6:00am. After this. She then calls her children and grandchildren to pray as a Christian.

She mostly takes rice as her breakfast before going to farm at 9:00am with her children. She returns from the farm in the evening around 4pm with foodstuff before she prepares supper but takes her launch at 1:00pm in the farm.

Madam A.A. prefers to bath twice in a day, so right from the farm she takes her bath before taking supper, usually before 7:00pm. She also enjoys taking oranges after her meals. According to her, she enjoys working as a farmer. She is a reserved type of person. She empties her bowel once daily and bladder elimination depends on cold weather and plenty intake of fluid which influence frequent urination. She also drinks water frequently.

Madam A.A. takes care of all her daily activities and care for the children alone as a widow, since her husband died 5 years ago.

1.6 Patient's Past Medical History

According to Madam A.A, she has never been admitted to the hospital for any treatment and has also not undergone any surgery before. She delivered all her eight (4) children through Spontaneous Vaginal Delivery (SVD). Client occasionally experienced coryza with headache and abdominal pains which she usually managed with drugs from the chemical shops. She has not noticed any allergy to any food nor drug.

1.7 Current Medical/Surgical History

According to Madam A.A, she has been well until she had a sudden onset of abdominal pain which was very painful which she initially tried managing with some medications like Tablet metronidazole and Syrup Magnesium Trisilicate which could not help her. Due to the persistence of the patient pain, she reported to the Outpatient Department of Dormaa Presbyterian hospital with her daughter on 29th November, 2021. She was seen by medical doctor. He assessed madam A.A. and later referred the client to surgical team for further review and management. She was reviewed and was diagnosed as having epigastric hernia. She was booked for herniorrhaphy.

1.8 Admission of Patient

Madam A. A. was admitted into the female's ward of the Dormaa Presbyterian Hospital by Dr.S. She arrived at the ward accompanied by her daughter through the Out Patient Department (OPD) on Monday 29th November 2021 around 4:30pm with a diagnosis of epigastric hernia. Prior to her admission to the ward, message was sent to the staffs at the females ward to prepare a bed for her. They were warmly welcome and a seat was given to her at the nurses' station. She was admitted into an already prepared bed in the females surgical ward. Her folder was collected to check and confirm basic information about Madam A.A and treatment regimen. Her vital signs were checked and recorded as follows;

Blood Pressure (BP)…………………………130/80 millimeters of mercury

Pulse………………………………………..86 Beat per minutes

Temperature…………………………………36.1 Degree Celsius

Respiration…………………………………..20 count per minutes

SPO2…………………………………………95 percent

I introduced myself to Madam A.A. and her daughter and informed them that I am a final year student nurse. The patient and her daughter were always addressed by their names and confidentiality was maintained. They were reassured that they were in the hands of competent nurses and that all efforts will be made to speed up her recovery and that their co-operation is needed and they should feel free to ask any staff for help. I also introduced the staff nurses present to them. She was informed that, she will be used as a special patient and cared for during her period of hospitalization.

After realizing that Madam A.A. had some confidence in me and looked relaxed, the further concepts about her condition were found out. The history was recorded in the nurses' notes and particulars entered into the admission and discharge book and daily ward state. The following investigations were ordered; blood for Full Blood Count, Malaria parasites estimation, Grouping and Cross matching. The following medications were prescribed for her;

Pre-Operative Medication

1. Intravenous normal saline infusion 500mililiters for 24 hours.
2. Intravenous ringers lactate infusion one (1) liter for 24 hours.
3. Intravenous Amoxiclav 1.2g tds for 48 hours.
4. 0.5% Bupivacaine 20miligram stat

Her daughter was told to bring Madam A.A. towel, sponge, spoon, cup, tooth paste and brush. She was taken through orientation to the ward and its environs including the bathroom

and toilet facility. She was introduced to the staffs present and the other patients at the ward. They were told of visiting hours as 6:00am to 7:00am in the morning, 12:00pm to 1:00pm afternoon and 6:00pm to 10:00pm evening; ward rounds, medications and vital signs. Her valuables were kept safely in bedside locker and they were assured of safety of their valuables.

Madam A.A. was admitted to the ward on the 29th of November 2021 to undergo a surgery (hernia repair) been scheduled on the 30th of November 2021. Therefore, pre-operative care was given as follows; she was reassured of competent medical and surgical team. Details of the operation was explained to her and she was encouraged to asked questions and express her fears and concerns as far as the operation was concerned. It was amazing that as old as patient was, she understood whatever was explained to her and also the anxiety level was low because of confidence she had under the whole health care management team. She was also educated on the need for personal hygiene and good nutrition before and after the surgery. She was told that she would be also put on nil per os (NPO) for six hours till when the need for oral intake was due.

I reassured her of good prognosis and competent healthcare. I reintroduced myself to patient and family as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my patient/family care study. Madam A. A. and relative were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of license in Registered General Nursing. I explained to Madam A.A. and her relative the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. Madam A.A. and relative agreed to my request and promised to offer me the necessary information and assistance. I mentioned to them that home visit is required to help know their home environment and how it contributed to

patient's illness and how to prevent reoccurrence of the disease. I informed them that all the nursing staff present will help in caring of patient and not necessarily me alone. I then expressed my gratitude to them. Discharge planning was initiated by educating her on the causes and its management and some post-operative management; how to care for the incisional site and education on the medications; thus, they will continue the care at home once she is well.

1.9 Patient's Concept of Her Illness

Following an interview with Madam A.A about her condition, she said she is not attributing her condition to any "juju", witchcraft or any force somewhere even though she knows they exist. She added that she thinks her illness is caused by lifting of heavy objects because she normally experiences the pain when she does heavy work. She also thought it is just a sickness and believes the Almighty Gods will heal her. And reassured her on good prognosis based on her views regarding her condition, she was educated on the causes and was reassured of good prognosis.

1.10 Literature Review on Hernia

A hernia occurs when an organ or fatty tissues squeezes through a weak spot in a surrounding muscle or connective tissue called fascia. (Carol, 2021).

In those affecting the digestive system, a piece of bowel protrudes through a weak point in either the musculature of the anterior abdominal wall or an existing opening.

A typical hernia consists of the following parts;

- The sac: This covers the content.
- The fundus: This refers to the weaken muscle or skin overlying the hernia.
- The neck: This is the entrance of the sac where strangulation usually takes place.

- The content: This is what is found in the sac and it is usually the intestine or omentum in abdominal hernia.

Types of hernia

The types of hernia can be classified according to the following:

- **Anatomical Site**
- **Severity**

Anatomical Site

- **Inguinal Hernia:** This is the protrusion of the intestines through the inguinal canal. The inguinal canal is an oblique passage about one and half inches (1.5) long and is taken through the lower abdominal wall by the testis and spermatic in males and by the round ligament in females.

An inguinal hernia may be direct or indirect.

A direct inguinal hernia: This occurs when the abdominal content pushes through the posterior wall of the inguinal canal. Direct hernias are always acquired and therefore could be seen in middle age or older adults. Strangulation indirect hernia is rare.

An indirect inguinal hernia: This occurs when the contents (organs) enter the internal inguinal ring, traverse the canal and immerges through the external ring and descend into the scrotum. It may be congenital or acquired and strangulation is common.

- **Femoral Hernia:** This hernia occurs when there is a protrusion through the femoral ring into the femoral canal. It easily becomes strangulated.
- **Umbilical Hernia:** This is the protrusion of bowel through the umbilical ring.
- **Incisional/Ventral Hernia:** This is hernia which occurs when there is a long gap in the linear alba producing a more extensive midline bulge as a result of previous surgical incision.

- Hiatus/Diaphragmatic/Epigastric Hernia: This is when the stomach protrudes through the diaphragm into the chest. Usually the defect is small and only contains small extra peritoneal fats.
- Richter's Hernia: This is where only the wall of the small intestine is caught up and strangulated by the femoral ring.

Severity

- **Reducible Hernia:** This is when the hernia can be placed back into the abdomen by applying pressure on it or lying on a recumbent position.
- **Irreducible (Incarcerated) Hernia:** Is when the hernia cannot be placed back by either manipulation or positioning.
- **Strangulated Hernia:** This is when the hernia becomes irreducible and blood supplies to the hernia structures are impaired.

Causes of Hernia

- Congenital or acquired weakening of containing membranes or muscles
- Increased intra-abdominal pressure

  Congenital or acquired weakening of containing membranes or muscles

  They include the following:

- Embryological or anatomical, e.g., internal inguinal ring, femoral ring, opening into the obturator canal.
- Aging, e.g., degeneration of the annulus fibrosus of the intervertebral disc.
- Illnesses such as Ehlers-Danlos syndrome or Marfan syndrome
- Stretching of muscles during pregnancy
- Scars from previous surgery
- Deposition of fat between muscle fibres or aponeurosis as in obesity.

- Site of penetration of blood vessels

Causes of Increased intra-abdominal pressure

According to Carol (2021), the causes of increased intra-abdominal pressure include:

- Frequent pregnancies
- Chronic cough as COPD with hard coughing bouts
- Chronic urinary obstruction from urethral stricture or benign prostatic hypertrophy
- Ascites
- Dyschezia with straining during a bowel movement
- Heavy lifting or lifting with improper technique
- Sharp blows to the abdomen
- Tight clothing and incorrect posture

SIGNS AND SYMPTOMS

According to Carol (2021), the signs and symptoms of Hernia include;

The signs and symtpoms of a hernia can range from noticing a painless lump to the painful, tender, swollen protrusion of tissue that you are unable to push back into the abdomen-possibly a strangulated hernia.

Asymptomatic Reducible Hernia

- New lump in the groin or other abdominal wall area
- May ache but is not tender when touched
- Sometimes pain precedes the discovery of the lump
- Lump increases in size when standing or when abdominal pressure is increased (such as coughing)

- May be reduced (pushed back into the abdomen) unless very large

Irreducible Hernia

- Usually painful enlargement of a previous hernia that cannot be returned into the abdominal cavity on its own or when you push
- Some may be long term without pain
- Can lead to strangulation
- Signs and symptoms of bowel obstruction may occur, such as nausea and vomiting

PATHOPHYSIOLOGY

- Mostly, epigastric 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 not present either with pain at the site, a visible or palpable lump, in some cases more vague symptoms result 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 persistent.
- Increasing intracranial pressure can cause part of the brain to herniated 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. (Carol, 2021).

Assessment/Diagnosis of Hernia

According to Carol (2021), the diagnostic investigation used for diagnosing hernia are;

- A bunch or lump is felt over the area.
- Popping out of a mass on lifting, straining or coughing.
- If reducible, on standing there is a bunch but on lying it disappears.
- If disappeared on arrival, bunching occurs upon instruction to cough.
- Pain if strangulated.

Other laboratory tests includes:

1. Full blood count
2. Grouping and cross match
3. Urine test

Surgical Management

According to Carol (2021), the surgical managements of hernia are;

- **Herniorrhaphy:** This is the removal of the hernia sac and the repair of posterior wall of the inguinal canal by an absorbable suture.
- **Herniotomy:** This involves the excision of the hernia sac without the repair of the posterior wall of the inguinal canal.
- **Hernioplasty:** This is the plastic repair of hernia.

Nursing Management

According to Carol (2021), the nursing management includes;

- Enforce nil per os.
- Positions the client in bed with lower part of the body elevated to enable hernia gravitate into place.
- Apply cold compress on the hernia.
- The management is usually described into two (2) phases, namely:
- Pre-operative nursing management
- Post-operative nursing management

PRE-OPERATIVE NURSING MANAGEMENT

Psychological preparation

Client and his family are reassured on the competent care with explanation that measures are being taken to help resolved the health problems. Patient's concerns, worries and fears are elicited so that counseling, education and reassurance can be given. For fear of unknown, every procedure should be explained in order not to aggravate the anxiety. It also helps to gain the patients co-operation during procedures.

Since client may not know the condition under which the operation may be performed, the role of anesthesia and analgesics are explained to him/her.

A client who is successfully recovering from the same condition is introduced to the client to give some hope.

Information about the surgery is given to the client and family and if they agree, the client is made to sign the consent form and if the patient is too young to sign, a psychiatric patient or unconscious patient, a relative is made to sign.

Physiological preparation

This comprises of all activities programmed to establish a tolerance data, detect abnormalities, correct imbalances and determine the fitness of the patient for the surgery. It includes the following laboratory investigations such as;

- Blood for hemoglobin level estimation, grouping and cross-matching and sickling.
- Urine testing and stool testing to rule out urinary tract and genitor-intestinal tract infections respectively. Stand by donors are made ready to donate.

Physical preparation

Patient was asked to empty her bowel early in the morning that is the day of surgery. The lower half of the abdomen is shaved as well as the pubic and perineal regions. Skin is washed with soap and water and kept dry. The patient is asked not to eat or drink anything the night to the surgery. Dentures, jewelries, if present are removed, labeled and kept in the ward.

Immediate pre-operative care

Patient is reassured of positive prognosis of the surgery. A theatre gown and head cap or gear is used to dress the patient. Baseline vital signs are checked and recorded. About 30-45 minutes prior to the surgery, the pre-operative drugs are given which include; Intravenous fluid such as dextrose and ringers lactate. The patient is then taken to the theatre with her folder and the accompanied nurse keeps reassuring the patient of competent medical and surgical team.

POST – OPERATIVE CARE

Immediate Post - Operative Nursing Care

The operation bed is first prepared to receive the patient from the theatre. All the necessary requirements such as IV tray, Blood pressure (BP) apparatus, drip stand, vital signs tray, and

pillow on a chair, dressing pack, oxygen, and suction machine are put in place before the arrival of the patient. As soon as the patient is received from theatre, quickly assess the patient to determine the conscious level in order not to receive a dead body into the ward. Make sure the chest is moving and place your fingers around the nostril to see if she is breathing. Assess operation site for bleeding. The vital signs such as blood pressure, pulse, respiration and temperature are checked and recorded. The patient's general condition and the anaesthesia given are assessed. The operation site is reinforced with gauze if there is bleeding. If the bleeding is profuse, the surgical team or theatre staffs are informed and the patient is sent back to the theatre for further investigation and management.

The patient is placed in a dorsal position with the head turned to one side without pillows to facilitate easy breathing and also to prevent aspiration of the secretion which may lead to hypostatic pneumonia. The patient's position is changed 4 hourly to prevent decubitus ulcer and also more blankets are added to the top sheet if the patient feels cold.

Whiles the patient is in the theatre, post-operative bed is prepared to receive the patient. A vital sign tray, resuscitation equipment such as, ambo-bag, suction machine, drip stand, blankets are arranged at the bed side for emergency use. Immediately the patient arrived at the ward from theatre, a quick assessment is made to ensure airway clearance and normal breathing pattern and also to assess the level of consciousness before she is received into bed.

General Post - Operative Care

Position

The patient is placed in a supine position without a pillow with the head turned to one side to keep the air way patent and facilitate breathing

Observation

The nurse on duty again observes the level of consciousness and the general condition of the patient. The vital signs, temperature, pulse, respiration and blood pressure are checked and recorded every 15min for 1 hour, then every 30min for 2 hours and hourly until the patient is stable. The incisional site is observed for bleeding. The intravenous fluid checked for regular flow as ordered. The urethral catheter is observed for kinking and frequent flow of urine, the color as well as the amount are also noted. The nurse on duty maintains a strict intake and output chart for recordings. The airway is again observed for patency to prevent asphyxiation. The patient is observed for complication such as shock, hemorrhage, wound infections and gaping.

Nutrition

The patient will be on intravenous fluids within the first 24 hours after surgery until the general condition improves. Within these hours, patient is put on nil per os.

To maintain energy, rehydrate patient and balance electrolytes. 5% of IV dextrose in water, normal saline and ringers lactate may be prescribed. Give sips of water, fluid diet and light diet, as bowel sounds return. Normal diet is introduced within 24 hours or as ordered by the surgeon.

Medication

Intravenous antibiotics such as, metronidazole, gentamycin, ampicillin may be prescribed to prevent infections. Intravenous injection of diclofenac or suppository diclofenac twice daily for three days or any analgesics is given to control pain.

Again, intravenous such as ringers lactate, dextrose 5% in water is given to rehydrate, provide nutrients and also maintain electrolyte balance. The therapeutic effects as well as the side effects are observed, recorded and when necessary reported.

Psychological care

The patient is constantly reassured and measures like taking in deep breath, how to cope with the incisional pain are explained to the patient

Diversional therapy in the form of listening to music or the nurse engages the patient in a conversation to divert her attention from the pain. The nurse also continues to establish a therapeutic relationship with the patient relatives/significant others and their contribution towards patient's care are always welcomed and they are also praised. Relatives are made comfortable and reassured as the nurse explains to them when to pay or visit the patient.

Exercise

The patient is engaged to perform deep breathing exercises to prevent hypostatic pneumonia. The patient is again educated on early ambulation which is necessary to prevent deep vein thrombosis and also to promote circulation of blood. The patient is encouraged to do passive exercise and also change her position to prevent pressure sores. The nurse instruct the patient to support the incisional site with the hand/pillow whiles coughing or sneezing to prevent gaping .

Personal hygiene

The patient is given bed bath or assisted bath depending on patient strength. Mouth care is given immediately the patient recovers from anesthesia. The urethra catheter is cleaned daily and soiled or dirty linens are changed. The nurse cares for the patient's hair, nails and pressure areas are treated to prevent pressure sores.

Elimination

Strict intake and output is observed and recorded throughout the various shifts. Urine is recorded, noting the color as well as the amount. When patient resumes normal diet, enough fluids and roughages are given to prevent constipation.

The patient is also served with bed pan to empty her bowels if necessary.

Wound care

The wound site is observed as soon as patient arrives from the theatre for bleeding or any abnormal discharge. If bleeding occurs at the incisional site, reinforce dressing but where bleeding is profuse inform the surgeon and the theatre team and take blood sample for grouping and cross-matching. Then prepare patient for theatre again. The wound is first inspected and dressed by the surgeon (within the 3rd or 5th day post-operative). The wound is assessed for its state in terms of dryness, infection, gaping or discharge and findings are noted and documented. The wound site is also observed for hematoma formation and infections. The dressings are changed when necessary. Removal of stitches depends on the kind of stitches, the surgeon's consideration and state of wound among others. When all stitches are removed the wound is cleaned with

Methylated spirit or iodine and left open or dressed with gauze daily or as required till healing is completed. The wound is dressed strictly under aseptic condition.

Complications

- **Hemorrhage**: Bleeding inside the incision is another complication of inguinal hernia repair. It can cause severe swelling and bluish discoloration of the skin around the incision
- **Hypovolemic shock**: this may be due to damage tissues as there is loss of blood or fluids from circulation (hypovolemic shock)
- **Infections**: The risk of wound infection is small and is more likely to occur in older adults and people who undergo more complex hernia repair. The person may experience a fever, discharge from the incision, and redness, swelling, or tenderness around the incision

- **Strangulated hernia**: when blood supply to the intestines ceases to part affected causing the neck of the hernia sack to become gangrenous.

1.11 Validation Of Data

Validation of data is the verification of information to make sure that it is free from errors, bias and misinterpretation, (Weller, 2009).

Information about the patient was collected from patient herself and her daughter. The information was cross checked from patient's past medical records as it was true.

I received most of my information from the client and her daughter. My visit to the client's house also confirmed most of what her daughter and she had told me and data was also collected from the relatives and caretaker which confirmed that the information was accurate.

I can therefore say that the information collected for the study was free from errors, bias and misinterpretations and hence suitable for the study.

CHAPTER TWO

ANALYSIS OF THE DATA

2.0 Introduction

Analysis is the act of determining the component parts of a substance (Weller, 2009). This chapter forms the second phase of the patient/family care study. Analysis of data collected deals with the critical examination and interpretation of the data collected during the assessment phase of the patient/family care study. It deals with comparison of the results of investigations carried out with standards in the literature review. It also gives the pharmacology of drugs prescribed by the medical officer. It further involves the interpretation and identification of the patient and family health needs; physical, spiritual, social and psychological. The chapter entails the causes and clinical manifestation of my client's condition, the diagnostic investigations, medical management, complications, patient and family's strength, related health problems identified and their corresponding nursing diagnosis.

2. 1 Comparison of Data with Standards

This is the process of comparing the information collected from patient/family and the care given, with standards set in the textbooks. This includes diagnostic investigations, causes, signs and symptoms, treatments and complications found in the literature review.

2.1.1 Diagnostic Investigation/Test

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 following are list of investigations which were carried out on Madam A.A during his period of hospitalization;

1. Blood film for malaria parasites
2. Blood for full blood count
3. Blood for grouping and cross-matching

Table 1: Comparison of Test Done on Master N. R. to Literature

Diagnostic Test outlined in literature review	Test Carried out on Patient
History, clinical manifestations and physical examination.	History of client and clinical manifestations were taken
Full blood count	Full blood count was carried out with my client
Urine Test	Urine test was carried out on patient
Grouping and Cross matching	Blood for grouping and cross-matching was carried out on patient

From the table 1 above, some diagnostic investigations were carried out for my patient as stated in the literature. However, other diagnostic investigations blood test for malaria parasites was not mentioned in the literature review but was done on the patient to rule out malaria.

Table 2 Diagnostic Investigation/Test conducted on Madam A. A.

DATE	SPECIMEN	INVESTGATION	RESULTS	NORMAL RANGE	INTERPRETATION	REMARKS
29-11-21	Blood	FULL BLOOD COUNT (FBC)				
		Haemoglobin level	12.0g/dl	11.5-16.5g/dL	Within normal range	No treatment was given
		White Blood Cell Count	5.37[10^3/uL]	4.60-10.20[10^3/uL]	Within normal range	No treatment was given
		Red Blood Cell Count	3.91 [10^3/uL]	3.80-5.80 [10^3/uL]	Within normal range	No treatment was given
		Neutrophil count	35.2mmol/L	40.0-70.0 mmol/L	Within normal range	No treatment was given
29-11-21	Blood	Grouping and cross matching	Blood group O positive	A (+ or -) AB(+ or -) B (+ or-) O (+ or -)	Client belonged to blood group O with Rhesus Positive, (O+).	No blood transfusion was given.
29-11-21	Blood	Blood film for malaria parasite	Negative	No parasite should be present	Patient has no parasite in the blood	No treatment given

2.3. Causes of my Client's Illness

With reference to the literature review, Madam A. A.'s condition was due to the protrusion of an abdominal content through a weakened abdominal wall which evolves into a localized hole or defect.

2.4 Clinical Manifestation

Table 3 Clinical Features presented by my client as compared to those outlined in the literature review.

Clinical Features in the Literature Review	Clinical Features Exhibited by my client
New lump in the groin or other abdominal wall area	New lump appeared in client's epigastric region.
May ache but is not tender when touched	The lump was painful
Sometimes pain precedes the discovery of the lump	3. There was swelling at the abdominal region.
Lump increases in size when standing or when abdominal pressure is increased (such as coughing)	4. There was tenderness.
May be reduced (pushed back into the abdomen) unless very large	5. Client did not complain of constipation.
Can lead to strangulation	6. Client had a normal pulse rate.
Signs and symptoms of bowel obstruction may occur, such as nausea and vomiting	7. There was no fever and chills.

From the above table, patient exhibited most of the clinical features from the literature review after comparing. This gives clear evidence that the patient is really suffering from epigastric hernia.

2.5 Specific Medical Treatment Given to the Client

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

Client was given the following medications that correspond to those in the literature review;

Pre-Operative Medication

1. Intravenous normal saline infusion 500 mililiters for 24 hours.
2. Intravenous ringers lactate infusion one (1) liter for 24 hours.
3. Intravenous Amoxiclav 1.2g tds for 48 hours.
4. 0.5% Bupivacaine 20miligram stat

Post-Operative Medication.

1. Intramuscular Morphine 10mg stat.

2. Intravenous ringers lactate one (1) liter for 24 hours.

3. Intravenous normal saline infusion 1000mls for 24 hours.

4. Intravenous metronidazole 500mg tds for 72 hours.

5. Suppository Diclofenac 100mg bd × 48 hours

6. Intravenous dextrose saline 1L x 48 hours.

Discharge Drugs

Tablets Amoksiclav 625mg bd × 7 days

Tablets metronidazole 400mg tid x 7 days

Suppository Diclofenac 100mg bd × 7 days

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

Treatment Outlined in Literature Review	**Treatment Given to Patient**
Herniorrhaphy	Herniorrhaphy was done
Herniotomy	Herniotomy was not done
Hernioplasty	Hernioplasty was not done

From the above table, the treatments given to patient were in line with the literature. Surgical intervention performed for patient was **Herniorrhaphy.**

Table 4 Pharmacology of Drugs Administered to MADAM A.A

Date	Drug	Standard and route of administration	Dose and route administered to my client	Classification	Desired effect/ action	Actual effect observed	Side effects
29-11-21 and 30/11/2021	Ringers lactate Infusion.	**Adult dose**: 25 mg – 30 mg/Kg **Child dose:** 10 – 15 mg /Kg Generally dose depends on clients fluids needs **Route**: Intravenous	2000mls for 48 hours Intravenously	Electrolyte solution and an isotonic replacement.	Restores normal fluid and electrolyte balance especially bicarbonates	Client was rehydrated and electrolyte balance maintained.	Fluid over load may lead to metabolic alkalosis. Patient did not show this side effect.
29-11-21 and 30/11/2021	Normal Saline Infusion.	**Adult dose**: 25 mg – 30 mg/Kg **Child dose:** 10 – 15 mg /Kg **Route**: Intravenous	1500mls for 48 hours Intravenously	Intravenous fluid electrolyte expander and isotonic replacement.	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 give rise to sodium accumulation, oedema and potassium loss. None was observed.

Date	**Drug**	**Standard and route of administration**	**Dose and route administered to my client**	**Classification**	**Desired effect/action**	**Actual effect observed**	**Side effects**
30-11-21 And 04-12-2021	Metronidazole (flagyl) Infusion.	**Adult dose**: 500 mg – 750 mg **Child dose:** 30 – 50 mg **Route**: Intravenous	**30-11-2021** 500mg tds for 72 hours Intravenously. **04-12-2021** 400mg tids x 7 days Orally	Antibiotic/Antiprotozoa	Its inhibit nucleic acid synthesis by disrupting the DNA of microbial cell	Infection was prevented.	Confusion, headache, weakness, constipation and vomiting. None was observed
30-11-21	Injection Morphine	**Adult**: 5-10mg **Child**:1.0-2.2mg/kg every 3 to 4 hours **Route**: intramuscular subcutaneous 3-4 hourly Prn	100mg stat Intramuscularly	An opioid narcotic analgesic	Relieves pain by inhabiting the reuptake of norepinephrine and serotonin	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

Date	Drug	Standard and route of administration [literature]	Dose and route administered to my client	Classification	Desired effect/action	Actual effect observed	Side effects
29-11-2021 and 04-12-2021	Tablet Amoxicillin + clavulanic acid (Amoksiclav)	**Adult dose**: 625mg bd for 7 to 14days. **Child dose**; 25-45mg/kg in divided doses **Route**-orally Patient dose; 625mg twice daily for 7days	**29-11-2021** 1.2g tds for 48 hours. intravenously **04-12-2021** 625mg bd for 7 days Orally	Broad spectrum antibiotic	Deoxyribonucleic acid (DNA) replication in susceptible bacteria preventing cell production.	Infection was prevented.	Headache, confusion weakness. Client did not show any of these
30-11-21 and 04-12-2021	Suppository diclofenac	Adult: 75-150mg daily. Child: 12.5-25mg/kg daily in divided doses **Route:** IM, oral, rectal and topical	**30-11-21** 100mg bd× 48hours per rectum. **04-12-2021** 100mg bd x 7 days Rectally	Non-steroidal anti-inflammatory agent. Analgesic and anti-pyretic	Relief inflammation, pain and fever	Relief inflammation, pain and fever	Depression, dizziness, drowsiness, insomnia, irritability, migraine, head, blurred vision, fluid retention. Patient did not experience any of these.

Date	Drug	Standard and route of administration [literature]	Dose and route administered to my client	Classification	Desired effect/action	Actual effect observed	Side effects
1-12-21	Dextrose Saline Infusion	Depends on clinical condition of patient	1000mls for 48hours intravenously.	Fluid and electrolyte replacement	Provides supplementary calories and fluids.	Client was hydrated and energy restored.	Confusion, fluid overload, oedema, glucosuria. None was observed

Complications

Madam A.A did not develop any complications with reference to the literature review stated above after going through the surgery successfully. This can be the reason of the competent clinical staff and drug compliance by the patient.

2.6 Patient/Family Strength

Strength is the physical activity used in embarking on activities such as lifting. The patient and family strength involves activities that the patient can do and what his family members can also do or provide to aid in the speedy recovery of the patient. These strengths could be emotionally, financially, physically and spiritually. In the care for Madam A.A, the following strengths were identified;

1. Patient was cooperative with nursing care in the presence of pain.
2. Patient/relatives expressed their state of fear and anxiety and had hope in the entire clinical team.
3. She was willing to be educated on her condition and was able to give some causes and management of her condition.
4. Patient could breathe when abdomen is splinted.
5. Patient communicated effectively with the clinical team on level of pain experienced.
6. Her condition improved on the 2nd post-operative day as she could perform minimal activities such as brushing her teeth when assisted.
7. Patient understood simple instructions on how not to infect the wound.

2.7 Health Problems Identified

Problem is defined as a situation that causes difficulties or a disorder with your health or with part of your body (Longman Dictionary, 2019). From the data collected during assessment, the following health problems were observed in Madam A.A. and family during their period of hospitalization.

Pre Operatively

1. Patient felt pain at the site of the swelling. (29/11/21)
2. Patient/family were anxious about the impending surgery. (29/11/21)
3. Patient/family had less knowledge about the condition. (29/11/21)

Post Operatively

4. Patient had difficulty in breathing. (30/11/21)
5. Pain at the site of incision. (30/11/21)
6. Patient was unable to care for her personal hygiene. (30/11/21)
7. The incisional site was prone to infection. (30/11/21)

2.8 Nursing Diagnoses

North American Nursing Diagnosis Association (NANDA) defined nursing diagnosis as a clinical judgement about individual, family, or community responses to actual or potential health problems/life processes (Gale Encyclopedia of Nursing and Allied Health, 2019). Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

Preoperative

- Altered body comfort (acute pain) related to tissue trauma. (29/11/21)
- Anxiety related to unknown outcome of impending surgery. (29/11/21)
- Knowledge deficit (patient/family) related to causes, signs and symptoms and management of the condition. (29/11/21)

Post-operative

1. Ineffective airway clearance related to effect of anesthetic agent and reluctance of breathe due to incisional pain. (30/11/21)
2. Acute pain related to incisional incision. (30/11/21)
3. Self-care deficit (bathing and grooming) related to confinement in bed and incisional pain. (30/11/21)
4. Risk for infection related to presence of surgical incision (wound). (30/11/21)

CHAPTER THREE

PLANNING FOR CLIENT/FAMILY CARE

3.0 Introduction

The nursing care plan is a systematic approach used in carrying out nursing activities with and for the client. It brings about the method of the primary nursing care. It also enables the health credit team to determine the patient's health status and to identify his health problems.

After these problems have been identified, the nurse will formulate diagnoses and plan the care that is adequate enough for the patient and implement

3.1 Objective and Outcome criteria

1. Patient would be relieved of pain within 2 hours as evidenced by;
   a. Patient verbalizing that there is no pain.
   b. Nurse observing that patient is relaxed with a cheerful facial expression.
2. Patient and family would be relieved of anxiety within 16 hours as evidenced by;
   a. Nurse observing that patient is relaxed and ready to undergo surgery.
   b. Patient relatives agreeing to sign consent form.
3. Patient and family would be well updated with the condition and its outcome within as evidenced by;
   a. The patient/relatives giving feedback on the condition and its post care.
   b. The patient/relatives verbalizing they have adequate understanding about hernia and its management.

4. Patient would have effective airway clearance within 24 hours as evidence by;

   a. Nurse observing patient breath without difficulty

   b. Patient expressing a relief in her difficulty in breathing.

5. Patient would be relieved of incisional pain throughout hospitalization as evidenced by;

   c. Patient verbalizing a pain level of 1 on the pain rating scale of 0-10.

   d. Nurse observing that patient is relaxed with a cheerful facial expression.

6. Patient would be able to maintain self-care by 48 hours as evidenced by;

   a. Nurse observing patient grooming herself.

   b. Patient verbalizing, she can take her bath when assisted.

7. Patient's wound would be free from infection within the period of hospitalization as evidenced by;

   a. Nurse observing that the wound site is clean and free from pus.

   c. Patient verbalizing there is less pain at the site.

Table 5 Nursing care plan

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION
29/11/21 4:50pm	Altered body comfort (acute pain) related to tissue trauma	Patient would be relieved of pain within 2 hours as evidenced by; a. Patient verbalizing that there is no pain. b. Nurse observing that patient is relaxed with a cheerful facial expression.	1. Reassure patient/relatives 2. Position patient in a comfortable position 3. Assess pain level of pain 4. Apply cold compress 5. Employ diversional therapy.	1. Patient/relatives were reassured that patient will be relief in no time. 2. Patient was position to assume a comfortable position. (prone) 3. Patient level of pain was assessed using numeric pain scale as a pain level of 6. 4. Cold compress was applied at patient site of pain.(epigastria region) 5. Patient was engaged in a conservation to divert her attention off the pain.	29/11/21 6.50pm Goal was fully met as patient was relief of her epigastric pain and was comfortable in bed.

			6. Serve prescribed analgesics	6. Prescribed analgesics like suppository diclofenac was served.	

Table 6 Nursing care plan

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUT-COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	EVALUATION
29/11/2021 4:45pm	Anxiety related to unknown outcome of impending surgery	Patient and family would be relieved of anxiety within 16 hours as evidenced by; a. Nurse observing that patient is relaxed and ready to undergo surgery. b. Patient relatives being happy and with high hopes for a positive outcome from the surgery.	1.Reassure patient / relatives 2.Introduce patient/relative to other patients who have undergone the same surgery successfully 3. Educate patient/relatives about the benefits of the surgery and its complications when not done	1. Patient/family were reassured that everything will be done possible for a successful surgery. 2. Patient/family were introduced to other patients who have undergone herniorrhaphy at the ward. 3. Patient/family were educated that if surgery was not done, patient was likely to develop complications such as peritonitis and intestinal obstruction	30/11/2021 8:45am Goal was fully met as nurse observed that patient is relaxed and ready to undergo surgery and patient relatives were happy and with high hopes for a

			4. Allow patient/relatives to express their fears by asking questions and answer them correctly. 5. Engage Patient in diversional therapy. 6. Encourage the patient to express his fear and concerns.	4. Patient/relative expressed her fears and all questions were answered tactfully. **5.** Patient was engaged in conversations which divert her attention. 6. Patient was encouraged to express his fear and concern.	positive outcome from the surgery.

Table 7 Nursing care plan

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT-COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION
29/11/2021 5:00pm	Knowledge deficit (patient/family) related to inadequate information on causes, signs and symptoms and management of the condition.	Patient/family will be well updated on the condition and its outcome within 2hours as evidence by; a. The patient/relatives giving feedback on the condition and its post care. b. The patient/relatives verbalizing they have adequate understanding about hernia and its management.	1. Assess patient's level of awareness of hernia. 2. Allow time for questions. 3. Establish rapport with client and relatives. 4. Educate patient/relative on the causes, signs and symptoms and	1. Patient's level of awareness about the condition was assessed through questions. 2. client and relatives were allowed to ask questions and they were answered tactfully to aid understanding 3. A good inter personal relationship was established with client and relatives to provide a good atmosphere for learning 4. Client and relatives were educated on the possible causes, signs and symptoms	29/11/21 7:00pm Goal fully met as patient/relatives gave feedback on the condition and its post care. and patient/relatives verbalized they had adequate understanding about hernia and its management.

			management of hernia 5. Educate patient on the n eed to adhere to treatment. 6. Ask for feedback after education.	and management of hernia 5. Patient was educated on the need to adhere to treatment. 6. Client and relatives were made to repeat what they have learned from the education and were praised for their efforts	

Table 8 Nursing care plan

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT-COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	EVALUATION
30/11/2021 11:20am	Ineffective airway clearance related to effect of anesthetic agent and reluctance of breathe due to incisional pain.	Patient would have effective airway clearance within 24 hours as evidence by; a. Nurse observing patient breath without difficulty b. Patient expressing a relief in her difficulty in breathing.	1. Monitor patients respiratory rate every 15 minutes. 2. Tilt patient's head (left lateral) to drain secretions and prevent aspiration 3. Monitor the arterial blood gases. 4. Place patient in a position that relieves pain. 5. Place patient in Fowler position when anaesthesia weans off to enhances chest breathing. 6. Administer oxygen as ordered	1. Respiratory rate was monitored and recorded as ordered. 2. Patient's head was tilted (left lateral) to drain secretions and prevent aspiration. 3. Patient's SPO_2 level was monitored. 4. Patient was placed on a confortable position that relieves pain. 5. The head end of the bed was elevated to enhance breathing. 6.Oxygen was administered	01/12/2021 11.20am Goal fully met as nurse observed patient breath without difficulty and patient expressed a relief in her difficulty in breathing.

Table 9 Nursing care plan

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION
30/11/21 12:30pm	Acute pain related to incisional incision.	Patient would be relieved of incisional pain throughout hospitalization as evidenced by; a. Patient verbalizing a pain level of 1 on the pain rating scale of 0-10. b. Nurse observing that patient is relaxed with a cheerful facial expression.	1. Reassure patient/relatives 2. Position patient in a comfortable position 3. Assess pain level of pain 4. Apply cold compress 5. Provide patient with a comfortable bed and put	1. Patient/relatives were reassured that patient will be relief in no time. 2. Patient was position to assume a comfortable position. (prone) 3. Patient level of pain was assessed using numeric pain scale 4. cold compress was applied at patient site of pain.(epigastria region) 5. Patient was provided with a comfortable bed and kept in a	04/12/2021 10:00am Goal was fully m et as patient verbalized a pain level of 1 on the pain rating scale of 0-10 and Nurse observed that patient is relaxed with a cheerful facial expression

			patient in a semi fowler's position. 6.Serve prescribed analgesics	semi fowler's position. 6. Prescribed analgesics like suppository diclofenac was served.	

Table 10 Nursing care plan

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION
30/11/2021 4:00pm	Self-care deficit (bathing and grooming) related to confinement in bed and incisional pain.	Patient would be able to maintain self-care by 48 hours as evidenced by; a. Nurse observing patient grooming herself. b. Patient verbalizing, she can take her bath when assisted.	1. Reassure patient/relatives. 2. Provide bedpan and urinal closer to bedside. 3. Assist patient to bath twice daily 4. Assist patient to change soiled clothes and linen when necessary 5. Assist patient to perform range of motion exercise and avoid touching wound to	1.Patient/relative were reassured that patient will be able to care for herself soon. 2. Bedpan and urinal was put c loser to bed side. 3. Patient was assisted to bath twice daily 4. patient was assisted to change her soiled clothing and bed linen where necessary 5. Patient was assisted to perfo rm range of motion exercise.	02/12/2021 4:00pm Goal fully met as Nurse observed patient grooming herself and patient verbalized, she can take her bath when assisted.

			promote wound healing. 6. Arrange needed items within easy reach of patient.	6. Patients items was arranged within easy reach so that he co uld reach to them easily.	

Table 11 Nursing care plan

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	EVALUATION
30/11/2021 5:00pm	Risk for infection related to presence of surgical incision (wound).	Patient's wound would be free from infection within the period of hospitalization as evidenced by; a. Nurse observing that the wound site is clean and free from pus. b. Patient verbalizing there is less pain at the site.	1. Assess patient's wound for signs of wound infection. 2. Dress patient's wound aseptically. 3. Serve patient with nutritious meals 4. Monitor patient's vital sign. 5. Educate patient on fact ors that delay wound heali ng.	1. Wound clean and dry with no sign of wound infection. 2. Patient wound dressed under aseptic technique. 3. Meals rich in protiens, vitamins and calories served. 4. Monitor patient's vital signs especially temperature was monitored to detect infections. 5. Patient was educated not to wet the wound, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material.	04/12/2021 10:10am Goal fully met as nurse observed that the wound site is clean and free from pus and patient verbalized there is less pain at the site.

			6. Serve all prescribed ant ibiotics.	6. Patient was served with Intravenous metronidazole 500mg tds for 72 hours.	

CHAPTER FOUR

IMPLEMENTATION OF PATIENT AND FAMILY CARE

4.0 Introduction

Implementation is putting the nursing orders into action to solve the patient's health problems and to ensure that direct nursing care is given to her in the professional human way. This is done using the nursing care plan as a guide.

4.2 Summary Of Actual Nursing Care Rendered To Madam A.A/Family

Day Of Admission (29th November, 2021)

Madam A. A. was admitted into the female's ward of the Dormaa Presbyterian Hospital by Dr.S. She arrived at the ward accompanied by her daughter through the Out Patient Department (OPD) on Monday 29th November 2021 around 4:30pm with a diagnosis of epigastric hernia. Prior to her admission to the ward, message was sent to the staffs at the females ward to prepare a bed for her. They were warmly welcome and a seat was given to her at the nurses' station. She was admitted into an already prepared bed in the females surgical ward. Her folder was collected to check and confirm basic information about Madam A.A and treatment regimen. Her vital signs were checked and recorded as follows;

Blood Pressure (BP)…………………………130/80 millimeters of mercury

Pulse…………………………………………..86 Beat per minutes

Temperature…………………………………36.1 Degree Celsius

Respiration…………………………………..20 count per minutes

SPO2…………………………………………95 percent

I introduced myself to Madam A.A. and her daughter and informed them that I am a final year student nurse. The patient and her daughter were always addressed by their names and confidentiality was maintained. They were reassured that they were in the hands of competent

nurses and that all efforts will be made to speed up her recovery and that their co-operation is needed and they should feel free to ask any staff for help. I also introduced the staff nurses present to them. She was informed that, she will be used as a special patient and cared for during her period of hospitalization.

After realizing that Madam A.A. had some confidence in me and looked relaxed, the further concepts about her condition were found out. The history was recorded in the nurses' notes and particulars entered into the admission and discharge book and daily ward state. The following investigations were ordered; blood for Full Blood Count, Malaria parasites estimation, Grouping and Cross matching. The following medications were prescribed for her;

Pre-Operative Medication

4. Intravenous normal saline infusion 500mililiters for 24 hours.
5. Intravenous ringers lactate infusion one (1) liter for 24 hours.
6. Intravenous Amoxiclav 1.2g tds for 48 hours.
5. 0.5% Bupivacaine 20miligram stat

Her daughter was told to bring Madam A.A. towel, sponge, spoon, cup, tooth paste and brush. She was taken through orientation to the ward and its environs including the bathroom and toilet facility. She was introduced to the staffs present and the other patients at the ward. They were told of visiting hours as 6:00am to 7:00am in the morning, 12:00pm to 1:00pm afternoon and 6:00pm to 10:00pm evening; ward rounds, medications and vital signs. Her valuables were kept safely in bedside locker and they were assured of safety of their valuables.

Madam A.A. was admitted to the ward on the 29th of November 2021 to undergo a surgery (hernia repair) been scheduled on the 30th of November 2021. Therefore, pre-operative care

was given as follows; she was reassured of competent medical and surgical team. Details of the operation was explained to her and she was encouraged to asked questions and express her fears and concerns as far as the operation was concerned. It was amazing that as old as patient was, she understood whatever was explained to her and also the anxiety level was low because of confidence she had under the whole health care management team. She was also educated on the need for personal hygiene and good nutrition before and after the surgery. She was told that she would be also put on nil per os (NPO) for six hours till when the need for oral intake was due.

I reassured her of good prognosis and competent healthcare. I reintroduced myself to patient and family as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my patient/family care study. Madam A. A. and relative were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of license in Registered General Nursing. I explained to Madam A.A. and her relative the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. Madam A.A. and relative agreed to my request and promised to offer me the necessary information and assistance. I mentioned to them that home visit is required to help know their home environment and how it contributed to patient's illness and how to prevent reoccurrence of the disease. I informed them that all the nursing staff present will help in caring of patient and not necessarily me alone. I then expressed my gratitude to them. Discharge planning was initiated by educating her on the causes and its management and some post-operative management; how to care for the incisional site and education on the medications; thus, they will continue the care at home once she is well.

After that, she was assisted to change into her hospital gown and emphasized on the willingness to meet her needs at all times.

On admission at 4:50pm, patient complained of pain at the epigastric region. A nursing diagnosis of altered body comfort (acute pain) related to tissue trauma was made. An objective was set to relieve patient of pain within 2 hours. Nursing interventions implemented includes; Patient/relatives were reassured that patient will be relief in no time. Patient was position to assume a comfortable position (prone). Patient level of pain was assessed using numeric pain scale as a pain level of 6. Cold compress was applied at patient site of pain.(epigastria region). Patient was engaged in a conservation to divert her attention off the pain. Prescribed analgesics like suppository diclofenac was served.

At 4:45pm, patient and her daughter verbalized that they were anxious about the impending surgery. Anxiety related to unknown outcome of impending surgery was the nursing diagnosis made. Inteventions done to help relieve anxiety within 16 hours were: Patient/family were reassured that everything will be done possible for a successful surgery. Patient/family were introduced to other patients who have undergone herniorrhaphy at the ward. Patient/family were educated that if surgery was not done, patient was likely to develop complications such as peritonitis and intestinal obstruction. Patient/relative expressed her fear s and all questions were answered tactfully. Patient was engaged in conversations which diver t her attention. Patient was encouraged to express his fear and concern.

At 5:00pm, questions asked about condition revelaed that, patient had inadequate information about condition. Nursing diagnosis formulated was knowldge deficit (patient/family) related to inadequate information on causes, signs and symptoms and management of the condition. Nursing interventions included: Patient’s level of awareness about the condition was assessed through questions. Client and relatives were allowed to ask questions and they were answered tactfully to aid understanding. A good inter personal relationship was established with client

and relatives to provide a good atmosphere for learning. Client and relatives were educated on the possible causes, signs and symptoms and management of hernia. Patient was educated on the need to adhere to treatment. Client and relatives were made to repeat what they have learned from the education and were praised for their efforts.

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

At 6:50pm, evaluation was made for the problem of epigastric pain. Goal was fully met as patient was relief of her epigastric pain and was comfortable in bed.

At 7:00pm, the goal set 2 hours ago to enable patient and family gain adequate information on condition was evaluated. Goal was fully met as patient/relatives gave feedback on the condition and its post care and patient/relatives verbalized they had adequate understanding about hernia and its management.

Comprehensive pre-operational preparation were instituted for patient. The preparations were grouped under the following headings.

Physiological Preparation

In preparing her physiologically for the surgery; Blood sample had already been sent to the laboratory for the various investigations. Medications including infusions were made ready for the surgery. She was taught how to apply pressure when coughing as she would apply it after the operation to prevent gaping of the wound. The required investigations were ready for the surgeon and anaesthetist review before the surgery. Patient's vital signs were checked and recorded.

Psychological Preparation

Psychologically, Madam A.A. was allowed to sign the consent form after a thorough explanation. She was introduced to other patient who had undergone similar surgical procedure were allowed to interact with each other to share their experience as shown in the careplan. This was done to relieve anxiety. She was educated on causes, signs/symptoms of the disease condition.

Physical Preparation

In preparing Madam A.A. physically for the Herniorrhaphy,

Oral fluids and food intake was restricted the night before surgery to prevent aspiration.

Around 7:30pm, the surgeon reviewed Madam and the laboratory investigations and assured her and her daughter of a better outcome of the surgery.

Patient was assessed for coughing since this has a potential for gaping the incision site and impending gaseous exchange during anaesthesia effect but none was observed. The surgeon confirmed her fit for operation.

The site for the operation was not asked to be shaved, but the surgeon ordred to wash with soap and water, rinsed and cleansed with savlon and kept dry in the morning nefore the surgery.

Second Day Of Admission (Day Of Operation) - (30th November, 2021)

According to the night nurse, patient had sound sleep and woke up at 4:00am, said her prayers and took her bath. She was encouraged to eliminate her bladder and bowel if she feels the urge to do so. The site of the operation was inspected and was cleaned and disinfected again using aseptic technique, the site was then labelled with plaster.

Vital signs were checked and recorded. Due medication and IV fluids were served.

Afterwards, patient was given a theatre gown to wear and then the theatre staffs were alerted that the patient was ready for the surgery.

At 8:45am, just before patient was abot to be taken to the theatre, an evaluation was made for the objective set to relieve anxiety. Goal was fully met as nurse observed that patient is relaxed and ready to undergo surgery and patient relatives were happy and with high hopes for a positive outcome from the surgery.

At 8:50am patient was sent to the theatre and was accompanied by two nurses with her folder and was handed over to the receiving theatre staff.

I stayed with patient through the intra operative period. The operation ended around 11:00am. Intermediate post-operative care normally takes place at the theatre; hence patient was cared for appropriately by the theatre nurses till she was partially recovered from anaesthesia before she was sent back to the female surgical ward.

Immediate Post-Operative Care

Before the return of Madam A.A. from the theatre, the necessary items such as; post anaesthetic tray (swab- holding forceps, dissecting forceps and a tongue spatula), pulse oximeter, vomiting bowl, mouth care tray, vital signs tray, screen, bedside rails, infusion stand and sphygmomanometer were made available.

Madam A.A. was received from the theatre to the surgical ward onto an operation bed at 11:15am on a stretcher after a successful Herniorrhaphy. She was received in a semi-conscious state as she underwent general anaesthesia. She was put to bed in a dorsal recumbent position with her head turned to one side and the infusion (dextrose saline 500ml) hanged on the infusion stand.

The amount of infusion running was noted and then the flow rate was adjusted as ordered. The incision site was inspected for bleeding, swelling, discharge and discolouration. Patient vital signs including the temperature, pulse, respiration and blood pressure were checked every 15minutes for one hour, 30minutes for 1 hour and 1 hour for 4 hours till patient fully conscious.

At 11:20am, ineffective airway clearance was diagnosed. An objective was set that patient would have effective airway clearance within 24 hours. Respiratory rate was monitored and recorded as ordered. Patient's head was tilted (left lateral) to drain secretions and prevent aspiration. Patient's SPO_2 level was monitored. Patient was placed on a confortable position that relieves pain. The head end of the bed was elevated to enhance breathing. Oxygen was administered.

At 12:30pm, patient complained of incisional pain, a nursing diagnosis of acute pain related to incisional incision was made. An objective was set to help patient be relieved of incisional pain throughout hospitalization. Nursng interventions carried out included: Patient/relatives were reassured that patient will be relief in no time. Patient was position to assume a comfortable position. (prone). Patient level of pain was assessed using numeric pain scale. Cold compress was applied at patient site of pain.(epigastria region). Patient was provided with a comfortable bed and kept in a semi fowler's position. Prescribed analgesics like suppository diclofenac was served.

At 1:05pm, her infusion got finished and 500mls dextrose was continued as prescribed. A calm environment was also ensured.

At 4:00pm a diagnosis of self-care deficit (bathing and grooming) related to confinement in bed and incisional pain. was formulated. Patient would be able to maintain self-care by 48 hours was the objective set. Patient/relative were reassured that patient will be able to care for herself soon. Bedpan and urinal was put closer to bed side. Patient was assisted to bath twice daily. Patient was assisted to change her soiled clothing and bed linen where necessary. Patient was assisted to perform range of motion exercise. Patients items was arranged within easy reach so that he could reach to them easily.

At 5:00pm, patient was diagnosed with risk for infection. Risk for infection related to presence of surgical incision (wound) was nursing diagnosis made. Intervention carried out

included: Wound clean and dry with no sign of wound infection. Patient wound dressed under aseptic technique. Meals rich in proteins, vitamins and calories served. Monitor patient's vital signs especially temperature was monitored to detect infections. Patient was ed ucated not to wet the wound, not to be touching the incisional site with hand and not cover th e incisional site with any unsterile material. Patient was served with Intravenous metronidazo le 500mg tds for 72 hours.

In the evening patient was provided with bed bath, dim light with less noise environment was then provided for patient. All nursing activities rendered for the patient were entered into the nurses' notes. Patient was handed over to the night nurse at 8:30pm.

First Post Operative day (1st December, 2021)

Patient woke up at 4:30am. Her personal hygiene including mouth care and bed bath were carried out. Madam A.A. was provided with a comfortable bed and adequate ventilation was also provided. Her vital signs were checked and recorded as;

Temperature…………………… 36.4° C

Pulse Rate………………………80 beat per minutes

Blood Pressure………………….....120/75 millimetre mercury

Spo2………………………….... 96percent

The surgical team conducted ward rounds and during the rounds, her incision site was inspected and site was clean and dry. It was also concluded that patient could start taking sips of plain tea. Medication IV Amoksiclav 1.2g was administered.

She was advised to avoid touching incision site with hands.

At 11.20am, goal set to help relieve patient's difficulty breathing was fully met as the nurse observed patient breath without difficulty and patient expressed a relief in her difficulty in breathing.

In the afternoon, Madam A.A. was served light diet. IV metronidazole 500mg was served at 2pm.

At 4:00pm, permission was sough from patient to allow me visit her house for my first home visit. The aim of the visit was explained. Patient agreed and direction to the house was given.

At 6:00 pm, patient was assisted to bath and pressure areas were treated. She then took in soft rice balls and light soup for supper. Her vital signs were then checked and recorded.

In the evening around 8:00pm, dim light, low noise and proper ventilation were provided to promote sleep. All nursing activities rendered were documented and patient was handed over to the night nurses at 8:30pm.

Second Post Operative day (2nd December, 2021)

Patient woke up at 6:00am and was assisted to perform her hygienic needs such as oral care and bathing as she complained of body weakness. Activity restrictions were maintained and a restful environment was provided to promote rest by reducing noise at the ward. His vital signs were checked and recorded on the chart and prescribed medications were duly served;

Temperature……………………. 36.5 degree Celsius

Pulse Rate……………………….76 beat per minutes

Blood Pressure…………………. 110/70 mmHg

Spo2…………………………….97 percent

Madam A.A. took a cup of porridge as breakfast. The dressing on her wound was inspected for any discharge, but it looked clean and dry. She was congratulated for co-operating with treatment. She was advice on the need to avoid lifting heavy objects and avoid touching the incision site was reinforced. She was engaged in conversation concerning her health and social status.

At 10am, vital signs were checked and recorded as shown in appendix.

At 2:00pm, her daughter came to visit her, she ate rice and soup. Together with her daughter, she was assisted to ambulate around the hospital environment and also engaged in a conversation. IV ringers lactate therapy was given.

At 4:00pm, the objective set on 30th November, 2021 to help patient be able to maintain self-care by 48 hours was evaluated. Goal fully met as nurse observed patient grooming herself and patient verbalized, she can take her bath when assisted.

At 6:00pm, her daughter brought her fufu and light soup for supper.

His vital signs were checked and recorded as:

Temperature……………….... 37.0 degree Celsius

Pulse rate…………………… 76 beat per minutes

Blood Pressure………………. 110/70 millimeters of mercury

Spo2……………………… 98 percent

Patient had her bath and oral hygiene done and was made comfortable in bed. All nursing activities rendered to him were documented in the nurses' note and she was handed over to the night nurse.

Third Post Operative day (3rd December, 2021)

On this day her health had improved considerably. She woke up at 5:30am with no complains she could get in and out of bed without any help. All personal hygiene activities were maintained by the patient herself.

Vital signs were checked and recorded as:

Temperature…………………...36.2 degree Celsius

Pulse rate………………….......68 beat per minutes

Blood Pressure………………...110/70millimeters of mercruy

Spo2…………………………...99 percent

During ward rounds at 9:00am, the Doctor ordered that the wound be opened for inspection and the wound was dry and clean. They were very happy to see the wound in a good state. They ordered for the continuation of daily wound dressing. They declared the patient for possible discharge the next day if condition remains the same. There was no complain, her condition was stable and incision site was clean and dry.

Around 10:30am, her wound was dressed with alcohol under aseptic condition after which due medications were served.

After the ward rounds, Madam A.A. took wheat porridge. Her daughter paid her a visit around 12:00noon with her lunch. Around 2:00pm, his vital signs were checked and recorded as:

Temperature…………………36.7 degree Celsius

Pulse rate……………………...74beat per minutes

Blood Pressure………………... 110/70 millimetres of mercury

Spo2…………………………...98 percent

In the evening, he took her bath with assistance and afterwards she ate her supper, and took in fruits as dessert. Her vital signs were checked and recorded.

She was made comfortable in bed and handed over to the night nurse for continuity of care.

Day Of Discharge (4th December, 2021)

According to the night nurse, patient had a sound sleep and there was no complaint. Madam A.A. preferred bathing with cold water. Her vital signs were checked and recorded as:

Temperature………………...37.0 degree Celsius

Pulse rate…………………...76 beat per minutes

Blood Pressure……………...120/70 millimetres of mercury

Spo2…………………………...99 percent

During the ward rounds at 9am, patient made no complaints, condition was stable and incision site was clean and dry. Even though the wound was not completely healed, she was discharged by Dr. S. but to come for wound dressing at the dressing unit. After she has taken her breakfast at 9:30am, her daughter was informed about the discharge.

At 10:00am, the objective set to relieve patient of inciconal pain was evaluated. Goal was fully met as patient verbalized a pain level of 1 on the pain rating scale of 0-10 and Nurse observed that patient is relaxed with a cheerful facial expression

At 10:10am, goal set for risk of infection were evaluated. Patient wound was clean and without pains at the incisional site, had absence of redness and swelling. Patient temperature was within 36.3°C and 36.5°C. This indicated a fully met goal.

They were given comprehensive discharge teachings which includes; the avoidance of strenuous activities such as lifting of heavy objects, putting pressure on the site, avoid touching the incision site with the hands, using the hands to support when coughing or sneezing and keeping the site clean and dry to prevent infection.

Since patient is a NHIS subscriber, there were no bills to pay by her children. Patient valuables were handed over to her daughter. After helping her daughter pack her belongings, they expressed their gratitude to the nurse in charge and the entire staff of the ward. They were reminded of the review date, which was on 10th December, 2021.

I escorted them to the roadside to board a taxi. I bid them goodbye and assured them of another home visit. I returned to the ward to disinfect the bed, pillow and locker and made it ready for another admission. Her name and other particulars were then entered into the admission and discharge book and the daily ward state.

4.2 Preparation Of Patient / Family For Discharge And Rehabilitation

The preparation towards Madam A.A. and family's discharge began the day she was admitted, 29th November 2021. It was aimed at restoring patient back home and into the

community as early as possible. Patient and daughter were educated on Epigastric Hernia, the causes, clinical manifestations, surgical and nursing management and their implications. As part of the discharge education, patient and daughter were instructed in ways to prevent infection, which include avoidance of dressing wound with any herbs or hot water. Patient and daughter were advised to keep the wound site clean and dry to prevent infection. Daughter was educated to provide patient with a lot of fruits and nourishing diet to promote healing.

Moreover, health education was given to her and family on good personal hygiene, rest and sleep and passive exercises. She was also educated to avoid lifting heavy objects to prevent reoccurrence of the condition when discharged home.

The date for review, 10th November, 2021 was mentioned to them, but was advised to come to the hospital if there is any problem before the said date. The health insurance scheme covered the entire bill and the patient's name was entered into the admission and discharge book and the daily ward state.

4.3 Follow Up/Home Visit/Continuity Of Care

Home visit is a planned visit that the health worker makes to the patient's home and community in which the patient and family lives. The aim is to access the actual home situation and to identify health problems in the patient's home. This is to help find solution to those problems identified and to educate them on how to solve them to prevent future complications.

First Home Visit (1st December 2021)

This was made on 1st December, 2021 when Madam A.A. was on admission. Madam A.A. lives at Dormaa Ahenkro in Bono Region. I arrived at the house around 4:30pm. I was warmly welcomed by her daughter, and was offered a seat. I told her the reason for my visit

was to familiarize myself with the house and to help solve problems that might trigger reoccurrence of Madam A. A's condition. And also to validate the data obtained. Upon inspection, it was observed that the surroundings of the house were tidy although the compound was not cemented. They have a toilet and bathroom in the house. I congratulated her daughter for keeping the house clean and I encourage her to keep it up. I was informed by her daughter that they get their source of drinking water from the borehole. I educated her to boil the water and filter it before they drink it if they realize the water is unclean. She was also educated to sleep in insecticide treated mosquito net to avoid malaria and cover buckets of water to avoid dust. Madam A.A's daughter was advised to see to it that, Madam A.A. avoids strenuous activity or heavy lifting to help her to recover fully and prevent reoccurrence of the inguinal hernia. I promised to come back again when Madam A.A. is discharged. I then sought permissioned and left.

Second Home Visit (6th December, 2021)

On 6th December, 2021 at 12:00pm, I made my second home visit to Madam A.A. and family. The purpose of this visit was to ensure the maintenance of her health, find out the health status of patient and to remind them of review date. I was warmly welcomed and offered a seat and water to drink and they were all happy to see me. Patient and daughter had no complains.

The incision site was inspected and was observed that the dressing was clean and dry. I congratulated them for adhering to the education given to them and for taking proper care of the wound. I reinforced the education on the need to avoid activities such as stressful work as well as adapting to good nutrition, personal and environmental hygiene and advised them to go by them. They were reminded of the review date, which was on 10th December, 2021.

They were also reminded that during the third home visit, care will be terminated.

Madam A.A. looked cheerful and participated throughout our conversation. The family expressed their gratitude for the total nursing care rendered to them.

First Review (10th December 2021)

Madam A.A. came to the O.P.D. of Dormaa Presbytarain Hospital for review on 10th December, 2021 as scheduled, she was active and healthy looking.

After retrieving the folder and having her vital signs checked, we proceeded to the consulting room to meet the Doctor. The surgical team carefully examined her and the wound site examined for healing. The incision site was clean with no discharge so stiches were removed. Wound had healed by first intension.

Doctors prescribe plan was:

1. Tablets Amoksiclav 625mg bd × 7 days
2. Tablets metronidazole 400mg tid x 7 days
3. Suppository Diclofenac 100mg bd × 7 days

Patient was again educated to avoid lifting heavy objects and straining to have bowel movement. She was also encouraged to ensure adequate fluid intake, fruits and vegetable intake as well as maintaining good nutrition and moderate exercises. She was asked to come to the hospital if she finds problems with herself. Patient was encouraged to adhere to treatment regimen and honour follow up visits. Patient was scheduled for a final review on 31st December 2021. She was escorted to board a car to house after informing her on my plans on terminating care with her and the family on my last visit which was to be scheduled on 2nd January, 2022.

Third Home Visit (2nd January 2022)

On 2nd January 2022, I paid my last home visit to Madam A.A. and her family. Madam A.A. had fully recovered. I was offered a seat, water and welcomed. Patient had no complains. The

incision site was inspected and it was observed that the site was completely healed with little scar formation.

The health education on his personal and environmental hygiene was reinforced and was reminded not to lift heavy objects. I used this opportunity to terminate the care rendered to her and family. The family expressed their gratitude for the total nursing care rendered to them, and the good nurse to patient relationship established during her stay at the hospital. They promised to go by the knowledge and experience they have acquired. I thanked them for their co-operation which contributed to the success of this care study and also were advised that, they visit the hospital any time they feel unhealthy.

Since the wound has healed completely with no complication I decided to hand over patient to family. They assured me of a permanent friendship being established and saw me off.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO MADAM A.A. AND FAMILY

5.0 Introduction

Evaluation is aimed at determining patient's response to the nursing interventions rendered and the extent to which the goals set have been met. It includes statement of evaluation, amendment of nursing care plan and termination of care.

5.1 Statement of Evaluation

MadamA.A. reported at the Out Patient Department of Dormaa Presbyterian hospital, upon examination by Dr S., she was diagnosed as having Epigastric Hernia.

1. **Patient was relieved of pain within 2 hours**

On admission (29th November, 2021) at 4:50pm, patient complained of pain at the epigastric region. A nursing diagnosis of altered body comfort (acute pain) related to tissue trauma was made. An objective was set to relieve patient of pain within 2 hours. Nursing interventions implemented includes; Patient/relatives were reassured that patient will be relief in no time. Patient was position to assume a comfortable position (prone). Patient level of pain was assessed using numeric pain scale as a pain level of 6. Cold compress was applied at patient site of pain.(epigastria region). Patient was engaged in a conservation to divert her attention off the pain. Prescribed analgesics like suppository diclofenac was served.

On the same day at 6:50pm, evaluation was made for the problem of epigastric pain. Goal was fully met as patient was relief of her epigastric pain and was comfortable in bed.

2. **Patient and family were relieved of anxiety within 16 hours**

On 29th Novemeber, 2021 at 4:45pm, patient and her daughter verbalized that they were anxious about the impending surgery. Anxiety related to unknown outcome of impending surgery was the nursing diagnosis made. Inteventions done to help relieve anxiety within 16 hours were: Patient/family were reassured that everything will be done possible for a successful surgery. Patient/family were introduced to other patients who have undergone herniorrhaphy at the ward. Patient/family were educated that if surgery was not done, patient was likely to develop complications such as peritonitis and intestinal obstruction. Patient/relat ive expressed her fears and all questions were answered tactfully. Patient was engaged in con versations which divert her attention. Patient was encouraged to express his fear and concern.

On 30th November, 2021 at 8:45am, just before patient was abot to be taken to the theatre, an evaluation was made for the objective set to relieve anxiety. Goal was fully met as nurse observed that patient is relaxed and ready to undergo surgery and patient relatives were happy and with high hopes for a positive outcome from the surgery.

3. **Patient/family were well updated on the condition and its outcome within 2 hours.**

On 29th Novemeber, 2021 at 5:00pm, questions asked about condition revelaed that, patient had inadequate information about condition. Nursing diagnosis formulated was knowldge deficit (patient/family) related to inadequate information on causes, signs and symptoms and management of the condition. Nursing interventions included: Patient's level of awareness about the condition was assessed through questions. Client and relatives were allowed to ask questions and they were answered tactfully to aid understanding. A good inter personal relationship was established with client and relatives to provide a good atmosphere for learning. Client and relatives were educated on the possible causes, signs and symptoms and

management of hernia. Patient was educated on the need to adhere to treatment. Client and relatives were made to repeat what they have learned from the education and were praised for their efforts.

At 7:00pm, the goal set 2 hours ago to enable patient and family gain adequate information on condition was evaluated. Goal was fully met as patient/relatives gave feedback on the condition and its post care and patient/relatives verbalized they had adequate understanding about hernia and its management.

4. **Patient had effective airway clearance within 24 hours.**

On 30th November, 2021 at 11:20am, ineffective airway clearance was diagnosed. An objective was set that patient would have effective airway clearance within 24 hours. Respiratory rate was monitored and recorded as ordered. Patient's head was tilted (left lateral) to drain secretions and prevent aspiration. Patient's SPO_2 level was monitored. Patient was placed on a comfortable position that relieves pain. The head end of the bed was elevated to enhance breathing. Oxygen was administered.
On 1st December 2021 at 11.20am, goal set to help relieve patient's difficulty breathing was fully met as the nurse observed patient breath without difficulty and patient expressed a relief in her difficulty in breathing.

5. **Patient was relieved of incisional pain throughout hospitalization**

On 30th November, 2021 at 12:30pm, patient complained of incisional pain, a nursing diagnosis of acute pain related to incisional incision was made. An objective was set to help patient be relieved of incisional pain throughout hospitalization. Nursng interventions carried out included: Patient/relatives were reassured that patient will be relief in no time. Patient was position to assume a comfortable position. (prone). Patient level of pain was assessed using numeric pain scale. Cold compress was applied at patient site of pain.(epigastria

region). Patient was provided with a comfortable bed and kept in a semi fowler's position. Prescribed analgesics like suppository diclofenac was served.

On 4th December, 2021 at 10:00am, the objective set to relieve patient of inciconal pain was evaluated. Goal was fully met as patient verbalized a pain level of 1 on the pain rating scale of 0-10 and Nurse observed that patient is relaxed with a cheerful facial expression

6. **Patient was be able to maintain self-care by 48 hours**

On 30th November, 2021 at 4:00pm a diagnosis of self-care deficit (bathing and grooming) related to confinement in bed and incisional pain. was formulated. Patient would be able to maintain self-care by 48 hours was the objective set. Patient/relative were reassured that patient will be able to care for herself soon. Bedpan and urinal was put closer to bed side. Patient was assisted to bath twice daily. Patient was assisted to change her soiled clothing and bed linen where necessary. Patient was assisted to perform range of motion exercise. Patient's items was arranged within easy reach so that he could reach to them easily.

On 2nd December 2021 at 4:00pm, the objective set on 30th November, 2021 to help patient be able to maintain self-care by 48 hours was evaluated. Goal fully met as nurse observed patient grooming herself and patient verbalized, she can take her bath when assisted.

7. **Patient's wound was free from infection within the period of hospitalization.**

On 30th November, 2021 at 5:00pm, patient was diagnosed with risk for infection. Risk for infection related to presence of surgical incision (wound) was nursing diagnosis made. Intervention carried out included: Wound clean and dry with no sign of wound infection. Patient wound dressed under aseptic technique. Meals rich in proteins, vitamins and calories served. Monitor patient's vital signs especially temperature was monitored to detect infections. Patient was educated not to wet the wound, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material. Patient was served with Intravenous metronidazole 500mg tds for 72 hours.

On 4th Decemebr, 2021 at 10:10am, goal set for risk of infection were evaluated. Patient wound was clean and without pains at the incisional site, had absence of redness and swelling. Patient temperature was within 36.3°C and 36.5°C. This indicated a fully met goal.

5.2 Amendment Of Nursing Care Plan For Partially Met/ Unmet Outcome Criteria

Amendment is the process of making a change or improvement in the nursing care plan. Amendment is made when a goal or objective is partially met or unmet. During the care of Madam A.A, no amendments were made as all set goals were fully met at the stipulated time.

5.3 Termination Of Care

Termination of care begun from the day of admission on 29th November 2021, Madam A.A. came with the diagnosis of Epigastric Hernia with signs and symptoms of abdominal pain and swelling at the epigastric region and a feeling of pulling sensation. Nursing, medical and surgical interventions and health education were given to them throughout their period of hospitalisation. Her daughter was made aware that Madam A.A. will be discharge home when her condition has improved. She was discharged on 4th December 2021 before and after discharge, home visits were made to ensure continuity of care. Madam A.A. was reviewed twice after discharge. The family was made to understand that although therapeutic care will be terminated, the relationship established will still hold.

On the last review day, 31st December 2021 the need for termination of care was communicated to Madam A.A. On 2nd January 2022, I paid my last home visit to Madam A.A. and her family. Madam A.A. had fully recovered. I was offered a seat, water and welcomed. Patient had no complains. The incision site was inspected and it was observed that the site was completely healed with little scar formation.

The health education on his personal and environmental hygiene was reinforced and was reminded not to lift heavy objects. I used this opportunity to terminate the care rendered to her and family. The family expressed their gratitude for the total nursing care rendered to them, and the good nurse to patient relationship established during her stay at the hospital. They promised to go by the knowledge and experience they have acquired. I thanked them for their co-operation which contributed to the success of this care study and also were advised that, they visit the hospital any time they feel unhealthy.

Since the wound has healed completely with no complication I decided to hand over patient to family. They assured me of a permanent friendship being established and saw me off. However, I assured them that they can contact me in case of any health problem and I will visit them occasionally.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This is the last step of the patient/family care study which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing

6.1 Summary

Madam A.A. was admitted to Medical/Surgical Ward through the Out Patient Department on 29th November 2021 at Dormaa Presbyterian hospital. He was admitted with a diagnosis of Epigastric Hernia by Dr. S.

On arrival, Madam A.A. reported with the history of swelling at the Epigastric region, pain at the affected area, and a feeling of pulling sensation. The nursing process approach was used to plan a comprehensive nursing care and necessary nursing, medical, surgical interventions were carried out to meet the identified health problems. Patient spent six days on the ward and was discharge on 4th December, 2021.

During evaluation, goals set were fully met without complications. Madam A.A. was discharged on 4th December, 2021 when she had fully recovered. Madam A.A. was booked for review by Dr. S. on 10th December 2021 and 31st December, 2021. After the review by the Doctor, Madam A.A. was declared fit.

Home visits were made to ensure continuity of care. During the third home visit, on 2nd January 2022, care was terminated when A.A. condition had improved greatly.

6.3 Conclusion

This care study has really enlightened me and provided me with the requisite skills in rendering individualized nursing care to a patient by using nursing process approach. The care study has also helped me to obtain more knowledge about the causes, signs and symptoms, treatment regimen, complications and prevention of Hernia. I have also realised that quality of care is difficult to be achieved without the nursing care plan.

After writing the study, I realized that the study has broadened my understanding and the need to care for patients individually and to render holistic care regardless of the physical, social, economic and spiritual background

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APPENDIX

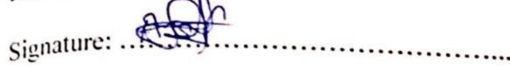
Table 12: VITAL SIGNS CHART

DATE/ TIME	TEMPERATURE (°C)	PULSE (bpm)	RESPIRATION (cpm)	BLOOD PRESSURE (mmHg)
29/11/2021 4:30pm	36.1	86	20	130/80
Post-Operative Vital signs				
30/11/2021				
11:15am	36.6	83	18	140/90
11:30am	35.7	90	18	140/70
11:45am	35.7	88	18	140/90
12:00pm	36.0	80	20	130/80
12:30pm	36.0	80	20	130/80
1:00pm	37.2	80	20	130/93
3:55pm	36.9	78	19	129/86
01/12/2021				
6:00am	36.4	80	18	120/75
10:00am	36.6	76	20	110/80
2:00pm	36.2	70	18	110/70
6:00pm	36.1	68	16	110/70
10:pm	36.5	74	18	126/78
02/12/2021				
6:00am	36.5	76	16	110/70
10:00am	36.6	68	18	120/80
2:00pm	36.0	70	18	120/70
6:00pm	37.0	76	16	110/70
10pm	36.2	69	18	127/76
03/12/2021				
6:00am	36.2	68	16	110/70
10:00am	36.6	72	18	110/80
2:00pm	36.7	74	16	100/70
10:00pm	36.5	66	16	110/70
04/12/2021				
6:00am	37.0	76	18	120/70
10:00am	36.2	70	16	113/74

SIGNATORIES

1. **The Student Nurse**

Name: ANSUAA ABIGAIL

Signature: 

Date: 4th October, 2022

2. **Nurse In-Charge of Female Medical/ Surgical ward – Dormaa Presbytarian Hospital**

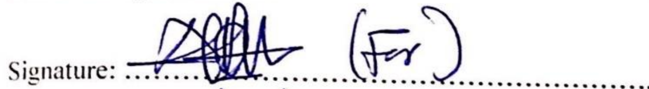
Name: [illegible]

Signature:

Date: 4TH OCTOBER 2022

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

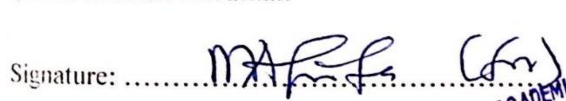
Name: Bridget Dzibede

Signature: 

Date: 04/10/2022

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

Name: Monica Nkrumah

Signature: 

Date: 5th October, 2022

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