CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment is the systematic collection of data to determine the patient's health status and any actual or potential health problems (Smeltzer, Bare, Hinkle & Cheever, 2010). It is the first stage and a vital tool in the nursing process. Assessment can be done through observations, interviewing and investigations such as laboratory results, X-ray reports and physical examination of the patient. It includes the patient's particulars, patient/family medical and surgical history, patient's socioeconomic history, patient's developmental history, patient's lifestyle and hobbies, patient past medical and surgical history, patient present medical and surgical history. It also includes admission of patient, patient and family concept of his illness, literature review on the condition from which analysis will be made to identify the patient problems and validation of data. These help the nurse to determine the health status of the patient and his family in order to plan an effective nursing care towards recovery. All information was gathered from the patient and his relatives, as well as the patient's folder.

1.1 Patient's Particulars

Patient's particulars are defined as the biographical state of an individual within a geographical area at a particular time (Myers, 2006). Mr. A. A. D. is a 38-year-old Ghanaian, born on 20th June, 1983 to Mr. A. N and Mrs. Y.C. He was delivered at the Dormaa Ahenkro Presbyterian Hospital. He comes from Dormaa Ahenkro a town in Bono Region. He lives at Agyei Darko in Sunyani. He stays in a mission house with the house number BF0087 where he works as a pastor. He is the first born of six children. Which include four boys and two girls. His next of kin

is his daughter A.O. who also lives at Agyei Dark. Mr. A.A. D. is a Pastor. He is a member of the Great Action Power Ministries at Agyei Darko. He had his basic education at Dormaa Ahenkro D/A Primary and Junior High School at Dormaa Ahenkro. His best subjects were Twi and English. He did not get the opportunity to further his education to the secondary level because he decided not to go to school again. He speaks both French, Bono and Twi. He is Bono by tribe. He is dark in complexion, weighs 65kg and is 168 centimetres tall. He has no physical impairments or disabilities.

1.2 Family's Medical History.

According to Mr. A.A.D his grandparents are deceased. They died of old age. His parents and siblings are alive and healthy. 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 and traditional medicines) but if symptoms persist, they usually report to Sunyani Regional Hospital. This is the first time he is being hospitalized. The source of medical treatment for Mr. A. A D's family are both orthodox and herbal medicine. There are no known allergies in the family. According to patient, some of his family members has undergone surgery before but didn't specify the exact family member. There is no history of mental illness.

1.3 Family Socio-economic History

Mr. A. A. D's family has a very good relationship and cohesion. Socially the family is not noted for smoking or drinking alcohol. He revealed that family members depend solely on his income from his pastoral work and his wife's trading. Church members are always willing to support each

other in times of financial hardships. Mr. A. A. D's doesn't depend much on his extended family for financial support but rather depends on his salary. He earns an estimated amount of 900 cedis every month. His family members are well known for their enormous participation in religious activities, their kindness and generosity. Patient said they have no taboos in their family, rather they conform to the rules and believes of the Christian religion. He also indicated that the National Health Insurance Authority cover most of his bills whenever he seeks for treatment at the hospital.

1.4 Patient's Developmental History

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014). Maturation is the process of becoming completely developed mentally or emotionally (Walter, 2013). Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2014). The developmental history was given by patient himself as told by his mother. Mr. A. A D indicated that, his mother went through normal pregnancy of nine months' gestation without any pregnancy associated disorders and had normal delivery with the help of medical staff at the Dormaa Ahenkro Presbyterian Hospital. He was born without any congenital abnormality such as cleft lip or palate, hydrocephalous and undescended testis (cryptorchidism) and was immunized against the vaccine preventable diseases as evidenced by Bacilli Calmat Guerin (BCG) scar on his right shoulder. Mr. A. A. D. was breastfed for a period of six months before he was introduced to complimentary foods like porridge. He went through a normal developmental milestone. This includes sitting up at the 7^{th} month, crawling at the 10^{th} month, walking, talking and running between the ages of one and three years old. Mr. A .A D at age Fifteen (15), begun to experience secondary sexual characteristics such as deepening of voice, broadening of chest and facial hair appearance. He started his basic and junior high education at

Dormaa Ahenkro D/A Primary and Junior High School at Dormaa Ahenkro. After his junior high education, he decided not to go to school again. Patient is married.

Erikson's theory of psychosocial development in 1964 describes the human life cycle as a series of eight ego developmental stage from birth to death.

According to the Erik Erikson's psychosocial stage of development, Mr. A. A. D. is 38 years and therefore falls under the generativity vs. stagnation (36-60 years) of Erik Erikson's theory of psychological development. According to Erickson at this stage people experiences the need to create or nurture things that will outlast them or creating positive changes that will benefit the society. He gives back to the society through raising his children, being productive at his work as a pastor and becoming involved in community activities and organizations.

I am sincerely convinced that patient is in the intimacy dimension of Erikson's psychosocial development because he is eager to blend his identity with friends and explore personal relationship.

1.5 Patient's Lifestyle and Hobbies

Mr A. A. D. usually goes to bed around 9:00pm and wakes up at 5:30am. He mostly empties his bowels once, bath twice and empties his bladder five times and maintains his oral hygiene. According to Mr. A. A. D during the weekdays he goes to work with his friends and after work he helps with household chores. And during weekends, on Saturday he washes his cloths and goes to the church with his wife and daughters. And on Sunday, in the morning he prepares to go to church. After church he rest for some one hour and then joins his friends to study bible after the bible study, he then goes home and prepare for work the next day. For breakfast, patient mostly takes "Milo" drink and sometimes porridge with bread. Patient has no known allergy to food or drugs.

Mr. A. A. D. favourite food is Fufu with groundnut soup. He takes three eals per day. However, he usually takes fruits and does not smoke nor drink alcohol. He usually attends social activities like weddings and funerals. His hobbies are, reading bible, and listening to the radio. He has keen interest in football and is a very dedicated fan of Chelsea football club in England. He periodically participates in church youth sporting activities and exercises. He described himself as an extrovert who has interest in reading bible with friends, and listening to radio. Patient usually uses both verbal and non-verbal communication styles such as eye contact and gestures to register his displeasure when his siblings go wrong. He dislikes dishonesty and all sorts of immoralities but likes generosity and hard work. My personal impression about him is that, he is very benevolent and generous.

1.6 Patient's Past Medical History

Mr. A. A. D. never experienced any childhood illness like whooping cough, poliomyelitis, measles, neonatal tetanus, tuberculosis, and diphtheria and has not identified any allergy to drugs, animals or insects. He revealed that he usually suffers from minor sign and symptoms such as diarrhoea, constipation, headaches and common cold which he usually treats with traditional medicines and sometimes with over-the-counter medications. When symptoms persist or becomes worse, he visits a nearby hospital or clinic. Mr. A. A. D. said he had never been involved in a Road Traffic Accident. He has no physical disability due to illness. Mr. A. A. D. also indicated that he never goes for health check-ups unless his ailment becomes difficult to treat with traditional medicine and over the counter medications.

1.7 Patient's Present Medical History

According to patient, he has had this swelling in his inguinal area since childhood. At times it reduces and reappears mostly when do activities. In August 2021, he went to gym for some

exercise and lifted some heavy metals. He felt a sharp pain in the left inguinal region during the process and as a result he couldn't continue the exercise. He came home and took some analgesics for the pain to subside. According to patient the pain continued for about two months anytime he tries to lift something at home.

He therefore decided to report to the Regional hospital Sunyani for proper medical attention. He reported to the Out Patient Department on 16th November 2021 and was seen by the doctor and was diagnosed of left inguino-scrotal hernia. He was scheduled for hernia repair on 22nd November 2021.

1.8 Admission of the Patient

Admission simply means allowing a patient or client to stay at hospital for observation, investigation and treatment. The admission was a planned one as patient was pre informed about the admission when he reported to the Out Patient Department.

Mr. A A. D was admitted into the Male Surgical ward accompanied by his wife and an Apostle of his church in a conscious and ambulatory state, through the Out Patient Department of the Sunyani Regina Hospital, on the 21st of November, 2021 at 5:30pm with the diagnosis of left inguino scrotal hernia scheduled for surgery on 22nd November 2021 by Dr. M. Z. The patient and his Wife and the Apostle were welcomed and was offered a seat. He was put in an admission bed; patient looked anxious. He was reassured to allay fears and anxiety.

Patient was made comfortable in bed and his vital signs were checked and recorded accurately as follows;

- Temperature - 36.4^{o}C
- Pulse - 63 beats per minute
- Respiration - 18 cycles per minute

- Blood pressure - 121/71 mmHg

Patient's weight was 65 kg on admission.

Physical examination was performed on the patient from head to toe and no abnormalities were seen. Patient was to be prepared for surgery the next day. Preoperative preparations begun and client signed his consent form in the presence of the surgeon.

Patient was oriented to time, place and person. He was also oriented to the ward annexes.

He was introduced to the staffs present and was assured of the competency of the healthcare team. His particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and the daily ward state. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained.

Patient and family were told the rules and regulations including visiting hours and meal time. He was asked to get his own bowl, spoon, drinking cup, bathing sponge, bucket, towel, pyjamas and other toiletries. Patient was then introduced to the other patients who were on the ward.

Patient was to undertake full blood count. Therefore, an IV cannula was secured and blood sample was taken for the test. Patient was informed about NPO as he would not be allowed to eat again after supper until the surgery is over.

I reintroduced myself to patient as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my care study. Mr. A A D and his wife and Apostle were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of Licence to practice as a Registered General Nurse I explained to the patient and his wife the concept of the patient/family care study and assured them of privacy and confidentiality.

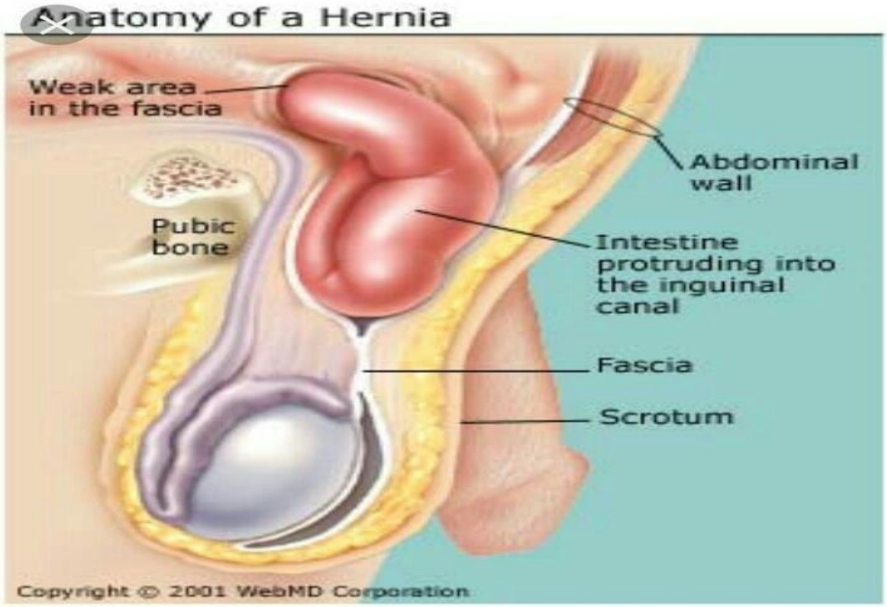
It was added that a report will be written after the entire event. Mr. A. A. D. and his wife and Apostle agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the relative thus they will continue the care at home once he is well. I decided to choose the patient for my case study because I wanted to use this opportunity to nurse a patient with Hernia and apply the theoretical knowledge gained in class room on hernias.

Patient's condition on admission was fair and he was made comfortable in bed.

1.9 Patient's Concepts about His Illness

Mr. A A.D did not associate his illness to any spiritual cause. He believes that it is a physical problem. Patient stated that he surely belief with no doubt that his condition probably has a link with the lifting of objects he did at the gym. However, he did not know the exact cause of his condition, but he believed that God would surely heal him from this condition. He hoped to get well with the care and treatment given to him by the competent health workers.

1.10 Literature Review



Introduction

Literature review gives an overview of the condition. It comprises of the definition, incidence, etiology, pathophysiology, clinical features, diagnostic investigations, complications and management of the condition.

Definition

Hernia is a protrusion of an organ or part of an organ through the wall of the cavity that normally contains it (Hinkle & Cheever, 2014). 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.

1. **The sac**: This covers the content.
2. **The fundus**: This refers to the weaken muscular or skin overlying the hernia.
3. **The neck**: This is the entrance of the sac where strangulation usually takes place.
4. **The content**: This is what is found in the sac and it is usually the intestine or omentum in the abdominal hernia.

Types of hernia

1 Inguinal Hernia. This is the protrusion of the intestine 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. **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 elderly people. Strangulation in direct hernia is rare.

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

2. **Femoral Hernia**: A loop of intestines protruding into the femoral canal.
3. **Umbilical Hernia**: This is the protrusion of bowel through the umbilical ring.
4. **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.
5. **Diaphragmatic 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.
6. **Richter's Hernia**: This is where only the wall of the small intestine is caught up and strangulated by the femoral ring.
7. **Reducible Hernia**: This is when the hernia can be returned to its normal position by manipulative measures.
8. **Irreducible (Incarcerated)Hernia**: Is when the hernia cannot be replaced by manipulation.
9. **Strangulated Hernia:** This is when the hernia becomes irreducible and blood supplies to the hernia structure are impaired

Causes of Hernia

1. **Congenital¬** This occurs as a result of defect in the abdominal muscle wall at birth.
2. **Acquired** It can occur as follows:

a. Weakening defect of the abdominal muscle due to ageing.

b. Severe infection affecting the peritomuscular structures.

c. Post-surgical incision.

d. Increased intra ¬abdominal pressures.

Predisposing factors of Hernia

According to Raftey, (2005) Below are the predisposing factors of hernia

1. Persistent cough
2. Straining on defecation.
3. Lifting or pushing object.
4. Obesity.
5. Pregnancy.
6. Ascites.
7. Bearing as with chronic constipation.
8. Enlargement tumour or lesion

Pathophysiology

Abdominal hernia develops by a combination of two factors: when a weakness in the abdominal wall evolves into a localized hole or defect in the muscle wall. The muscular wall defect may arise from congenital factors including impairment of collagen tissue and musculature integrity. Acquired muscular weakness may develop because of trauma or with the ageing process.

Also, increase intra ¬ abdominal pressure under several circumstances such as straining to lift heavy object, straining on defecation and during forceful coughing or sneezing. A segment of the intestine or abdominal organ moves into a weak area of the abdominal cavity. At first, the defect in the abdominal wall is small as the hernia persist and the organ continue to protrude, the defect grows larger. Eventually protruding organ may become trapped within the weakened pouch and adhesion may develop between the hernia sac and it content resulting in an incarceration hernia. If blood flows to or from the protrusion is obstructed the hernia is referred to as strangulation. Immediately surgery is usually involved when there is incarceration to prevent necrosis and gangrene.

Clinical manifestation of inguinal hernia

Smelter et al. (2010), outline the following as clinical manifestations of hernia.

1. Pain at site of strangulation**.**
2. Signs of bowel obstruction such as nausea, vomiting and distention.
3. A feeling of pulling sensation which is relieved when hernia is reduced.
4. Fever and chills.
5. Swelling of the hernia sac which is tense
6. Constipation.
7. Anxious facial expression
8. Pulse rate may be increased.

Complications

According to Lemone and Burke (2008), the complications of hernia which can occurs includes.

1) **Damage of spermatic cord in males;** The spermatic cord extends through the inguinal canal which suspend the testis in the scrotum. In inguinal hernia repair, poor surgical

technique and inexperience can therefore damage the spermatic cord as well as the strangulated hernia compressing organs within the inguinal region including the spermatic cord and also at the time of pulling of the intestines into the inguinal area there can be damaged to the spermatic cord as result of the contents passing through the testicular canal.

2) **Strangulated hernia:** Occurs due to excessive compression of the intestinal wall or loop obstructing blood supply and flow of intestinal content.
3) **Infections;** During the surgical repair, if aseptic techniques are not taking into consideration there can be invasion of microbes causing infection.
4) **Hypovolemic shock:** Strangulation can cause intestinal obstruction which has a cardinal sign of profuse vomiting leading to fluid and electrolyte loss which causes decreased blood volume leading to hypovolemic shock.
5) **Haemorrhage:** Is as a result of bleeding from the incisional site post operatively.
6) **Bowel obstruction:** If the omentum or a loop of intestine becomes trapped in the weak point in the abdominal wall it can obstruct the bowel.
7) **Oedema of the scrotum:** This comes as a result of the swelling or congestion of the protruded organ.
8) I**rreducibility**: This is when the hernia contents cannot be pushed back into the abdomen which may be due to swelling or congestion of the protruded organ.

Diagnostic Investigation

The diagnostic investigations for hernia as specified Lewis et al (2014), includes:

1. Abdominal or pelvic x-ray reveals the protrusion of the viscus outside its normal cavity.

2. Abdominal Ultrasound and Computer Tomography Scan may be done to confirm the type of hernia.
3. Physical examination on patient reveals an abdominal swelling or lump in the inguinal area or scrotum.
4. Laboratory studies which includes complete blood count, electrolyte, white blood cells count will be elevated.

(A) Medical Treatment

There is no medical treatment for hernia. Until surgery is performed, antibiotics and intravenous fluids are administered to prevent infections, fluid and electrolyte imbalance and dehydration**.** Some of the drugs administered includes:

1) Intravenous fluids such as normal saline, ringers lactate and dextrose saline.
2) Analgesics such as diclofenac, ibuprofen and pethidine for pain.
3) Antibiotics such as metronidazole (flagyl) and Amoxiclav.
4) Oral iron tablet (folic acid) to control anaemia.

B**) Surgical treatment**

Procedures that may be used are:

1) Herniotomy

This operation involves opening the hernia sac and reducing its content into the abdominal cavity.

2) Herniorrhaphy

It involves removal of the hernia sac after it has been dissected and free from the surrounding structures and the content have been replaced in the abdominal cavity and the neck has been ligated.

3) Hernioplasty

In hernioplasty, the weaken areas is reinforced with synthetic sutures such as steel mesh, fascia, a wire. It is an attempt to prevent reoccurrence (Brunner, et al.2010)

Nursing Management

Lewis (2014), describes the nursing management of hernia as follows;

Specific Pre-Operative Nursing Care

Observations

(A) Assess the patient for upper respiratory tract infection, chronic cough, and sneezing or constipation, it may be necessary to postpone the operation, because coughing or sneezing could weaken the post-operative wound.

(B) Closely monitor vital signs such as temperature, pulse, respiration, blood pressure and intravenous fluid administration.

(C) In emergency conditions of strangulated or incarcerated hernia, the nurse prepares the patient as in any other acute surgical condition. The following points should however be taken into consideration:

- The patient is nursed in a recumbent position with the foot end of the bed elevated.
- The supra pubic area should be shaved up to the anterior surface area of the thigh.
- An intravenous line should be maintained to correct fluid and electrolyte imbalance.

- Apply cold compresses to the site of the hernia to relax the muscles.
- Temperature, pulse, respiration and blood pressure are monitored half hourly.
- Reassure patient and his relatives by explaining procedure to them.

Patient Education

Reinforce the surgeon's explanation of the surgery and its possible complications. An emphasis in place on deep breathing exercise and leg movement**.**

Post-Operative Care

Is the care you received after surgical procedure. It often includes pain management and wound care. Post-operative care begins immediately after surgery**.**

Specific Post-Operative Nursing Care

- If general anaesthesia is used oral fluid and food are restricted until peristalsis occurs.
- Check for retention of urine, the patient may face difficulty in voiding following spinal anaesthesia. Catheterization may be necessary to relief or avoid retention of urine.
- For more extensive hernia repair, nasogastric suction may be used to prevent distension, vomiting, and straining.
- The nurse must encourage early ambulation but warn patient against lifting.
- Any elevation in temperature should be reported to the surgeon.
- If the patient develops coughs, or sneeze, instruct him to splint the incision site with his hands to lesser pain and protect the incision.
- The sutures are removed on the 7th and 9th post operatively. Clip are removed on the 5th day after **o**peration**.**

Reassurance and Psychological Care

- Patients with hernia mostly experience pains, patient will become anxious. Psychological support to patient is necessary to assure him that the requisite care will be given to him to allay fear and anxiety.
    - Patient is also reassured by educating him about his disease condition and assuring him of competent nursing care in the management of his condition.
    - All procedures to be performed are explained to the patient to elicit his co-operation.
    - Diversional therapy such as watching television and listening to the radio are employed to divert patient's attention from his pains and worries.

Rest and Sleep

- Patient should be nursed in a comfortable bed with the end of bed elevated.
- The environment should be quiet to enhance rest and sleep.
- Apply ice pack on the hernia in order to reduce pain.
- There should also be proper ventilation to ensure complete bed rest so that the patient will be relieved of headaches and fatigue.

Personal Hygiene

- Depending on the patient condition he is either assisted to bath when he can do so or given bed bath. This help to remove dirt from the skin, improves circulation and muscles tone.

- Patient's oral hygiene should be maintained to stimulate appetite and to prevent conditions such as gingivitis, angular stomatitis, dental caries, glossitis and otitis media.
- The skin and pressure areas should be treated for regularly to prevent decubitus ulcer.

Wound Care

- Patients wound is observed for signs of bleeding and infection, any offensive odour, discharges of pus or signs of wound gapping.
- Wound is dressed aseptically from inside out to prevent wound contamination.
- Also, alternative stitches are removed aseptically as directed by the surgeon. The patient is educated to keep the wound dry and not to be touching it with the hand to prevent wound infection.
- Also patient is encouraged to take in high protein and vitamin to promote wound healing and repair worn out tissues**.**

Observations

There should be frequent monitoring and observation of the;

- Vital signs; temperature, pulse, respiration and blood pressure should be monitored frequently to detect whether the condition is improving or deteriorating.
- Level of consciousness which can be a sign of impending crisis.
- General condition; paleness, cyanosis, altered respiration as well as desired effects and side effects of drugs. If there is oedema warm pads are applied.
- Intake and output chart should also be monitored

- Potential complications such as shock and infection.

Drug Administration

- Patient prescribed drugs are served both pre operatively and post operatively.
- Ensure that the right drug is given in the right dose and at the right time.
- Educate the patient on the effects and side effects of the drugs being administered.

Elimination

- Serve patient with bedpan on request and encourage patient to take more fluid and roughages to prevent constipation.
- If the patient is unable to pass urine, the following measures are carried out: open nearby taps to stimulate urination or apply warmth over the bladder and perineum**.**

Position

- Patient is placed on the supine position to reduce pain and facilitate breathing after surgery.
- The patient is allowed to assume a comfortable position which is not contra indicated to his condition to help prevent complications**.**

Health Education

- The patient should be educated on his diet to eat food rich in iron. He should also take roughages such as oranges to prevent constipation.
- Educate patient to avoid dry food to prevent constipation and straining.

Patient Education before Discharge

- Instruct him to watch for signs of wound infection such as oozing, tenderness, warmth and redness of the incisional site or wound.
- Warn the patient against lifting or straining.
- Inform him that he will be able to return to work or resume normal duties within four weeks.
- Remind him to take surgeons permission before returning to work or completely resuming his normal activities
- Encourage early ambulation, but warn the patient against bending and lifting or other strenuous activities.

1.11 Data Validation

Validation is the extent to which a measure, indicator, or a method of data collection possesses the quality of being sound or true as far as it can be judged (Weller, 2014). All the information gathered from the patient was found to be true after comparing with information obtained from patient's relative through series of interviews. Also the patient's folder provided the information to confirm the data collected. The information from the literature review also confirmed the data gathered. After collecting all these information, I realized that the data collected were similar and so considered valid for the study.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis of data is the act of separating information that have been mixed up to enable the nurse identify the actual and potential problem present in the practice of nursing volume one (Weller, 2010).

Analysis of data is the second phase of the nursing process. It contains information on the comparison of data gathered with standards. This helps the nurse to identify the problems of the patient and his family, their strengths and also makes his nursing diagnoses, objectives and gives appropriate interventions.

2.1 Comparison of Data with Standards

This is where the data collected on the health of the patient and family is compared with those in the Literature review. These include:

- Diagnostic Investigation/Tests
- Causes/Risk factors
- Clinical manifestation/Sign and Symptoms
- Medical/Surgical treatment
- Complication.

(A) Diagnostic Investigation/ Test

Test is the analysis of the body composition by the use of chemical reagents, and/or to determine the presence or absence of a substance Weller (2009). Before the treatment of any illness or disease, it is important for diagnostic investigation to be conducted to identify the exact cause of the illness and to select the most appropriate treatment available for the illness. To help in

establishing a more reliable diagnosis of patient's condition, and to formulate a potent treatment for patient, the following investigations were carried out

a) Physical assessment of the abdomen and groin.

b) Full blood count (FBC)

c) Abdominal scan (was done when client reported to the OPD on 16th November 2021)

The details of the investigations carried out on patient can be found in the table below.

Table 1: **Diagnostic Investigations/Tests In Literature Review Compared With Those Carried Out On Patient.**

Diagnostic Test Outlined In Literature Review	**Diagnostic Test Carried Out On The Patient**
1. Abdominal or pelvic x-ray	1. Abdominal or pelvic x-ray was not done for patient.
2. Abdominal Ultrasound and Computer Tomography Scan	2. Abdominal Ultrasound was done.
3. Physical examination	3. Physical examination was done.
4. Laboratory studies which includes complete blood count.	4.) Full blood count (FBC)

The comparison with the literature review, patient had some of the diagnostic investigations done except for x-ray of the abdomen and CT scan because the physician was satisfied with the investigations carried out (physical examination conducted, the clinical manifestation presented by my patient and the abdominal ultrasound confirmed his diagnosis). From the table above it

shows that patient was diagnosed correctly as most of the diagnostic Investigations stated in literature review were conducted on patient.

TABLE 2: DIAGNOSTIC INVESTIGATION DONE FOR PATIENT

DATE	SPECIMEN	INVESTIGATIONS	RESULTS	NORMAL VALUES	INTERPRETATION	REMARKS
21/11/2021	Blood	**FULL BLOOD COUNT**				
		Hemoglobin (Hb level)	14.7g/dl	**Males:** 14 g/dL - 17.5g/dL **Females:** 12.3 g/dL - 15.3g/dL	Within the normal range. Patient is not anemic.	No treatment was given
		White blood cell count	3.9 x 10^ /L	3.50-9.50 x 10^ /L	White blood cell within normal range. Patient do not have infection	No treatment was given
		Red blood cell count	4.9 x 12^ /L	3.8-5.10 12^ /L	Within the normal Range. Patient is not anaemic.	Absence of anemia. No treatment given

B. CAUSES OF PATIENT'S CONDITION

With reference to the literature review on the cause of inguino scrotal hernia, is caused by a combination of co-existence of certain factors, which may include congenital defects, a weaken muscle of the abdominal walls, intra-abdominal pressure as in constipation, lifting heavy objects with little precautionary measures and so on. Mr. A.A. D's had the acquired type which was brought about as a result of weaken at the inguinal canal coupled with intra-abdominal pressure caused by the lifting of heavy objects at the gym.

C. CLINICAL MANIFESTATIONS

TABLE 3: COMPARISON OF PATIENT'S CLINICAL FEATURES WITH THOSE IN THE LITERATURE REVIEW.

Clinical features in the literature review	**Clinical feature exhibited by Mr. A.A. D's**
1. Pain at the affected area	1. Patient experienced pain at the affected area
2. A feeling of pulling sensation which is relieved when hernia is reduced.	2. Patient experienced a feeling of pulling sensation which was relieved when hernia was reduced.
3. Sign and symptoms of bowel obstruction such as nausea, vomiting and abdominal distention may occur.	3. Patient did not experience signs and symptoms of obstruction such s nausea and vomiting.
4. Swelling of the hernia sac which is tense	4. Swell appears tense when touched.
5. Fever and chills.	5. Patient did not experience fever and chills.
6. Constipation	6. Patient did not experienced constipation.
7. Anxious facial expression	7. Patient exhibited anxious facial expression.
8. Pulse rate may be increased	8. Patient pulse rate did not increase.

With reference to the table above, patient presented most of the clinical manifestations as stated in the literature review.

D. TREATMENT

Treatment is the use of medications to treat and manage disease conditions (Weller, 2009).

Mr. A.A. D's had left inguino-scrotal hernia. Herniorraphy (Hernia Repair) was done under spinal anaesthesia and the patient recovered without post-operative complication.

The following are the drugs and infusion administered to Mr. A.A. D's

Pre-operative medication

1. Intravenous Amoxiclav 1.2g stat.
2. Intravenous Normal Saline 1L stat

Post-operative medication

1. Intramuscular pethidine 50mg qid x 24 hours
2. Intravenous Amoxiclav 1.2g bd x 24 hours.
3. Intravenous Paracetamol 1g tds x 24 hours
4. Intravenous 5% Dextrose 2L for 16 hours

Discharge medications

1. Tablet Doreta 37.5/325 mg tds x 5 days
2. Tablet Metronidazole 400mg tds x 5 days
3. Tablet Ciprofloxacin 500mg bd x 5 days
4. Tablet Diclofenac 50mg tds x 5 days

Table 4: Comparison of Medication given to Patient with Those in Literature Review

Treatment In The Literature Review	**Medication Given To Patient**
1. IV Fluids a. Ringers Lactate b. Dextrose saline c. Normal saline	**1.IV Fluids** a. Ringers Lactate was not given b. IV 5% Dextrose 2L for 16 hours was given c. Intravenous Normal Saline 1L stat was given.
2.ANALGESICS **a.** Pethidine b. Diclofenac c. Ibuprofen	**2. ANALGESICS** a. IM pethidine 50mg qid for 24 hours was given b. Diclofenac 50mg tds x 5 days was given. c. Ibuprofen was given.
3. ANTIBIOTICS a. Metronidazole b. Amoxiclav	**3. IV Fluids** a. Tablet Metronidazole 400mg tds x 5 days was given. b. Intravenous Amoxiclav 1.2g bd x 24 hours was given.
4. Oral iron tablet (folic acid)	4. Oral Iron tablet was not given
5. Herniotomy	5. Herniotomy was not done
6. Herniorrhaphy	6. Herniorrhaphy was done for patient
7. Hernioplasty	7. Hernioplasty was not done

From the above table, the treatments given to patient were in line with the literature. Analgesics like pethidine and diclofenac were given to patient since patient felt pain at the hernia site and incisional site. Antibiotics were also given to prevent infection after surgery.

TABLE 5: PHARMACOLOGY OF DRUGS GIVEN TO MR. A. A. D.

Date	**Drugs**	**Standard dosage/route of administration per literature**	**Dosage/route of administration To Patient**	**Classification**	**Desired effect observed**	**Actual action observed**	**Side effect/remarks**
21/11/21 and 22/11/21	Amoxicillin + Clavulanic Acid (Amoxiclav)	**Dosage:** Adult: **1.2**g-2.4g **Child:** 20mg-40mg/kg **Route**: IV, Oral	**Dosage:** 1.2g stat and 1.2g tid x 24 hours. **Route**: Intravenously	Antibiotic: beta lactase, antibiotic amino penicillin.	To inhibit enzyme (bata lactamase)	No sign of infection was observed.	Diarrhea, nausea, rash, but no side effect observed.
21/11/21	Normal saline	**Dosage**; Amount depends on patient's fluid and electrolyte level, age and as well as by doctor's prescription. **Route**: IV	**Dosage:** 1L stat. **Route:** Intravenously	Isotonic solution.	To correct fluid and electrolyte imbalance.	Patient's body fluids and electrolytes were maintained.	Oedema, over hydration, hypocalcemia. None of these side effects were observed.

TABLE 5: PHARMACOLOGY OF DRUGS GIVEN TO MR. A. A. D. cont.

Date	Drugs	Standard dosage/route of administration per literature	Dosage/route of administration To Patient	Classification	Desired effect observed	Actual action observed	Side effect/remarks
22/11/21	Pethidine	**Dosage:** **Acute pain:** 25 – 100mg every 4 hours. **Postoperative pain:** 25 – 100mg every 2-3 hours **Route:** Intramuscular and subcutaneous	**Dosage:** 50mg qid x24 hours **Route: IM**	Opoid analgesic. (Narcotic)	Relief pain, depressed pain, impulse transmission at the spinal cord level by interacting opioid receptors.	Patient was relieved of post-operative pain.	Pruritus, urticarial, sedation, dizziness, weakness none were observed with patient

TABLE 5: PHARMACOLOGY OF DRUGS GIVEN TO MR. A. A. D. cont.

Date	Drugs	Standard dosage/route of administration per literature	Dosage/route of administration To Patient	Classification	Desired effect observed	Actual action observed	Side effect/remarks
22/11/21	Paracetamol	**Dosage:** Oral: 0.5 to 1g every 4-6 hours, maximum dose is 4g. IV: 1g every 4 -6 hours over 15 minutes. **Route**: Oral, rectal and intravenous.	**Dosage:** 1g tid x 24 hours **Route**: Intravenously.	Analgesic / Antipyretic	To reduce pain and fever by preventing the releases of prostaglandins that increase pain and body temperature.	Patient had a reduction in pain and did not experience any increase in temperature	Malaise, skin reactions, Stevens-Johnson syndrome, Haematological reactions, allergic reactions and liver damage No side effects were observed.

TABLE 5: PHARMACOLOGY OF DRUGS GIVEN TO MR. A. A. D. cont.

Date	Drugs	Standard dosage/route of administration per literature	Dosage/route of administration To Patient	Classification	Desired effect observed	Actual action observed	Side effect/remarks
22/11/21	Intravenous 5% Dextrose	**Dosage:** Amount depends on patient's fluid and electrolyte level, age and as well as by doctor's prescription. **Route:** IV	**Dosage:** 2 L for 16 hours **Route**: Intravenously	Intravenous fluids (glucose)	Correct dehydration and fluid imbalance.	Patient was well hydrated, fluid and electrolyte maintained and energy restored.	Confusion, fluid overload, oedema, glucosuria. None was observed.
24/11/21	Metronidazole (Flagyl)	**Dosage** 400- 800mg three times daily.	**Dosage:** 400mg tds x 48 hours **Route:** Orally.	Antibacterial and antiprotozoan	Known to disrupt DNA and inhibit nucleic acid	Patient did not experience any signs of	Nausea, an unpleasant metallic taste, anorexia,

		Route Oral and IV.			synthesis. It is effective against dividing and non-dividing cells.	infection after surgery.	vomiting and diarrhoea. None of these side effects were observed.
24/11/21	Ciprofloxacin	**Dosage:** Adult: 500- 750 mg x bd Child:1month-18years 20mg/kg x bd **Route:** Oral and Intravenous	**Dosage:** 500mg bd x 5 days **Route**; Orally	Broad spectrum antibiotic (Quinolone)	They are bactericidal agent and act by interfering bacterial cell synthesis	Infection subsided as patient condition improved	Skin rash, dizziness, drowsiness and insomnia, stomach pains or discomfort, diarrhea, nausea and vomiting and No side effect was observed in patient

TABLE 5: PHARMACOLOGY OF DRUGS GIVEN TO MR. A. A. D. cont.

Date	Drugs	Standard dosage/route of administration per literature	Dosage/route of administration To Patient	Classification	Desired effect observed	Actual action observed	Side effect/remarks
24/11/21	Diclofenac	**Dosage** Adult: 50mg-100mg Paediatrics:2mg-3mg/kg **Route:** IM, oral, Rectal	**Dosage** 50mg tds x 5 days **Route:** Orally	Analgesic anti-inflammatory drug and anti-pyretic	To relieve fever, headache and bodily pain	Patient's post-operative pain was relieved.	Irritability, dizziness, headache, insomnia. None was observed with patient.
24/11/21	Doreta (Acetaminophen + Tramadol)	**Dosage:** Tramadol/paracetamol 37.5mg / 325mg. **Route:** Oral	**Dosage:** 37.5/325 mg tds x 5 days **Route:** Oral.	Combined analgesic	For relief of pain and headache.	Patient's post-operative pain was relieved.	Vomiting, constipation, flatulence, dry mouth. None was observed.

E. Complication

Due to the good management given to the patient, no complication as stated in the literature review was observed. He had successful operation and healing of wound by first intension. He was discharged in a very good condition.

2.2 Patient / Family Strengths

Patient and family's strength involve the activities that the patient can do for himself and what the family can do for the patient to help the health staff in the management of patient ailment to promote recovery Weller (2009).

Pre - Operative Strengths.

The following were, identified as patient/family's strength during pre-operative stage;

1. Patient could express his level of anxiety and was able to take simple instructions.
2. Patient could tolerate IV fluids set up pre operatively.
3. Patient was willing to know more about his condition.

Post- Operative Strengths.

1. Patient could describe his level of pain from 0-10 and had a good pain coping mechanism.
2. Patient kept wound dry and did not wet wound.
3. Patient could wash the face and eat without assistance.

2.3 Patient's Health Problems

Health problem is defined as state of inability to function normally (Snadden, 2006)

Pre-Operative Problems.

1. Patient had change in his eaten pattern to meet treatment regimen (NPO) (21st November, 2021)
2. Patient had inadequate information on hernia, risk factors, clinical features, management and care. (21st November, 2021).
3. Patient was anxious about impending surgery (22nd November, 2021).

Post- Operative Problems.

4. Patient complains of pain at the incisional site. (22nd November, 2021).
5. Patient had surgical incision (wound). (22nd November, 2021).
6. Patient could not perform daily activities (Bathing), (22nd November, 2021).

3.4 Nursing Diagnosis

This is the phase of the nursing care plan where the identified health problems are developed into prioritized diagnosis. The nurse through her education and experience is able to identify health problems and develop them into prioritized diagnosis and solve the health problems.

1. Risk of nutritional imbalance (less than body requirement) related to changes in patient's eaten pattern to meet treatment regimen (NPO) (21st November, 2021).
2. Knowledge deficit related to insufficient information on hernia, risk factors, clinical features, management and care. (21st November, 2021).
3. Anxiety related to unknown outcome of impending surgery. (22nd November, 2021).
4. Acute pain at the left iliac region related to surgical incision. (22nd November, 2021).

5. Risk for surgical wound infection related to presence of incisional wound. (22nd November, 2021).
6. Self-care deficit (partial) related to post-operative weakness. (22nd November, 2021).

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2014). This is the third phase in the nursing process which deals with setting of goals and objective/outcome criteria to meet the health needs of the patient. These objectives/outcome criteria are set in order of priority which can be long or short term. This is made possible based on the actual and potential problems identified.

3.1 Objective/ Outcome Criteria

1. Patient would maintain his nutritional status within the period of hospitalization as evidence by;

a. The nurse observing that patient has eaten about 2/3 of 600mls of wheat and milk served after surgery.

b. Patient tolerating all IV fluids set up

2. Patient would get an insight into his condition, its predisposing factors, causes, signs and symptoms, preventive measures as well as its management within 24 hours as evidenced by:

a. Nurse observing that patient able to answer questions on hernia correctly.

b. Patient's wife verbalizes some of the causes, predisposing factors, signs and symptoms, prevention as well as management of hernia.

3. Patient and family would be relieved from anxiety within 24 hours as evidenced by;

a. Patient and family verbalizing they are relieved from the anxiety.

b. The nurse visualizing that patient and family are showing a cheerful facial expression.

4. Patient would be relieved of pain within 48hours as evidenced by:

a. Patient verbalizing that his pain has subsided.

b. The nurse assessing and recording normal vital signs.

5. Patient wound would not get infected within the period of hospitalization as evidence by:

a. Wound healing with minimal scar tissue.

b. Nurse observing no purulent wound drainage.

6. Patient would be able to perform self-care activities within 48 hours as evidence by:

a. Patient demonstrating self-care activities like bathing, and grooming.

b. Nurse observing that patient is well groomed.

Table 6: Nursing Care Plan for Mr. A.A.D.

Date And Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date And Time**	**Evaluation**	**Sign**
21/11/21 at 6:30pm	Risk of nutritional imbalance (less than body requirement) related to changes in patient's eaten pattern to meet treatment regimen (NPO)	Patient would maintain his nutritional status within the period of hospitalization as evidence by a. The nurse observing that patient has eaten about 2/3 of 600mls of wheat and milk served after surgery. b. Patient tolerating all IV fluids set up.	1. Reassure patient. 2. Administer prescribed IV fluids. 3. Monitor IV fluids. 4. Observe client for circulation overload as a results of IV fluids administered. 5. Check vital signs. 6. Monitor intake and output.	1. Patient was reassured that the changes is for the betterment of his health. 2. Prescribed IV fluids were administered. 3. Client IV fluids was monitored using the Intake and output chat. 4. Client was observed carefully to avoid fluid overload. 5. Patient's vital signs such as temperature, pulse, respiration and BP was monitored and recorded. 6. Client intake and output was monitored and recorded.	24/11/21 at 3:30pm	Goal fully met as patient was able to eat about 2/3 of 600mls of wheat and milk served and patients tolerated all IVF set up.	D.P.

Table 6: Nursing Care Plan for Mr. A.A.D.

Date and Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	**Sign**
21/11/21 at 8:00pm	Knowledge deficit related to insufficient information about condition**.**	Patient would get an insight into his condition, its predisposing factors, causes, signs and symptoms, preventive measures as well as its management within 24 hours as evidenced by: a. Nurse observing that patient able to answer questions on hernia correctly. b. Patient verbalizes some of the causes, predisposing factors, signs and symptoms, prevention as well as management of hernia.	1. Reassure patient. 2. Assess patient's level of awareness of hernia. 3. Educate patient on hernia 4. Allow patient to ask questions on hernia and answer in simple language 5. Explain every procedure to be carried out and it rationale to patient.	1. Patient's mother was reassured that the disease can be treated and complications can be prevented from occurring. 2. Patient's level of awareness about the condition was assessed through questions. 3. Patient was educated on the causes, signs and symptoms, treatment and the prevention of hernia. 4. Patient was allowed to ask questions and answers were provided in clear simple terms in native language (Twi). 5. Every procedures and rationale were explained to the patient to enable patient	22/11/21 at 8:00pm	Goal fully met as a. Nurse observed that patient was able to answer questions on hernia correctly b. Patient's verbalized some of the causes, predisposing factors, signs and symptoms and prevention of hernia.	D.P.

			6. Educate patient on the need to adhere to treatment.	gain more knowledge on condition. 6. Patient was educated on the need to adhere to treatment.			

Table 6: Nursing Care Plan for Mr. A.A.D.

Date and Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date And Time**	**Evaluation**	**Sign**
22/11/21 at 08:30am	Anxiety related to unknown outcome of impending surgery.	Patient and family would be relieved from anxiety within 24 hours as evidenced by; A. Patient and family verbalizing they are relieved from the anxiety. B. The nurse visualizing that patient and family are showing a cheerful facial expression.	1. Reassure patient and relatives. 2. Explain the important of surgery to client and relatives. 3. Introduce other patients who have undergone the same surgery and are recovering well to the patient. 4. Engage patient in diversional therapy.	1. Patient and relatives were reassured that competent nursing staff will handle his condition so that no complication would arise after the surgery. 2. Patient and relatives were told that the surgery will help reduce the pain, eliminate the swelling, so that he could live his normal life. This helped them to gain more confidence in the health staff. 3. Other patient who was successfully recovering from herniorrhaphy was introduced to patients and was made to converse with them. 4. Patient was engaged in conversations which divert his attention.	23/11/21 08:30am	Goal fully met as Patient was relieved from anxiety, by verbalizing and had a cheerful facial expression.	D.P.

			5. Encourage the patient to express his fear and concerns. 6. Explain procedure to the patient.	5. Patient was encouraged to express his fear and concern. 6. Procedures concerning the surgery was explained to the patient which helped cleared patient preoccupied fears.			

Table 6: Nursing Care Plan for Mr. A.A.D.

Date and Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	**Sign**
22/11/21 at 2:30pm	Acute pain at the left iliac region related to surgical incision.	Patient would be relieved of pain within 48 hours as evidenced by: a. Patient verbalizing that his pain has subsided. b. The nurse assessing and recording normal vital signs.	1. Assess patient level of pain using a pain rating scale of 0-10. 2. Reassure patient that pain would subsides with available nursing interventions. 3. Provide patient with a comfortable bed and put patient in a semi fowler's position.	1. Patient pain was assessed on a pain rating scale of 0-10 and pain level was 4. 2. Patient was reassured that pain would subside with the available nursing intervention 3. Patient was provided with a comfortable bed and kept in a semi fowler's position.	24/11/21 at 2:30pm.	Goal fully met as patient verbalized that his pain has subsided and the nurse assessed and recorded normal vital signs.	D.P.

			4. Employ diversional therapy such viewing favourite pictures and conversion with patient. 5. Apply cold compresses on the abdomen. 6. Administer prescribed analgesics.	4. Diversional therapy such as viewing favourite pictures and conversing with the patient was employed. 5. Cold compresses was provided with a wrapped ice to help relieve patient of pain. 6. Pain medications such as IM pethidine 50mg administered to help relieve patient of incisional pain.			

Table 6: Nursing Care Plan for Mr. A.A.D.

Date and Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	**Sign**
22/11/21 at 3:00pm	Risk for surgical wound infection related to presence of incisional wound.	Patient's wound would not get infected within the period of hospitalization as evidence by patient having an intact skin looking at the incisional site.	1. Reassure patient and relatives. 2. Educate patient on factors that delay wound healing.	1. Patient and relatives were reassured that the incisional wound would heal with time. 2. Patient was educated on factors that delay wound healing process, by not wetting the site with water, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material.	24/11/21 at 3:00pm	Goal fully met as patient's wound was not infected and had an intact skin looking at the incisional site.	D.P.

			3. Assist patient to position well. 4. Dress wound aseptically. 5. Encourage client to eat high protein diet and food rich in vitamins. 6. Serve all prescribed antibiotics.	3. Patient was assisted to assume the supine position in order to observe the incisional site 4. Incisional wound was dressed aseptically to prevent any infection. 5. Patient was encouraged to eat high protein foods like beans and vitamin foods like kontomire, orange. 6. Patient was served prescribed IV Amoxiclav 1.2g.			

Table 6: Nursing Care Plan for Mr. A.A.D.

Date and Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	**Sign**
22/11/21 at 3:10pm	Self-care deficit (partial) related to post-operative weakness.	Patient will be able to perform self-care activities within 48 hours as evidenced by 1. Patient demonstrating self-care activities like bathing and grooming. 2. Nurse observing that patient is well groomed.	1. Reassure patient that he will be assisted to perform his self-care activities like bathing and grooming. 2. Provide bedpan and urinal closer to bedside. 3. Assist patient to clean the mouth twice daily.	1. Patient was reassured that he will be assisted to perform his self-care activities. 2. Bedpan and urinal was put closer to bed side. 3. Patient was assisted to clean mouth in the morning and night.	24/11/21 at 3:10pm	Goal fully met as a. Patient demonstrated self-care activities like bathing and grooming. b. Nurse observed that patient is well groomed.	D.A

			4.Care for patient hand and feet and treat for pressure areas 5. Arrange needed items within easy reach of patient. 6. Assist patient to perform range of motion exercise and avoid touching wound to promote wound healing.	4. Care of hands and feet done and pressure areas were treated 5. Patients items was arranged within easy reach so that he could reach to them easily. 6. Patient was assisted to perform range of motion exercise.			

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

The implementation phase of the nursing process involves carrying out the proposed plan of nursing care. The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, other members of the nursing team, and other members of the health care team, so that the schedule of activities facilitates the patient's recovery (Hinkle & Cheever, 2014).

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

The actual nursing care rendered to patient and his family started on the day of admission, 21st November, 2021 to the time care was terminated. The management of patient and his family was planned to meet their physiological, emotional, spiritual and physical needs.

First Day of Admission (21st November, 2021)

Mr. A A. D was admitted into the Male Surgical ward accompanied by his wife and an Apostle of his church in a conscious and ambulatory state, through the Out Patient Department of the Sunyani Regina Hospital, Sunyani on the 21st of November, 2021 at 5:30pm with the diagnosis of left inguino scrotal hernia scheduled for surgery on 22nd November 2021 by Dr. M. Z. The patient and his Wife and the Apostle were welcomed and was offered a seat. He was put in an admission bed; patient looked anxious. He was reassured to allay fears and anxiety.

Patient was made comfortable in bed and his vital signs were checked and recorded accurately as follows;

- Temperature - 36.4^{o}C
- Pulse - 63 beats per minute

- Respiration - 18 cycles per minute
- Blood pressure - 121/71 mmHg

Patient's weight was 65 kg on admission.

Physical examination was performed on the patient from head to toe and no abnormalities were seen. Patient was to be prepared for surgery the next day. Preoperative preparations begun and client signed his consent form in the presence of the surgeon.

Patient was oriented to time, place and person. He was also oriented to the ward annexes.

He was introduced to the staffs present and was assured of the competency of the healthcare team. His particulars such as name, sex, age, and residential address were recorded in the admission and discharge book and the daily ward state. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained.

Patient and family were told the rules and regulations including visiting hours and meal time. He was asked to get his own bowl, spoon, drinking cup, bathing sponge, bucket, towel, pyjamas and other toiletries. Patient was then introduced to the other patients who were on the ward.

Patient was to undertake full blood count. Therefore, an IV cannula was secured and blood sample was taken for the test. Patient was informed about NPO as he would not be allowed to eat again after supper until the surgery is over.

I reintroduced myself to patient as a final year student nurse of the Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my care study. Mr. A A D and his wife and Apostle were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of Licence to practice as a Registered General Nursing. I explained to the patient and his wife the concept of the patient/family care study and assured them of privacy and confidentiality.

It was added that a report will be written after the entire event. Mr. A.A D. and his wife and Apostle agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the relative thus they will continue the care at home once he is well. I decided to choose the patient for my case study because I wanted to gain more knowledge about the condition.

At 6:30pm, Patient was placed on nil per os and therefore had a change in his eaten pattern to meet treatment regimen. A nursing diagnosis of Risk of nutritional imbalance (less than body requirement) related to changes in patient's eaten pattern to meet treatment regimen (NPO). Objectives were set to help patient maintain his nutritional status within the period of hospitalization. Interventions carried out were; Patient was reassured that the changes is for the betterment of his health. Prescribed IV fluids were administered. Client IV fluids was monitored using the Intake and output chat. Client was observed carefully to avoid fluid overload. Patient's vital signs such as temperature, pulse, respiration and BP was monitored and recorded. Client monitor intake and output was checked and monitored by measuring patient's fluids and liquid diet and output as well.

At 8:00pm, interactions with patients and his family revealed that patient had inadequate information on hernia, risk factors, clinical features, management and care. Knowledge deficit related to insufficient information about condition was the nursing diagnosis stated. Goal was set to enable patient gain an insight into his condition, its predisposing factors, causes, signs and symptoms, preventive measures as well as its management within 24 hours. Nursing interventions carried out to tackle this problem includes; Patient's mother was reassured that the disease can be treated and complications can be prevented from occurring. Patient's level of awareness about the condition was assessed through questions. Patient was educated on the

causes, signs and symptoms, treatment and the prevention of hernia. Patient was allowed to ask questions and answers were provided in clear simple terms in native language (Twi). Every procedures and rationale were explained to the patient to enable patient gain more knowledge on condition. Patient was educated on the need to adhere to treatment.

At 10:00pm vital signs were checked and recorded as temperature-36.1C, pulse-68bpm, respiration-21cpm, blood pressure 120/60mmHg. Patient was allowed to rest and at 10:45pm patient went to bed.

Second Day of Admission/ Day of Surgery (22nd November, 2021)

Mr. A. A. D. woke up around 4:50am, he performed his personal hygiene and went back to lie on his bed. At 6:00am, routine vital signs were checked accordingly and recorded.

The vital signs were recorded as follows:

Temperature –36.0^0C

Pulse – 62bpm

Respiration – 16cpm

Blood pressure – 110/70 mmHg

During the ward rounds at 8:00am, the medical officer attended to Mr. A.A.D. and plan was to prepare him for herniorrhaphy, IVF 1L Ringers lactate set up.

Interactions with patient indicated patient was anxious about impending surgery. A nursing diagnosis of anxiety related to unknown outcome of impending surgery was formulated at 8:30am. Patient and family would be relieved from anxiety within 24 hours was the objective set.

Interventions carried out to relief patient on anxiety includes; Patient and relatives were reassured that competent nursing staff will handle his condition so that no complication would arise after the surgery. Patient and relatives were told that the surgery will help reduce the pain, eliminate the swelling, so that he could live his normal life. This helped them to gain more confidence in the health staff. Other patient who was successfully recovering from herniorrhaphy was introduced to patients and was made to converse with them. Patient was engaged in conversations which divert his attention. Patient was encouraged to express his fear and concern. Procedures concerning the surgery was explained to the patient which helped cleared patient preoccupied fears.

Final preoperative preparation for the surgery.

A hair to toe examination was conducted on patient to assess the physical health of the patient. Baseline vital signs before surgery was checked and recorded as vital signs were checked and recorded as Temperature –36.0^{0}C, Pulse – 72bpm, Respiration – 21cpm, Blood pressure – 110/80 mmHg. Patient had been put on nil per os since morning and was on IV fluids which were continuously administered and monitored due to the anticipated surgery. Patient was encouraged to empty the bladder and bowel before surgery to help minimize risk of injury and complications during and after surgery. Patient was educated on deep breathing and coughing exercises to prevent chest complications after surgery as well as active and passive exercises of limbs to prevent postoperative deep vein thrombosis. He was then assisted to change into hospital gown. Surgical site was assessed for any skin abnormalities such as rash, keloid, scar or incision of a previous operation, neatly prepared and draped. Patient was educated to remove all jewelleries. Patient's wrist band was labelled with his name, diagnosis and type of surgery. Patient was taken to the theatre at 9:25am.

Immediate post-operative care

Before the return of Mr. A.A D. from the theatre, the following items were assembled: operation bed, anaesthetic tray (swab- holding forceps, dissecting forceps and a tongue spatula), oxygen cylinder and a suction machine, pulse oximeter, vomiting bowl, mouth care tray, vital signs tray screen, infusion stand, sphygmomanometer.

Mr. A.A D was received from the theatre successfully at the male surgical ward at 2:10pm on a stretcher. He was received in a semi- conscious state as he was sedated during the surgery with an intravenous infusion (normal saline) running. He was put to bed in a dorsal recumbent position and the infusion hanged on the infusion stand. The amount of infusion running was noted and then the flow rate was adjusted as ordered. His vital signs (Temperature, Pulse, Respiration and blood pressure) were checked every 15minute for one hour, 30 minutes for other hours till condition is stable. Vital signs were recorded in appendix. The incisional site was inspected for any bleeding. The following orders were given for his postoperative management:

Post-operative medication

5. Intramuscular pethidine 50mg qid x 24 hours
6. Intravenous Amoxiclav 1.2g bd x 24 hours.
7. Intravenous Paracetamol 1g tds x 24 hours
8. Intravenous 5% Dextrose 2L for 16 hours

At 2:30pm, patient complained of pain at the incision site. He was therefore placed in a lateral position, incisional site observed for tight adhesions, the cause of pain was explained to him. A nursing diagnosis of acute pain at the left iliac region related to surgical incision. An objective was set to relief patient of pain within 48 hours. Nursing interventions include: Patient pain was assessed on a pain rating scale of 0-10 and pain level was 4. Patient was reassured that pain

would subside with the available nursing intervention. Patient was provided with a comfortable bed and kept in a semi fowler's position. Diversional therapy such as viewing favourite pictures and conversing with the patient was employed. Cold compresses was provided with a wrapped ice to help relieve patient of pain. Pain medications such as IM pethidine 50mg administered to help relieve patient of incisional pain.

At 3:00pm, due to patient's surgical incision (wound), it was observed that patient is at risk for infection. A nursing diagnosis of risk for surgical wound infection related to presence of incisional wound was made. Patient wound would not get infected within the period of hospitalization was the set. Nursing interventions implemented include; Patient and relatives were reassured that the incisional wound would heal with time. Patient was educated on factors that delay wound healing process, by not wetting the site with water, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material. Patient was assisted to assume the supine position in order to observe the incisional site. Incisional wound was dressed aseptically to prevent any infection. Patient was encouraged to eat high protein foods like beans and vitamin foods like kontomire, orange. Patient was served prescribed IV Amoxiclav 1.2g.

At 3:10pm, it was realized that patient would not be able to perform daily activities such as bathing. A nursing diagnosis of self-care deficit (partial) related to post-operative weakness. An objectives was set to help patient be able to perform self-care activities within 48 hours. Nursing interventions implemented include; Patient was reassured that he will be assisted to perform his self-care activities. Bedpan and urinal was put closer to bed side. Patient was assisted to clean mouth in the morning and night. Care of hands and feet done and pressure areas were treated

Patient's items was arranged within easy reach so that he could reach to them easily. Patient was assisted to perform range of motion exercise.

At 6:00pm, his infusion got finished and 500mls dextrose was put in situ as prescribed. A calm environment was also ensured.

At 8:00pm upon interaction with patient it was realized that patient has gained adequate knowledge. The goal set was fully met as nurse observed that patient was able to answer questions on hernia correctly and patient's verbalized some of the causes, predisposing factors, signs and symptoms and prevention of hernia.

At 10 pm, vital signs were checked and recorded as Temperature - 36.4^{o}c, pulse - 78bpm, Respiration - 20cpm Blood pressure- 120/70mmHg. Patient was made comfortable in bed and allow to have enough rest.

Due medications were served and the necessary documentations were made. Patient went to bed at 9:30pm.

Third Day of Admission/First Day Post-Operative (23rd November, 2021).

Patient woke up at 4:50am and the night nurse narrated that the patient had a sound sleep the previous night.

At 6:00am, his vital signs were checked and recorded as follows:

Temperature 36.5ºC

Pulse: 72bpm

Respiration: 20cpm

Blood pressure: 120/70mmHg.

Intramuscular pethidine 50mg, Intravenous Amoxiclav 1.2g and Intravenous Paracetamol 1g were administered. Patient was relieved on nil per os and was encouraged to take light food.
At 8:30am, evaluation was made for the objective set to help relieve patient of anxiety. Goal was fully met as patient verbalized he was less anxious at the theatre before the surgery was conducted yesterday.

At 9:05am, the doctor and other health care team members conducted a ward rounds. During the ward rounds, his incision site was inspected and site was clean and dry. His infusion was also ordered to be discontinued. It was also concluded that patient could start taking sips of oral fluids. Patient enquired about his discharge and the doctor encouraged him to be calm as he wanted to observe him for the day and discharge him the following day if condition remains stable.

He was educated on the need to avoid strenuous exercise that would exert pressure on the site with hands or pillow when coughing, sneezing, straining or changing position. After the ward rounds, patient took a cup of tea [Lipton] for breakfast.

At 10:00 am routine vital signs were checked and recorded as shown in the appendix.

Intramuscular pethidine 50mg was given to patient at 12:00pm.

Patient was informed that I will be visiting their home that very day while he is still on admission; my purpose of going was told and direction was given to his house. He also gave me his wife's number to call when I am approaching the location he gave.

At 2pm, In the afternoon, his vital signs were checked and recorded as temperature 36.6 ^{o}c, pulse 70bpm, respiration18cpm, blood pressure 110/70mmHg. Intravenous Paracetamol 1g was administered. Thereafter, he took light soup as lunch. He was then engaged in a series of conversations concerning his health and social life. Patient was assisted in the performance of activities of daily living such as hands and feet care. All needed items were also positioned within easy reach to avoid undue body stresses. He was allowed to perform activities according to his strength. He was also advised to take in adequate oral fluid to prevent constipation. He was further told to perform minor range of exercise in bed to prevent constipation and also promote wound healing; he was also encouraged to defecate whenever the urge is felt and to take in high fibre diet such as oranges and pineapple etc.

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

Intramuscular pethidine 50mg and the last dose of Intravenous Amoxiclav 1.2g was administered and recorded as shown in appendix. Patient was seen engaged in a conversation with other patients at the cubicle.

The last dose of Intravenous Paracetamol 1g was administered at 10pm and his routine vital signs recorded as; Temperature –37.0^{0}C, Pulse – 84bpm, Respiration – 23cpm, Blood pressure – 110/70 mmHg. Patient was recessed to bed at 10:40pm.

Day of Discharge/Post-Operative Day Two (24th November, 2021).

Patient had an uninterrupted sleep during the night according to night staff and woke up at 5:00am. He performed his oral hygiene, emptied his bowl and took his bath.

His vital signs checked and recorded as; Temperature - 36.1^{o}c, pulse - 81bpm, Respiration - 20cpm Blood pressure- 110/70mmHg.

He was later reviewed at 9am to resume normal diet. During routine ward rounds, patient was to be discharged since his condition was stable and he had no complains. Discharged medications included; Tablet Doreta 37.5/325 mg tds x 5 days, Tablet Metronidazole 400mg tds x 5 days, Tablet Ciprofloxacin 500mg bd x 5 days and Tablet Diclofenac 50mg tds x 5 days.
Patient was asked to come for review in two weeks' time (8th December 2021).

Patient was informed and the bills were assessed to be paid. He told us we have to wait for her wife to return to settle the bills as the wife had just left the hospital to the house to prepare food.

Patient was educated on his drugs, the need to eat food containing high fibre like whole grains, the entire essential food nutrients, for example protein, vitamins and irons, as well as maintaining good personal hygiene and the need for follow ups and regular check-ups. Patient was also educated on the need to stop treating minor signs and symptoms such as diarrhoea, constipation, headaches and common cold with traditional medicine and over the counter medications. The need to continue with medications and review date were emphasized.

Patient's wife arrived around 2pm and was told to go to the accounts department and settle their bills for discharge. Patient took jollof rice with egg prepared by his wife as launch.

At 2:30pm, evaluation was made for the objective set on the 22nd November to help relief patient of pain within 48 hours. Goal was fully met as patient verbalized that his pain has subsided and the nurse assessed and recorded normal vital signs.

At 3:00pm, the goal set to protect patient's wound from being infected was evaluated and goal was fully met as patient's wound was not infected and had an intact skin looking at the incisional site.

At 3:10pm, evaluation for the objective set to enable patient gain strength to perform self-care activities within 48 hours was made. Goal was fully met as patient demonstrated self-care activities like bathing and grooming and nurse observed that patient is well groomed.

Because patient was on NPOs for most of his stay at the hospital, an objectives was made to maintain his nutritional status within the period of hospitalization. The goal was evaluated at 3:30pm and goal fully met as patient was able to eat about 2/3 of 600mls of wheat and milk served and patients tolerated all IVF set up.

They were helped to pack their belongings. Bed linens were removed, the mattress and pillow were as well disinfected. Patient and the wife bade the ward inmates and staff goodbye. I accompanied them to the hospital taxi rank. The discharge procedure was documented in the admission and discharge book and in the daily ward state as well as in the nurse's notes.

4.1 Preparation of Patient and Family for Discharge and Rehabilitation

Preparation of patient/family for discharge started on the day of admission when they were told that the hospital is a temporal place for them and that they will be discharged if patient health is restored. The aim was to make them comfortable and understand that the hospital was a temporary place for health care and patient would be discharged home to continue treatment when his condition improves. Patient and his wife were once again educated on the risk factors, signs and symptoms, treatment, possible complications and prevention of hernia. They were educated on the need for good personal hygiene and good nutrition. Patient and his wife were advised on the importance of review and to keep to the said date (08/12/21) and also to report promptly to the hospital for proper management if any change occurs in patient's condition before the review date.

4.3 Follow Up/Home Visit/Continuity of Care

A home visit is a visit to the home of the patient with the aim of promoting health through education and assessment of health status. It is carried out before and after discharge. The reasons for this visit is to help assess the nature of patient and family's home/community and the people in the home/community to determine people at risk (vulnerable) to diseases. It also helps patient's family to be educated on any unhealthy living and factors that will be identified. State of patient and family's health are assessed and documented.

First Home Visit (23rd November, 2022).

My first home visit was made on the 23rd November, 2021 while patient was on admission. A planned visit was made to Adjei Darko in Sunyani in the Bono region where my patient resides. He resides in the mission house of the church. The purpose of this visit was to know my patient's residence and the environment in which he lives, verify the information given to me as well as to identify the risk factors such as familial tendency and lifting heavy weights that can lead to his condition. To enable me know patients nearest health facility for possible referral and validation of patient data. Patient and wife were informed about my intention to visit their home whiles he was still on admission on. He also gave me one of his elder's number to call when I am approaching the location he gave. I left the Regional Hospital around 9:00am and alighted at Adjei Darko exactly 9:30pm. The patient's house was directly opposite to a Weldering shop on the Sunyani – Techiman Road with number BF0087. When we arrived at the house, patient's children were all around and they were happy to see us. Mr. A. A. D.'s house is a mission house and even though he is the current occupant of the house he cannot say he is the owner of the house. The house is self -contained with four bedrooms, with a toilet and bath separately in the

house. The master bed room has an inbuilt toilet and bath. There is a kitchen in the house as well. The house is built with cement blocks, and decorated with terrazzo tiles. The whole house is fully wired with electricity power, had glass made windows. I educated on the need to open the windows to promote proper ventilation since the whole area is enclosed. They have a dustbin with a well-fitting lid in which they dump their waste materials and it is emptied every morning to the community refuse disposal site. The pipe borne water in the house is from the Ghana Water Company is which the source of water for the entire house. The environment was well swept and clean. The patient lives in the house with his wife, children and an elder of the church. In total they were seven people staying in the house. Observations made in the room revealed well-furnished wall with television set, sound system a standing fan, bed, couch and a wooden centre table. I also had the opportunity to enter their room and it was very neat and well organized and they were applauded for that.

I also entered the toilet and saw that it is a water closet. The place was clean, with the container for toilet papers emptied. Mr. A. A. D.'s children was educated on the need to practice good environmental and personal health and also encouraged them to continue to keep their home and surroundings clean. I reassured Mr. A. A. D.'s children of competent nursing care and that he will be well very soon. They thanked me and assured me that they will ensure that all what I said will be done before I come for my next home visit. I left Adjei Darko at 11:30am and got to the hospital at 12:10pm. Comments made on the condition of the house, education and recommendations were repeated to Mr. A. A. D.'s and he also promised to do everything in his power to ensure that all the recommendations are done. Information given to me by patient and father were similar to what the mother told me when I went to the house.

Second Home Visit (28th November, 2021)

My second home visit took place on 28th November, 2021, four days after my patient was discharged to find out the health status of patient and to remind them of review date. I left pastoral centre at around 3:00pm and boarded a car on the road side to Adjei Darko. At 3:40pm when I got to the area I went straight to his house. On arrival at patient's house he warmly welcomed me and offered me a seat after exchange of pleasantries with patient and family. Enquiry was made of any new complaint and general health of Mr. A.D.D and the family. There were no complaints as he looked very active and cheerful. Patient was asked about his state of his wound and asked for permission to assess the wound. On assessment, the wound looked clean with no discharges or odour. Enquires were made about the discharge medications and I was told he was taking them as prescribed. He was encouraged to continue taking his medications and also to report to the hospital if he notices anything unusual before the review date. I further stressed on the importance of good nutrition, the need to eat more fruits and vegetables and also the importance of maintaining environmental and personal hygiene.

They were reminded of the review date which was 8th December, 20121. After having some chats on Mr. A.D.D's condition, permission was sought to leave. At 5:00pm, Patient escorted me to the road side where I bordered a taxi and came back to pastoral centre.

Review (8th December 2021).

Mr. A. A. D. came to the Out Patient Department of the Sunyani Regina Hospital, Sunyani for review on 8th December 2021 around 8:00am. I went with him to retrieve his folder from the records. Upon my interaction with patient, it was observed that his condition had really

improved. His vital signs were checked and were within normal range thus, Temperature: 36.4^{o}C, Respiration: 19cpm, Pulse: 74bpm and blood pressure: 120/80 mmHg

Patient was escorted to the consulting room of the surgical out-patient department and upon assessment by the doctor he confirmed the condition had improved and that his wound should be dressed and stitches removed. When patient came out I escorted him to the dressing room for his wound to be dressed and stitches removed. After he thanked me, I bade him goodbye and he took a taxi home at around 11:00am.

Third Home Visit (10th December, 2021)

The main reason for conducting the third home visit were to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care.

On the said date, I set off early around 8:00am with a taxi. I got to patient's house around 8:35am. Patient and family were doing well as they looked cheerful and had no complains. The environment was tidy as there were no rubbish nor stagnant water around. I thanked them for their support and co-operation throughout the interaction. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication. I asked about patient's drugs and it was found that he had been taking his medications and that it is finished, the recommended foods had also been adhered to. After interacting with patient and family for a while, I reemphasized on health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I terminated my care by handing them over to the community health nurse at the clinic at Adjei Darko and thanked them for their cooperation. I handed over patient to the community health nurse for continuity of care but encouraged them to report to the Regional Hospital in case of any emergency. Again patient and his family expressed their gratitude by showing how grateful they

were to me for the support and care given to them. I eventually sought permission to leave and bid them the final farewell.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process, (Smeltzer, Bare, Hinkle & Cheever, 2010). The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to my patient and family.

5.1 Statement of Evaluation.

Throughout the period of admission, six health problems were recorded and objectives were set to solve them. Below is the summary of the interventions carried out and to what extent the goals were met.

1. **Patient maintained his nutritional status within the period of hospitalization**

On 21st November, 2021 at 6:30pm, Patient was placed on nil per os and therefore had a change in his eaten pattern to meet treatment regimen. A nursing diagnosis of Risk of nutritional imbalance (less than body requirement) related to changes in patient's eaten pattern to meet treatment regimen (NPO). Objectives were set to help patient maintain his nutritional status within the period of hospitalization. Interventions carried out were; Patient was reassured that the changes is for the betterment of his health. Prescribed IV fluids were administered. Client IV fluids was monitored using the Intake and output chat. Client was observed carefully to avoid fluid overload. Patient's vital signs such as temperature, pulse, respiration and BP was monitored

and recorded. Client monitor intake and output was checked and monitored by measuring patient's fluids and liquid diet and output as well.

On 24th November 2021, the goal was evaluated at 3:30pm and goal fully met as patient was able to eat about 2/3 of 600mls of wheat and milk served and patients tolerated all IVF set up.

Patient gained an insight into his condition, its predisposing factors, causes, signs and symptoms, preventive measures as well as its management within 24 hours.

On 21st November, 2021 at 8:00pm Interactions with patients and his family revealed that patient had inadequate information on hernia; risk factors, clinical features, management and care. Knowledge deficit related to insufficient information about condition was the nursing diagnosis stated. Goal was set to enable patient gain an insight into his condition, its predisposing factors, causes, signs and symptoms, preventive measures as well as its management within 24 hours. Nursing interventions carried out to tackle this problem includes; Patient's mother was reassured that the disease can be treated and complications can be prevented from occurring. Patient's level of awareness about the condition was assessed through questions. Patient was educated on the causes, signs and symptoms, treatment and the prevention of hernia. Patient was allowed to ask questions and answers were provided in clear simple terms in native language (Twi). Every procedures and rationale were explained to the patient to enable patient gain more knowledge on condition. Patient was educated on the need to adhere to treatment.

At 8:00pm on 22nd November 2021, interaction with patient revealed that patient has gained adequate knowledge. The goal set was fully met as patient was able to answer questions on hernia correctly and patient verbalized some of the causes, predisposing factors, signs and symptoms and prevention of hernia.

2. **Patient and family were relieved from anxiety within 24 hours.**

On 22nd November 2021 Interactions with patient indicated patient was anxious about impending surgery. A nursing diagnosis of anxiety related to unknown outcome of impending surgery was formulated at 8:30am. Patient and family would be relieved from anxiety within 24 hours was the objective set. Interventions carried out to relief patient off anxiety includes; Patient and relatives were reassured that competent nursing staff will handle his condition so that no complication would arise after the surgery. Patient and relatives were told that the surgery will help reduce the pain, eliminate the swelling, so that he could live his normal life. This helped them to gain more confidence in the health staff. Other patients who were successfully recovering from herniorrhaphy were introduced to patients and was made to converse with them. This helped to allay his fears. Patient was engaged in conversations which divert his attention. Patient was encouraged to express his fear and concern. Procedures concerning the surgery were explained to the patient which helped cleared patient preoccupied fears.

On 23rd November, 2021 at 8:30am evaluation was made for the objective set to help relieve patient of anxiety. Goal was fully met as patient verbalized he was less anxious at the theatre before the surgery was conducted yesterday.

3. **Patient was relieved of pain within 48 hours.**

On 22nd November, 2021 at 2:30pm patient complained of pain at the incision site. He was therefore placed in a lateral position, incisional site observed for tight adhesions, the cause of pain was explained to him. A nursing diagnosis of acute pain at the left iliac region related to surgical incision was made. An objective was set to relief patient of pain within 48 hours. Nursing interventions include: Patient pain was assessed on a pain rating scale of 0-10. Patient

was reassured that pain would subside with the available nursing intervention. Patient was provided with a comfortable bed and kept in a semi fowler's position. Diversional therapy such as pictures and conversing with the patient was employed. Pain medications such as IM pethidine 50mg administered.

On 24th November 2021 at 2:30pm evaluation was made for the objective set on the 22nd November to help relief patient of pain within 48 hours. Goal was fully met as patient verbalized that his pain has subsided and the nurse assessed and recorded normal vital signs.

4. **Patient's wound was protected from infection within the period of hospitalization.**

On 22nd November, 2021 around 3:00pm, due to patient's surgical incision (wound), it was observed that patient was at risk for infection. A nursing diagnosis of risk for surgical wound infection related to presence of incisional wound was made. Patient wound would not get infected within the period of hospitalization was set. Nursing interventions implemented include; Patient and relatives were reassured that the incisional wound would heal with time. Patient was educated on factors that delay wound healing process, by not wetting the site with water, not to be touching the incisional site with hand and not cover the incisional site with any unsterile material. Patient was assisted to assume the supine position in order to observe the incisional site. Incisional wound was dressed aseptically. This was done to promote the healing process of the wound. Patient was encouraged to eat high protein foods like beans and vitamin foods like kontomire, orange. Patient was served prescribed IV Amoxiclav 1.2g.

On 24th November, 2021 at 3:00pm, the goal set to protect patient's wound from being infected was evaluated and goal was fully met as patient's wound was not infected and had an intact skin looking at the incisional site.

5. **Patient was able to perform self-care activities within 48 hours.**

On 22nd November 2021 at 3:10pm it was realized that patient was not able to perform daily activities such as bathing. A nursing diagnosis of self-care deficit (partial) related to post-operative weakness was made. An objective was set to help patient to perform self-care activities within 48 hours. Nursing interventions implemented include; Patient was reassured that he will be assisted to perform his self-care activities. Bedpan and urinal was put closer to bed side. Patient was assisted to clean mouth. Care of hands and feet done and pressure areas were treated. Patient's items were arranged within easy reach. Patient was assisted to perform range of motion exercise.

On 24th November 2021 at 3:10pm, evaluation for the objective set to enable patient gain strength to perform self-care activities within 48 hours was made. Goal was fully met as patient demonstrated self-care activities like bathing and grooming and nurse observed that patient is well groomed.

5.2 Amendment of Care Plan

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

5.3 Termination of Care.

On 10th December, 2021 I set off early around 8:00am with a taxi to patient's house for my final home visit. I got to patient's house around 8:35am. Patient and family were doing well as they looked cheerful and had no complains. The environment was tidy as there were no rubbish nor

stagnant water around. I thanked them for their support and co-operation throughout the interaction. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication. I asked about patient's drugs and it was found that he had been taking his medications and that it was finished, the recommended foods had also been adhered to. After interacting with patient and family for a while, I reemphasized on health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I terminated my care and handed them over to the community health nurse at the clinic at Adjei Darko and thanked them for their cooperation. I handed over patient to the community health nurse for continuity of care but encouraged them to report to the Regional Hospital in case of any emergency.

Again, patient and his family expressed their gratitude by showing how grateful they were to me for the support and care given to them. I eventually sought permission to leave and bid them the final farewell.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

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

6.1 Summary

Mr. A. A. D. the subject for the study is a 38-year-old Ghanaian, born on 20th June, 1983 to Mr. A. N and Mrs. Y.C. He lives at Agyei Darko in Sunyani with the house number BF0087.

Mr. A A. D was admitted into the Male Surgical ward accompanied by his wife and an Apostle of his church in a conscious and ambulatory state, through the Out Patient Department of the Sunyani Regina Hospital, Sunyani on the 21st of November, 2021 at 5:30pm with the diagnosis of left inguino scrotal hernia scheduled for surgery on 22nd November 2021 by Dr. M. Z.

On admission, he looked anxious. He was put in an admission bed. He was reassured to allay fears and anxiety.

Patient was made comfortable in bed and his vital signs were checked and recorded.

Patient was educated on hernia and its management. Patient was also assisted in maintaining his personal hygiene, rest and sleep, nutrition, and exercises were also ensured. Throughout the stay patient was diagnosed with six (6) health problems. Objectives were set and interventions carried out to address all these problems.

The following are the drugs and infusion administered to Mr. A.A. D's throughout his stay at the hospital.

Pre-operative medication

4. Intravenous Amoxiclav 1.2g stat.
5. Intravenous Normal Saline 1L stat

Post-operative medication

9. Intramuscular pethidine 50mg qid x 24 hours
10. Intravenous Amoxiclav 1.2g bd x 24 hours.
11. Intravenous Paracetamol 1g tds x 24 hours
12. Intravenous 5% Dextrose 2L for 16 hours

Discharge medications

5. Tablet Doreta 37.5/325 mg tds x 5 days
6. Tablet Metronidazole 400mg tds x 5 days
7. Tablet Ciprofloxacin 500mg bd x 5 days
8. Tablet Diclofenac 50mg tds x 5 days

On 22nd November 2021, final preoperative preparation for the surgery was done and patient was sent to the theatre for herniorrhaphy. Mr. A.A D was received from the theatre successfully at the male surgical ward at 2:10pm on a stretcher. He was received in a semi- conscious state as he was sedated during the surgery.

During routine ward rounds on 24th November 2021, patient was to be discharged since his condition was stable and he had no complains. Patient was asked to come for review in a week time (8th December 2021). Patient reported on the said date for review as scheduled. It was to find out if patient was adhering to the advice and all the education given to improve his health and standard of living. Three home visits were embarked on. The first home visit was done while patient was still on admission on 23rd November, 2021, second home visit was on the 28th

November, 2021 and third home visit was on the 10th December, 2021. The care of Mr. A.A.D. and his family were terminated on the 10th December, 2021, during the third home visit when patient had fully recovered.

6.2 Conclusion

The study has equipped me with knowledge on how to care for a patient as an individual. Through this study, I have been able to put into practice actual and holistic nursing care as has been learnt theoretically. The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (family) relationship as well as broadened my knowledge on hernia, prevention, management and treatment.

It has also helped me to practice my skills acquired in the classroom theoretically. It has deepened my relationship with patients, families and the people in a given community as a whole.

It is my recommendation that all students are given the opportunity to embark on the patient/family care study to implement the nursing process in order to render individualized comprehensive care to patients/families. In brief, I really enjoyed every bit of writing this script despite the challenges encountered.

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Patient folder number: 007319/18 Bono Regional Hospital, Sunyani.

APPENDIX

Table 7: Vital signs of Mr. A. D. D.

Date	Time	Temperature (^{0}C)	Pulse (Bpm)	Respiration (Cpm)	Blood pressure (mmHg)
21/11/2021	10:30am	37.0	69	19	120/70
	1:00pm	36.1	68	21	120/60
	9:00pm	36.3	70	19	110/70
22/11/2021	5:00am	36.0	62	16	110/70
	9:00am	36.3	75	19	110/70
	1:00pm	36.0	72	21	110/80
	5:00pm	36.2	76	19	110/70
	5:15pm	36.9	77	20	120/80
	5:30pm	37.0	70	18	110/70
	5:45pm	36.8	78	20	110/70
	6:00 pm	36.7	72	21	120/70
	6:30pm	36.4	70	18	120/80
	7:00pm	36.5	78	19	120/7
	8:00pm	37.0	72	19	110/60
	9:00pm	36.4	78	20	120/70
23/11/2021	5:00am	36.5	72	20	120/70
	9:00am	36.8	69	19	110/60

	1:00pm	36.6	70	18	110/70
	5:00pm	36.8	72	21	120/80
	9:00pm	37.0	84	23	110/70
24/11/2021	5:00am	36.1	81	20	110/70
	9:00am	36.5	84	22	120/70
	1:00pm	36.4	76	19	120/80
	5:00pm	36.6	78	20	120/70
	9:00pm	36.6	77	19	120/70
08/12/2021 (Review day)	8:15am	36.4^{o}C	74	19	120/80

SIGNATORIES

1. **The Student Nurse**

Name: Dufie Patience

Signature: .....

Date: 5th October, 2022

2. **Nurse In-Charge of Male Surgical ward - Sunyani Regina Hospital**

Name: Miss Grace Mensah

Signature: .....

Date: 06/10/2022

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

Name: Joseph Appiah

Signature: .....

Date: 05/10/2022

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

Name: Monica Nkrumah

Signature: .....

Date: 06/10/2022

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