HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT AND FAMILY CARE STUDY ON HYDROCELE

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

AUGUST, 2022

PREFACE

Nursing is a profession within the health care sector that focuses on the care of individuals, families and communities so they may attain, maintain or recover optimal health and quality of life. The mother of modern nursing, Florence Nightingale (1820-1910), was the woman who instigated and brought much respect to the profession through her visions. The ability to provide comprehensive nursing care rest on the ability of the nurse to assess the client's condition, analyze, plan, implement and evaluate the effects of management on patient health status.

The patient /family care study is a report of a nursing care given to a selected patient within a specific period to meet physical, physiological, spiritual and socioeconomic needs and help to attain maximum health. The patient/family care study is also a requirement as a partial fulfillment for the award of a license to practice as a Registered General Nurse by the Nursing and Midwifery Council for Ghana to the students pursuing diploma in nursing in the country.

It also offers the student nurse an opportunity to put into practice the knowledge acquired at school to render an effective nursing care to client with reference to the patient's condition.

To add up to the above explanation, patient/family care study enables the student to obtain more knowledge about the cause, signs and symptoms, diagnosis and treatment given to patient with specific condition using the nursing process concept.

ACKNOWLEDGEMENT

My outmost gratitude goes to the almighty God for the intelligence and wisdom given me throughout this study.

My special thanks go to MR. F.A and his family for their outstanding co-operation and interaction given to me in conducting the study.

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My profound thanks go to the nursing officer in charge of the Male Surgical Ward and her staff at Sunyani Regional Hospital, for their assistance and guidance during the care and management of the patient.

I am grateful to the authors of the books with which relevant information were picked for this study.

Finally, I would like to thank my entire family especially my mum and dad for their unwavering love and support throughout my education.

I say may the almighty bless you all and answer your heart felt prayers.

INTRODUCTION

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

MR. F.A, a 37-year-old was my subject in the study. He came to the hospital on the 30th of November to have a lab test done towards the impending surgery. He was admitted at the male surgical ward at regional hospital, Sunyani on the 1st December, 2021 with complaints of mild hypogastric pain. Diagnostic investigations that was conducted on patient were physical examination and full blood count. Patient was diagnosed as having hydrocele and hydrocelectomy was performed. Patient spent four days at the ward, within and after which home visit was embarked on. Patient was managed under the following medications: iv cefuroxime 750mg tid x 24hrs, iv P'mol 1g tid x 24hrs, IM pethidine 500mg tid x 24hrs, IVF NS 1L R/L 1L and was prepared for surgery the next day.

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

After discharge, home visit was undertaken to ensure the continuity of care. The first home visit was embarked on the 3rd of December, 2021. This was done while the patient was still at the hospital. Second and third home visits were embarked on the 7th and 13th of December,2021.

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

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

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

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Nursing assessment is the gathering of information about patient's physiological, sociological and spiritual status by a licensed Registered Nurse. Assessment is the first step in the nursing process (Toney-Butler, Unison-Pace,2021). It involves the patient's particulars, family medical history and socioeconomic history.

Again, it focuses on the patient's developmental history, obstetric history, hobbies, lifestyle, past and present medical history. This assessment is done to assist in the diagnosis of the patient.

The data or information gathered is analyzed to help the nurse determine possible ways in which the patient can be nursed for good health and independent life.

1.1 Patient's Particulars

A patient is someone who is receiving medical treatment from a doctor or a hospital. (Collins dictionary, 2021). Particulars refers to facts or details about patient written down and kept as a record. For confidentiality purposes in this study, patients full name will be denoted with his initials as far as nursing ethics are concerned.

Mr. F.A is a 37-year-old born on 4th of January 1985. He was born in Nsoatre to Mr. A.I and mad. C.K. Mr. F.A is the second (2) born of four children, thus two (2) males and two (2) females. He is married to Mrs. W.H with three children. According to Mr. F. A, his mother had a spontaneous delivery during his birth and also had no severe challenges during the nine months of pregnancy. Mr. F.A is a Ghanaian. Mr. F.A. has his maternal grandmother and paternal

grandfather still alive. He resides at Asufufuo with house number 2021PHC/52/0080, a town in Sunyani which is the capital of the Bono Region. His father is still alive but mother unfortunately deceased. He is currently a university graduate with his first degree. Mr. F.A is a teacher while his wife is a community nurse who is currently in school to further her education. He is a Christian by religion and worships together with his family at the Presbyterian church in Sunyani. The languages used in communication are "Twi" and "English". Mr. F. A's next of kin is his wife.

Mr. F.A is dark in complexion and weighs 65kg. he is a short man with a bit of a round face. he has healthy teeth with nose and mouth in correct alignment. He has registered with the National Health Insurance Authority (NHIA). Patient had no physical impairment and no visible tribal marks on his face. Mr. F. A's folder number is AAD5812 at Regional Hospital, Sunyani.

1.2. Patient/family Medical History

Patient and family medical history is a collective data or information on the health of the patient and his relatives.

According to Mr. F. A, diabetes is the only known underlying condition in the family. He also confirmed that, there has been no report in the family of any signs of mental illness. The family most of the time experience some minor discomfort like headache, stomach ache and others. With this they mostly use over-the-counter medications and only go to the hospital when it becomes serious. Mr. F.A. also uses over- the -counter drugs when he feels mild discomfort. He does not usually like coming to the hospital when he is sick. Patient and family were given education on the disadvantages of taken over the counter drugs and the importance of coming to the hospital with even the minor things.

Mr. F.A. made it known that he has never been admitted to the hospital before, neither has he been operated on. He went on to say that they mostly do not get sick in their family. Mr. F.A. mentioned that he is allergic to snails. He mostly reacts and gets rashes when he consumes it.

1.3 Patient and Family Socio-Economic History

The socio-economic history of a family focuses on the social and economic background of the family and the patient.

Mr. F.A. is a teacher by profession. He lives with his wife who is a community nurse and their three children (nuclear family). He started to live alone after university. He made it known that the relationship between him and his extended family is that of a good one. He also continued to say that he has a good relationship with his father and siblings. Mr. F.A. made it clear that hospital bills or finances involving the hospital is mostly catered by him and his wife. But the rest of his family only comes in when things become serious and the money involved is huge. The national health insurance scheme is also another thing they fall on when coming to the hospital. He attends funerals, weddings and other programs in the community but do not really belong to any association both in the community and at church. He didn't really disclose his income but it was not difficult to predict since he is a government worker. He is not currently involved in any religious activity in his church.

1.4 Patient's Developmental History

In view of Oxford dictionary (2008), development is the increase or gradual growth of something so it can become advanced and stronger. Development mostly deals with the qualitative development of an individual.

Growth is said to be an increase in the size, weight or the physical appearance of an individual (Marcdante & Kliegman, 2015.)

Maturation is the state or process of becoming completely developed mentally or emotionally (Walter, 2013).

This section is a brief record that talks about patient's growth and development from when he was born till now. It throws more light on patients neonatal, infancy, childhood, adolescence and adulthood. It also deals with the stages of development in which the patient found himself and its associated behaviors.

In view of Mr. F.A., he was born on Sunday on the 4th of January,1985 in Nsoatre in the bono-region. His mother had a spontaneous delivery with no major complications. She practiced exclusive feeding for six months before supplementary foods were added. He was breastfed for a period of one year six months. Mr. F.A. was immunized during childhood against all the vaccine preventable diseases such as poliomyelitis, tetanus, whooping cough, tuberculosis and others as evidence by the mark of the Bacillus Calmette Guerin (BCG). He also went through the normal developmental milestone. He went on to say that his mother made it known to him that by the sixth month after he was born, he was able to sit without assistance, crawled at eight and walked when he was a year old. He said he was an energetic child and played around mostly with his sibling.

According to Eric Erikson's theory of psychosocial development, Mr. F.A. falls under intimacy versus isolation. This stage states that, young adults long or are eager to bond with friends, find love and be happy. They mostly explore personal relationships in other to fit in. Erikson believed that this stage is necessary for individuals to develop committed and close relationships with other people. Those who are successful are able to find, secure and settle down in relationships with others. While on the other hand, those who are unsuccessful are not able to secure their

relationships. Mr. F. A. is at the stage of intimacy versus isolation because he is happily married and is staying with his wife and three children.

1.5 Patient's lifestyle and Hobbies

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

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

Mr. F.A. is an outgoing person. He does not easily get angry and its down to earth. Because of the nature of Mr. F. A job, he mostly wakes up at 6:00am in the morning and prepares for school. He brushes his teeth with toothbrush and paste(fluoride) twice daily. He takes his bath with warm water before and most of the time cold water after he returns from work. He mostly takes tea with bread in the morning.

During weekends, Mr. F.A. enjoys watching football or playing it in his area. He goes to church with his family on Sundays. Relaxes after church and prepares for the next day's work.

Mr. F.A. has no personal habits like taking of tobacco, illicit drugs etc... he enjoys taking drinks with moderate level of alcohol but is not an alcoholic.

It is a routine of his to visit the toilet early in the morning before taking his bath every day. He has no special diet and enjoys every meal made by his wife provided there is no snail. He has no sleeping disorder like insomnia, sleepwalking and others.

1.6 Past Medical History

Past medical history can be referred to as the history on the patients past medical record (Weller, 2014).

Mr. F.A. informed me that he has no past medical record. After his normal weighing days as any other child, he has never been admitted at the hospital before neither has he been operated on. He

never experienced any severe illness as a child. He was an active and a healthy child when growing up. Even with this, he uses over the counter medications when he feels a little discomfort. The common pain killer he uses are paracetamol and ibuprofen. He sometimes uses antacid and Andrew's liver salt etc... to relieve indigestion. He is not a fond of herbal medicine.

1.7 Present Medical History

Present medical history of a patient is details or information about the patient's chief complaint. It is also the exact condition the patient brought to the hospital (NCBI Bookshelf, 2021).

MR. F.A. noticed about 5years ago that there was a bit of heaviness in his right testicle. He did not experience any pain when it started. About three weeks ago in late November 2021, he started experiencing pain at the site. He refused to visit the hospital when he noticed it years ago because of the information he got from others that he might be left impotent if he's operated on. On the 30th of November,2021 he reported to the Regional hospital, Sunyani. He reported to the record department to activate his card and later proceeded to the OPD department. Mr. F. A. had his vital signs checked and recorded and was asked to see the doctor. Patient complained of heaviness and pain in his right scrotum to the doctor. He was diagnosed of having hydrocele upon physical assessment by the physician and needed to undergo surgery to correct it. He was educated on the condition and encouraged to read more about it and also ask questions. The physician asked him to get a FULL BLOOD COUNT(FBC) done in other for him to know the HB level. This lab will later help to know if he could undergo the surgery.

1.8. Admission of Patient

Admission of a patient is the act of accepting him or her into an institution or organization, that is the hospital (Oxford dictionary,2008).

On the 1st of December 2021, Mr. F. A. reported to the male surgical ward alone at 11:00am. It had been communicated to him after he showed the labs to the doctor that he could undergo the surgery and he had given his concert. He arrived at the male surgical ward at 11:00am with diagnosis of hydrocele and was admitted right away. The surgical ward mostly had the list of people scheduled for surgery before they come. Mr. F. A.s hospital card was collected and compared with the list at the ward. This was to verify if it was the right patient. Patient was given a bed and vital signs were checked and recorded.

Temperature - 36.2 degrees Celsius

Pulse - 92 beat per minute(bpm)

Respiration - 17 cycle per minute(cpm)

Blood pressure - 138\ 93milliters of mercury(mmHg)

Oxygen saturation- 99%(spo2)

Mr. F. A. was reassured and informed to relax. His folder number was SU-AOI-AA-D5821. He was informed on the ward routine which were, the time allocated for visitation by relatives, time for vital signs, ward rounds and serving of medications. He was oriented to the ward. Mr. F. A. was taken round. He was shown the patients washroom, the nurse's station, kitchen, around the ward and the staffs on duty. Mr. F.A.'s surgery was scheduled for the next day but for the mean time was managed on the following medication(pre-operative):

1. IV cefuroxime 750mg tid x 24hrs
2. IV paracetamol 1g tid x 24hrs
3. IM pethidine 50mg tid x 24hrs
4. IV fluid normal saline 1liter

5. IV fluid ringers' lactate 1liter

All these medications were prescribed for Mr. F.A. to help prevent infection, reduce pain and also to increase his level of fluid before the surgery. Laboratory investigations were carried out the day before admission. Mr. F. A. had some of his drugs covered by NHIS but paid for most of them. Laboratory investigation was carried out, that is FBC (FULL BLOOD COUNT)

I introduced myself to Mr. F. A. and his wife later in the day when she joined him at the hospital. I mentioned that I was a final year student from Holy Family Nursing and Midwifery Training College, Berekum who wishes to use him and his family as my care study. I explained to them that it was a requirement by the Nursing and Midwifery Council (NMC) of Ghana before one can attain a diploma certificate and be awarded a license to practice as a Registered General Nurse. I assured them of maximum confidentiality and also gave them the opportunity to decide whether to accept or refuse. Mr. F.A. together with his wife agreed and gave me their full support. I thanked them and informed my ward in-charge that they had accepted. I chose Mr. F.A. for this study because this was the first time I was hearing about the condition (hydrocele) therefore decided to know more about it. I also wanted to find out how to manage the condition practically. Patient was made aware that the hospital was just a temporal place for him. he was informed that plans and processes of discharge will be made when an improvement was noticed. With this, patient was psychologically prepared for discharge on the day of admission. Patient was also made aware how bills would be paid and how it was necessary in order for one to be discharged.

1.10 Patient's Concept on Illness

Patient's and family concept of illness is the understanding retained in the mind from experience, reasoning or imagination about the patient illness (Park, 2013).

Mr. F.A. had a level of knowledge about his illness. He knew it had nothing to do with the spiritual. He went on to say that, as he read about it, he found out that it was fluid from his stomach that had filled his testicular sac because there was a space linking them. He believed that once he is here, he would recover soon and go home.

1.11. Literature Review

Brief anatomy and Physiology of the testes

As stated by Smeltzer and Bare (2018), the testes are the organs found below the penis.

They have a dual function which is spermatogenesis (production of sperms) and secretion of the male sex hormones testosterone, which induces and preserves the male characteristics.

The testes are formed in the embryo, within the abdominal cavity near the kidneys. During the last month of fetal life, they descend posterior to the peritoneum and pierce the abdominal wall of the groin.

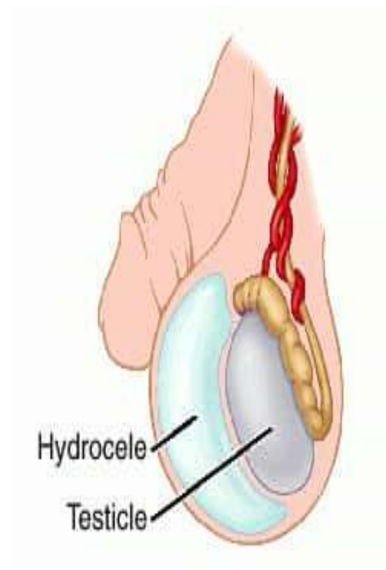
Later, they progress along the inguinal canal into the scrotal sac. In this decent, they are accompanied by blood vessels, lymphatics, nerves and the ducts which supports the tissues and make up the spermatic cord.

Hydrocele

A hydrocele is a collection of fluid, generally in the tunica of the testes, although it may collect within the spermatic cord (Smeltzer & Bare, 2008).

it mostly develops in newborns but mostly resolves by the age of one (1). it can also affect children and adults due to inflammation or injury within the scrotum.

We have about 10% of newborns (male infants) with hydrocele which often clears up on its own (Mayo Foundation For Medical Education And Research, 2020).



AETIOLOGY

1. **Primary or idiopathic:** with this the cause of the hydrocele is unknown.
2. **Secondary cause:** the hydrocele can be caused by either inflammation of injury to the scrotum (MFMER, 2020).

Types of hydroceles

Communicating hydrocele

This is a type of hydrocele that has contact with the fluid in the abdominal cavity. It happens when the processus vaginalis (the thin membrane that extends through the inguinal canal and extends into the scrotum) fails to closed up completely.

It is also associated with a hernia that remains open from the scrotum to the abdominal cavity.

A bulge in the inguinal area or the scrotum that increases with crying or straining and decreases when the child is at rest (Wint & Smith-Garcia, 2022)

Non-Communicating hydrocele

This is when the upper segment of the processous vaginalis has been obliterated or closed but the tunica vaginalis or the scrotal sac still contain peritoneal fluid.

It also occurs when residual peritoneal fluid is trapped with no communication to the peritoneal cavity which usually disappears by age one year. (Wint & Smith-Garcia, 2022)

RISK FACTORS

i) Scrotal injury

ii) Infection including sexually transmitted diseases and filarial infections

iii) obesity

iv) prior inguinal hernia (MFMER, 2020).

INCIDENCE

Hydrocele is the most common benign swelling of the scrotum and has been estimated to occur in as many as 1% of adult male population.

About 1 in 10 male infants has hydrocele at birth, but most hydrocele disappears without treatment within the first year of life. Hydrocele is a disease observed only in males. Most hydroceles occur in adults and are most common in older men. Adult-onset hydrocele usually occurs in men older than 40 years.

In India and tropical countries, the incidence is much higher due to the high prevalence of filarial infections. In one review of 500 cases of hydrocele from India, almost 43% were due to filarial infections. (Paderla, 2021)

PATHOPHYSIOLOGY

During normal development, the testicles descend down a tube from the abdomen into the Scrotum. Hydroceles result when this tube fails to close. Fluid drains from the abdomen through

the open tube. The fluid accumulates in the scrotum, where it becomes trapped. The trapped fluid causes the scrotum to enlarge.

Hydrocele denotes a pathological accumulation of serous fluid in a body cavity. It can also be noted as a minor malformation of new born due to high levels of lead in the father's blood during pregnancy.

A hydrocele testis is the accumulation of fluids around a testicle and is fairly common. It is caused by fluid secreted from remnant piece of peritoneum wrapped around the testicle called the tunica vaginalis. It can be the result of cancer trauma (such as a hernia) orchitis and can also occur in infants undergoing peritoneal dialysis (MFMER, 2020).

CLINICAL FEATURES

I) Frequency and urgency of urination

ii) Dysuria

iii) Painful scrotal swelling

iv) Pain at groin or testicle

v) heaviness in the affected testis (MFMER, 2020)

DIAGNOSIS

i) **Transillumination**: This is where a light is shunned through the scrotum with hydrocele, the light will outline the testicle, indicating that clear fluid surrounds it.

ii) **Physical examination**

iii) **Urine R/E for infections such as epididymiti**s

iv) **Blood test**

v) **Ultrasound imaging test** (UIT), this test uses frequency sound waves to create images of structure inside the body, which can rule out a hernia, testicular tumor or other cause of scrotal swelling (Cleveland Clinic,2020).

PROGNOSIS

The success rate for hydrocele repair is very high. Long – term prognosis is excellent. The prognosis for congenital hydrocele is excellent. The outcome of adult-onset hydrocele depends on its cause.

Most congenital hydroceles resolve by the end of the first year of life. Persistent congenital hydrocele is readily corrected surgically (Rudkin, 2021).

TREATMENT

Two types of treatment include;

Non-Operative Method

Tapping: This is making a hole in for drawing off liquid from a cavity. The site of puncture is first infiltrated with a local anesthesia which is drained using trocar and cannula. The fluid usually reaccumulates except in secondary hydrocele. Tapping is therefore palliative (Burkitt, Quick & Reed, 2008).

Aspiration and injection of Sclerosant: the hydrocele is aspirated through a site at the upper end. The sclerosant, sodium tetradecyl Sulphate, I milliliter for 5 – 10 milliliters of aspirant not exceeding 20 milliliters of tetracycline is injected. Aspiration and injection may be necessary. The hydrocele is usually cured in four months. Some researchers have found out that the use of Sclerosant in a way may result in epididymal obstruction (MFMER, 2020)

Medication or drugs administered

There is no medication available to treat hydrocele. A hydrocele usually goes away after six to twelve months of age. If the hydrocele does not resolve, then it needs to be surgically repaired to avoid further complications (Rudkin,2021).

Moreover, in managing, medications like antibiotics example ceftriaxone, cefuroxime and others are given to fight infection. If there is pain, analgesics like acetaminophen and ibuprofen are given. Opioids like pethidine, morphine and tramadol are also given if the patient undergoes surgery.

Operative method

Hydrocelectomy: This is a surgical procedure in which the processus vaginalis is identified and excised, fluid drained and both ends sutured (Cleveland Clinic,2022).

Lord's Operation: This is a type of operation in which the sac is opened through small skin incision and a series of 210 catgut sutures inserted into the sac from one side of the testis to the other. When the sutures are tied, the scarified surfaces of the tunica come together. A sterile inflammation reaction resulting in fibroses makes the two surfaces of the tunica adherent so that secretions of fluid cannot take place (Rudkin, 2021).

Nursing management

Pre-operative management

- ✓ Assess and correct any physiological problems like low Hemoglobin level, increased blood pressure, temperature, pulse, sickle cell disease etc. Take blood specimen for white

blood cell counts, Hemoglobin level, and blood clotting time and take vital signs for baseline data.

- ✓ Assess and correct all psychological problems like fear and anxiety by giving adequate information regarding the effect, benefit, risk of the surgery to allay any fear and anxiety.
- ✓ Instruct and demonstrate exercise that will be very beneficial after the surgery example deep breathing, splinting the abdomen when coughing to patient.
- ✓ Teach patient and significant others about the guidelines concerning the surgery for instance Nil per os before the surgery and after surgery until bowel sounds resume.
- ✓ Plan for discharge and projected changes in lifestyle due to the surgery.

Pre-Operative Preparations the Evening Before the Surgery

- ✓ Preparation of the skin is done by shaving the area which is to be incised and applying a sterile towel to ensure fast and quick action or effect of a drug. This is done to prevent microbes which might develop on the skin.
- ✓ Preparation of the gastrointestinal tract is done by restricting food and fluid intake. This is to prevent aspiration during procedure or reduce the possibility of vomiting and aspiration during anesthesia.
- ✓ Preparation for anesthetist is done by the anesthetist visiting the patient to explain the type, effect, and benefits of an anesthetic agent to be given to allay fear and anxiety. This is done for patient to have a clear understanding of some sensations to be felt after the surgery as a result of anesthesia.
- ✓ Promoting rest and sleep is done by ventilating the room and making a comfortable bed for patient to return back to his normal function after the surgery or restore homeostasis after the surgery.

Pre-Operative Preparations the Day of Surgery

- ✓ Assess and ensure for how well the skin has been performed. The area of incision should be washed with soap and water, well shaved, cleanse with anti-septic solution and application of sterile towel.
- ✓ Ensure proper bathroom bathing of patient. Ensure that patient has void that morning.
- ✓ Assess to see if there has been any oral intake. Help patient put on gown, check vital signs to serve as a baseline data.

Post-Operative Management

- ✓ Assess for the level of consciousness by calling patient by name.
- ✓ Position patient on side to prevent the tongue from blocking the airway.
- ✓ Monitor the respiratory rate, sound, pattern node and effort.
- ✓ Auscultate the lungs periodically.
- ✓ Assess for signs of fluid and electrolyte imbalance as decreased skin turgor, dry mucous membranes etc and administer the prescribed IV fluids.
- ✓ Check vital signs frequently every 15 minutes within an hour before every 30 minutes, and urine output which should be 30mls per hour.
- ✓ Assess wound site for bleeding and if excess exert pressure, and also elevate foot end of the bed.
- ✓ Implement measures to promote wound healing.
- ✓ Perform actions to maintain an adequate nutritional status.
- ✓ Ensure good level of comfort by ensuring bed rest and taken into consideration a well laid operation bed.
- ✓ Organize nursing care to allow for periods of uninterrupted rest and maintain activity restriction as ordered.

- ✓ Perform action to reduce pain by assessing for the intensity of pain using the pain rating scale.
- ✓ Reassure patient and father of a competent continuous care.

Complications of Hydrocele

i)inguinal hernia - inguinal hernia can result due to the space created in the processus vaginalis.

ii) Infection or tumor either may reduce sperm production or function - hydrocele can cause infection due to the accumulation of the fluid in the sac. This fluid can be a reservoir for bacteria (normal flora) to flourish and cause infection.

Patient / family Teaching

Educate patient and family on the following:

- The need to avoid strenuous activities like climbing trees
- The need to avoid lifting anything greater than 10 pounds for one month after the surgery.
- Teachings on the need to sleep in a treated mosquito net to avoid mosquito bite and subsequent plasmodium infection.
- The need to follow the treatment regimen.

The need to report any adverse effect of any of the drugs like nausea, headache and dizziness.

1.12 validation of data

Validation of data is the confirmation and verification of data collected. The purpose and main reasons are to keep the data free from errors, bias and misinterpretation as much as possible. Every information written or found in this study was obtained from Mr. F.A. himself and his wife, since they are the main subjects for this study and therefore assumed that any information given by them are true and real about the study. Also, lab investigations, manuals from members of the health team and test books were also taken. The data has been crossed-checked by patient

and wife, the doctors and nurses of the surgical ward and were found to be consistent and therefore true.

CHAPTER 2

DATA ANALYSIS AND NURSING DIAGNOSIS

2.0 Introduction

Nursing diagnosis is the end product, or outcome, of the nursing assessment. After the data has been collected, the nurse analyses the information, validates the available data and draws

conclusions based on these. Conclusions are then clustered or grouped together, and given a label: the nursing diagnosis.

Bailliere's nurses' dictionary for nurses (24th edition) defines nursing diagnosis as "a statement of a health status of patient for which the nurse is competent to intervene. From the nursing perspective, this implies two processes:

a) Analyzing the data collected from and about a given client.
b) Developing a statement that summarizes the interpretation of the data; that is the conclusion reached.

This summary statement is called the nursing diagnosis. The nursing diagnosis;

a) Describes actual and potential problems, or the client's responses to these, for which the professional nurse is qualified and licensed to intervene.
b) Is based upon scientific knowledge that the nurse must apply.
c) Involves analytical thinking and drawing inferences from the data collected.

Most important reason for the development and using nurses' diagnoses are;

1. To define the domain of nursing.
2. To communicate clearly to other professionals and public what nursing is all about.

2.1 Analysis of Data

Data collected during the nursing assessment have little value to the nurse or to the client unless they are analyzed and appropriate nursing diagnoses are formulated to give direction to care planning.

Data analysis involves looking at the information in the light of previously known information about a client and in relation to norms; for example, analyzing screening tests, laboratory values, age-appropriate height, weight and vital signs measurements.

2.1.1 Comparison of Data with Standard

Comparison of data is the act of finding out the differences and similarities between two or more people or information (Oxford Dictionary, 2008).

a. Diagnostic investigation

1. Blood for full blood count (FBC)

Test: it is a procedure intended to establish the quality or reliability of something, especially before it is taken into widespread use (Oxford dictionary, 2008).

Investigation: it is the process of examining a problem or statement carefully specially to identify the truth (Cambridge English dictionary,2022).

The tables below show the diagnostic investigations on Mr. F. A

Table 1: the table below shows the laboratory investigations done on MR.F.A. as compared to literature review.

diagnostic investigations in the literature review	**diagnostic investigations done on Mr. F. A.**
1.Transillumination (to detect fluid by using a beam of light)	This was not carried out on Mr. F.A.
2 physical examination (palpating for the presence of hydrocele)	Mr. F. A. was physically assessed by the physician to detect the presence of a hydrocele.

3 urine R/E for infection	This was not done for Mr. F. A.
4 blood tests (to detect levels of WBC, RBC, PLATELET etc…)	A full blood count was conducted on Mr. F. A.
5 ultrasound imagery tests	This was not carried out on Mr. F. A.

comment: with reference to the above table 1.0, transillumination, ultrasound imagery tests and urine R/E for infection was not conducted for MR.F. A simply because diagnosis was arrived and confirmed by the health history, physical examination and full blood count

Table2: result of diagnostic test and investigation carried on Mr. F. A.

DATE	SPECIMEN	INVESTIGATION	RESULTS	NORMALITY	INTERPRETATION	REMARKS
31/11/21	Blood	Full blood count	White blood cells $4.41x10^{9/L}$	White blood cells $3.50 – 9.50x10^{9/L}$	No infection present	No treatment given
			Red blood cell $6.0x10^{12/L}$	Red blood cell $3.8 – 5.1X10^{12/L}$	No anemia present	No treatment given
			Hemoglobin 15.8 g/Dl	Hemoglobin 12.5 - 17.5 g/Dl	No anemia present	No treatment given
			Platelets $242.0x10^{g/L}$	Platelets $140 – 440x10^{g/L}$	No presence of thrombocytopenia	No treatment given

b. CAUSE

In comparison with the literature review the cause of Mr. F. A'S disease is the primary type which is as a result of the processus vaginalis unable to close after the descent of his testis. This caused fluid from the peritoneum to fill the testicular sac and thereby resulted in his condition.

Table 3: Comparison of clinical features from literature review and those presented by MR. F. A

Clinical features found in the literature review	Clinical features presented by Mr. F.A
1. heaviness in testis	this was observed during palpation.
2. Frequency and urgency in urination	This was observed
3. Dysuria	Patient complain of pain when urinating
4. Pain at the groin and testis	Patient complained of pain at the groin and testis

Comment: from the clinical manifestations listed above in table 3, patient experienced most of the signs and symptoms listed in the literature review.

TREATMENT

Treatment is a medical care given to a patient for an illness or injury (oxford dictionary,2020).

the following drugs and infusions were ordered and administered to Mr. F. A

INFUSIONS

i) IV Ringers lactase 1litre x 2days

ii) IV Normal saline 1litre x 2days

Drugs

1) iv cefuroxime 750mg tid x 24hrs
2) iv paracetamol 1g tid x 24hrs
3) IM pethidine 50mg tid x 24hrs

Post-operative drugs

1. Cefuroxime
2. Paracetamol tablet
3. Pethidine injection

Table 4: treatment given to MR.F.A. compared to literature review.

Treatment outlined in literature review	Treatment given to MR.F. A
1. Analgesics (ibuprofen, acetaminophen)	Iv paracetamol 1g tid x 24hrs and paracetamol tablet was prescribed for MR.F. A for pain
2. Antibiotic (cefuroxime, ceftriaxone).	iv cefuroxime 750mg tid x 24hrs was prescribed for MR.F.A. to prevent infection
3. Opioid (morphine, pethidine, tramadol)	Iv pethidine 50mg tid x 24hurs was prescribed for MR.F. A for incisional pain after surgery
4. Tapping	This was not done for Mr. F.A
5. Aspiration and injection of Sclerosant	This was not done for Mr. F.A

6. Hydrocelectomy	Mr. F.A undergone this surgical procedure
7. Lord's Operation	This was not done for Mr. F. A

Comment: the medications listed above in table 4 were given to MR.F. A before and after surgery to manage problems like pain and infection.

TABLE 4: pharmacology of infusion and drugs given to MR.F. A

DATE	DRUG	STANDARD DOSE	DOSAGE/ROUTE OF ADMINISTRATION	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT	REMARKS
1/12/21	CEFUROXIME	Adult dose: 250- 500mg two times for 10days	500mg, Q1h x 7days route: orally	Antibiotic	to treat infection caused by bacteria	it prevented Mr. F. A's wound from getting infected.	nausea, vomiting, strange taste in mouth.	None was observed
	IV CEFUROXIME	750mg-3g every six to eight hours	750MG TID X 24HRS ROUTE: intravenously					
	IV PARACETAMOL	Adults:15mg/kg-60mg/kg	1g tid x 24hrs Route: intravenously 1g, Q8H x 5days	Analgesic	For treatment of mild and moderate pain	It helps to reduce Mr. F A. pain before and after surgery	Dryness in mouth, allergic reaction	None of these was observed

	TAB PARACETAMOL	Adult: 500-1g every 4 to 6hours	Route: orally					
	IV PETHIDINE	Adult: 25-100mg every 2-3 hours	50mg tid x 24hrs Route: intravenously	OPIOD	For treatment of severe pain	It was given to Mr. F.A. after surgery to reduce pain at the incisional site	Dizzy or sleepy, sweating and nausea	Sleepiness was observed
	Normal saline (NS)	50 to 250mls per dose	1 liter Route: intravenously	Infusion (Fluid and electrolyte replenisher)	Replaces lost electrolyte and restores fluid	It increased the fluid and electrolyte level of Mr. F.A before	Injection site swelling, redness and infection	

						and after the surgery.		
	ringer's lactase (RL)	Adult: 40 mL per kg	1 liter Route: intravenously	Infusion (normal saline with electrolyte and buffer)	Increases perfusion, provides the body with sodium lactate	It increased Mr. F.A perfusion	Agitation, decreased urine output, blurred vision	

d. Complications

none of the complications listed in the literature review was detected or developed by the patient. This is because, the condition was handled just well and in in time to cause any further complication.

2.2. Patient and Family Strength

Patient/family strengths are the things that the patient and family have and are they can achieve without assistance. The strengths include all the aspects of care i.e., biological, psychological, social or spiritual strengths.

Pre- operative strength

1. Mr. F. A. was able to express the level of pain using the pain rating scale (pain: 5). (1/12/21)
2. He and wife prepared for the procedure. (1/12/21)
3. Mr. F. A. could sleep for three hours during the night. (1/12/21)

Post- operative strength

1. Mr. F.A. was cooperative during wound dressing. (2/12/21)
2. Mr. F.A. had good pain coping mechanism. (2/12/21)
3. MR. F.A. had a clean wound that was free from infection. (2/12/21)

2.3 Patient and family health problem

A health problem is any condition or situation in which a patient requires help to regain a state of health or to achieve a peaceful death which is an unmet need the patient response to in a variety of ways based on the analysis of the collected data. Health problems are taken together to formulate nursing diagnosis for the patient.

The following are problems that were identified upon assessing Mr. F. A.

Pre-operative problems

1. Patient complained of pain in the right scrotum. (1/12/21)
2. Patient was anxious of the impending surgery. (1/12/21)
3. Patient had insomnia. (1/12/21)

Post -operative problems

4. Patient had little knowledge about wound care. (2/12/21)
5. Patient complained of incisional pain. (2/12/21)
6. Patient had a break in continuity of skin (surgical wound) (2/12/21).

2.4. NURSING DIAGNOSIS

Nursing diagnosis is a judgement that nurses make about what a particular illness or problem is after examining it. (Walter, 2013).

The following are nursing diagnosis formulated for the problems of Mr. F. A.

2.4a. Pre-operative

1. Alteration in body comfort (scrotal pain) related to accumulation of excessive fluid in the scrotum. (1/12/21)
2. Anxiety related to unfamiliar procedure, new environment and unknown outcome of the surgery. (1/12/21)
3. Insomnia related to pain and change in environment. (1/12/21)

2.4b Post- operative

4. Impaired skin integrity related to surgical procedure (hydrocelectomy). (2/12/2021)

5. Acute pain related to tissue trauma and reflex muscle spasm associated with the surgery. (2/12/21)
6. Knowledge deficit related to lack of information of wound care (3/12/21).

CHAPTER 3

PLANNING CARE FOR PATIENT AND FAMILY

3.0 Introduction

Planning is the process in which the nurse and the patient together consider the goals to achieve in meeting the patient's potential problems in daily life and produce an individual care plan (Weller B, 2014). Planning is the third stage in the nursing process. It involves a systematic process which involves making decision and solving the health problems of the patient.

3.1 Outcome criteria/objectives

Objective refers to something that you plan to do or achieve

The following patient/family health problems were identified and objectives were set for it.

1. Mr. F.A will be relieved of pain within 24hrs as evidenced by

a. Patient describing satisfactory pain control at a level less than 3 to 4 on a rating of 0 to 10

b. Nurse administering both pharmacological and non-pharmacological relieve strategies. Example; diversional therapy and prescribed drugs.

c. Patient displaying improvement in mood and coping with the pain.

2. Mr. F.A will be relieved of anxiety within 2hrs as evidence by
    a. Patient demonstrating positive coping mechanism and describing his own anxiety.
    b. Nurse encouraging patient to ask questions and providing tactful answers.
    c. Nurse and patient identifying the signs and intensity of the anxiety

3. Mr. F.A will be able to sleep 6-8 hours in the night within 24hrs as evidenced by

a. Nurse observing patient having uninterrupted sleep at night as evidence by sleeping at least 6 hours at night.
b. Patient obtaining optimal amount of sleep as evidenced by, verbalization of feeling rested and improvement of sleep pattern.

4. Mr. F. A. will have intact skin integrity as evidenced by
   a. Nurse observing proper healing alignment at incisional site.
   b. Patient verbalizing no signs of infection

5. Mr. F. A. will be relieved of incisional pain within 48hrs as evidenced by

a. Nurse observing patient having a relaxed facial expression.
b. Patient verbalizing relieve of pain after taken his medication

6. MR. F.A. will have enough information about wound care as evidence by
   a. Nurse observing patient's motivation to learn about wound care.
   b. Patient describing how to dress and care for wound upon discharge to prevent infection.

Table 5: Care plan for Mr. F. A.

Date and time	Nursing diagnosis	Objective and outcome criteria	Nursing orders	Nursing intervention	Date and time	Evaluation	Sign
1/12/21 At 2:00pm	Alteration in body comfort (scrotal pain) related to accumulation of excessive fluid in the scrotum.	MR.F.A. will be relieved of pain within 24hrs as evidence by a. patient describing satisfactory pain control at a level less than 3 to 4 on a rating of 0 to 10. b. Nurse administering both	1. Assess for; i. restlessness ii. facial expression iii. withdrawal iv. diaphoresis 2.Assess patient's pain patterns example; location, quality, onset, duration, precipitating factors, aggravating factors and alleviating factors	1.The patient was assessed for a. restlessness b. facial expression c. withdrawal d. diaphoresis 2. The pain patterns e.g.: location, duration, unset, quality, precipitation factors were assessed using patient facial expression	2/12/21 At 2:00pm	Goal was fully met as patient reported reduction of pain	B. F

		pharmacological and non-pharmacological relieve strategies. Example; diversional therapy and prescribed drugs.	3. Provide scrotal support by putting a pillow under patient's scrotum 4.Implement measures to promote rest e.g. a. minimize environmental activities and noise b. Ensuring adequate ventilation.	3. Scrotal support was provided under patient's scrotum to support the scrotum. 4. Measures such as minimizing environmental activities and noise, opening windows for ventilation were performed to promote rest.			

1/12/21 At 6:00pm	1. anxietrelatedto Anxiety related to unfamiliar procedure, new environment and unknown outcome of the surgery.	1.Mr. F. A will be Mr. F.A will be relieved of anxiety within 2hrs as evidenced by 1.Patient demonstrating positive coping mechanism. a. Nurse encouraging patient to ask questions and providing tactful answers.	1. Reassure and establish rapport with patient and wife. 2.Explain unfamiliar procedures, equipment and environment to patient to help calm him down. 3.Orient patient and wife to the hospital in a calm	1. Patient was reassured by words of mouth. 2. Unfamiliar procedures, equipment was introduced to the patient. 3. Patient and wife were oriented to the ward	1/12/21 At 8:00pm	Goal fully met Goal was fully met as evidenced by absence of physical discomfort patient showing proper coping skills	**B. F**

		b. Nurse and patient identifying the signs and intensity of the anxiety	quiet and simple manner. 4.Encourage wife to stay with the patient. 5.Avoid any intrusive or painful procedures. 6.Provide diversional activities appropriate for patient's cognitive ability and condition.	and its environment in a quite manner. 4. The patient's wife was encouraged to stay with patient. 5.Painful procedures was avoided as much as possible. 6. Television set at the ward was switched on for patient to watch.			

1/12/21 At 11:00pm	Insomnia related to pain and change in environment.	Mr. F.A will be able to sleep 6-8 hours in the night within 24hrs as evidenced by a. Nurse observing patient having uninterrupted sleep at night. b. Patient obtaining optimal amount of sleep as evidenced by rested, verbalization of feeling rested and	1.Implement measures to promote rest e.g. a. minimizes environmental activities and noise. b. Ensuring adequate ventilation. **2.**assess for level of pattern and things or methods that help to alleviate the pain.	1.Television set and radio at the ward was switched off to provide calm and restful environment. 2.the level and pattern of pain was assessed and necessary alleviation methods were used.	2/12/21 At 11:00pm	goal fully met as evidence by patient self-report nurse observing patient been able to sleep 8hrs at night.	**B. F**

		improvement of sleep pattern	3.Instruct patient to avoid long periods of sleep during the day. 4. Involve the client in exercises	Example, diversional therapy(music) 3.Client was involved in exercises during the day in order to induce sleeping at night. 4.Patient was discouraged from sleeping long hours during the day.			

date and time	nursing diagnosis	outcome criteria/objective	nursing order	nursing intervention	date and time	Evaluation	sign
2/12/21 At 1:00pm	Impaired skin integrity related to surgical procedure(hydrocelectomy).	Mr. F. A. will have intact skin integrity within 48hrs as evidenced by a. Nurse observing proper healing alignment at incisional site. b. nurse observing no signs of infection	1. use aseptic technique during dressing to prevent wound infection 2.teach patient ways to take care of incisional site to prevent infection. 3.inspect incisional site	1. patients wound was dressed on the second day using proper aseptic technique. 2.patient was taken through ways he could take care of his incisional site, especially not to let water enter the dressing. 3.incisional site was inspected for any form	4/12/21 At 1:00pm	Goal was fully met as evidence by nurse observing patient having intact skin, no sign of infection and no sign of allergic reaction to the plaster. Patient self-report when	**B. F**

			taking into consideration the color of the skin, presence of drainage and odor.	drainage, change in color and odor. it was also checked for rashes or anything that shows allergy to latex.		attending review.	

2/12/21 At 1:00pm	Acute pain related to tissue trauma and reflex muscle spasm associated with the surgery.	Mr. F. A. will be relieved of incisional pain within 48hrs as evidence by a. Nurse observing patient having a relaxed facial expression. b. patient verbalizing relieve of pain after taken his medications patient having stable vital signs	1. Assess for a. grimacing facial expressions b. restlessness c. diaphoresis 2. Assess patient's pain pattern example; location, quality, onset, duration, precipitating factors, aggravating factors	1.Patient was assessed for the following: a. Grimacing facial expression. b. Restlessness. c. Diaphoresis. 2. The patterns of pain such as the duration, onset, quality, location and precipitating factors were assessed using facial expression.	4/12/21 At 1:00pm	Goal was fully met as evidence by patient verbalized less pain. Patient been able to go about daily activities.	B. F

			3. Implement measures to promote rest example, minimize environmental activities and noise, dress bed to be free from creases and cramps. 4. Implement measures to reduce fear and anxiety.	3. Measures such as avoidance of dragging beds, grouping procedures at a goal, dressing of bed to be free from creases and cramps, were ensured for adequate rest. 4.Threatening equipment were removed from patient's sight to reduce fear and anxiety.			

			5.Teach patient how to splint the incision site when coughing. 6. Serve prescribed analgesics e.g., paracetamol	5.Patient was encouraged to splint incisional site when client is coughing. 6. prescribed analgesics was served post-operatively to reduce pain.			

date and time	nursing diagnosis	Outcome criteria/objective	nursing order	nursing intervention	date and time	Evaluation	Sign
3/12/2021 At 10:00am	Knowledge deficit related to lack of information of wound care.	MR. F.A. will have enough information about wound care within 3hrs as evidenced by a. Patient been educated on how to dress and care for wound upon discharge to prevent infection. b. Patient showing more motivation to learn about wound care.	1. patient should be educated on the process in caring for his wound. That is, how to clean it, cover it and prevent water from entry to cause infection. 2. Patient should be taught how to assess for color, odor, appearance which will help identify whether wound is healing or not.	1. Patient was educated on the process of caring for his wound. That is, how to clean it, cover it and prevent water from entering. 2.Patient was taught how to assess for color, odor and appearance which will guide him in knowing how properly the wound was healing.	3/12/21 At 1:00pm	Goal was fully met as evidence by; 1.patient verbalizing his understanding in the education. 2. patient and wife making conscious effort to implement whatever information received in caring for the wound.	**B. F**

			3.Patient should be assessed for his level of knowledge on his disease condition. 4.Patient should be encouraged to asked questions during education.	Patient was assessed for his level of knowledge on his condition before additional education was added. Patient was encouraged to asked questions during the education. Tactful answers were given in answering the questions.			

CHAPTER 4

IMPLEMENTATION OF PATIENT AND FAMILY CARE

4.0 Introduction

Implementation in the nursing care study is referred to as the steps which involves action or doing and the actual carrying out of nursing interventions outlined in the plan of the care (Oxford Dictionary, 2008). This chapter gives a vivid account of the nursing care that was rendered to the patient and relative from the day of admission to the day he was discharged based on the health problems identified. It also deals with follow up visits/home visits to ensure continuity of care.

4.1. Summary of actual nursing care

the nursing care rendered to Mr. F. A. started from the day of admission which was on the 1st of December 2021, and continued till he was discharged on the 4th of December,2021.

The nursing care was geared towards providing comfort to the patient and to promote her recovery with no complications. The nursing care rendered to patient is summarized on daily basis.

4.2. First Day of Admission (1/12/2021)

Patient was admitted to the surgical ward on the 1st of December, 2021 at the Regional Hospital in Sunyani. Patient came alone and was ambulant. He had only one complain and that was the pain he felt in his right scrotum.

He was under the care of doctor I.Y. I welcomed the patient and assured him of competent nursing care.

His name was confirmed and introduction was made to the staff on duty. His data like the name, date of birth, address, sex, occupation, and date of admission were recorded into the admission and discharge book. Vital signs were checked and recorded at 10am as follows;

Temperature: 36.2ºC

Pulse: 92bpm

Respiration: 17cpm

Blood pressure: 138/93mmhg

Oxygen saturation: 99%

His already prepared bed was shown to him and was introduced to his roommates. I explained the ward routines such as the time for medication, meals, morning devotion, doctors' rounds and daily dressing.

Mr. F.A. was to be managed with the following medications

1. IV cefuroxime 750mg tid x 24hrs
2. IV paracetamol 1g tid x 24hrs
3. IM pethidine 50mg tid x 24hrs
4. IV fluid normal saline 1liter
5. IV fluid ringers' lactate 1liter

All these drugs were prescribed for MR.F. A to reduce pain, prevent infection and restore fluid balance to normal in order not to cause complications.

MR.F. A is a registered member for the National Health Insurance Authority (NHIA) which aided in the reduction of the prices of the prescribed drugs.

The following Laboratory Investigation was ordered;

¬ Full Blood Count (FBC)

I introduced myself to Mr. F. A. and his wife later in the day when she joined him at the hospital. I mentioned that I was a final year student from Holy Family Nursing and Midwifery Training College, Berekum who wishes to use him and his family as my care study. I explained to them that it was a requirement by the Nursing Ang Midwifery Council (NMC)of Ghana before one can attain a diploma certificate and be awarded to practice as a Registered General Nurse. I assured them of maximum confidentiality and also gave them the opportunity to decide whether to accept or refuse. Mr. F.A. together with his wife agreed and gave me their full support. I thanked them and informed my ward in-charge that they had accepted. I chose Mr. F.A. for this study because this was the first time I was hearing about the condition (hydrocele) therefore decided to know more about it. I also wanted to find out how to manage the condition practically. Patient was made aware that the hospital was just a temporal place for him. He was informed that plans and processes of discharge will be made when an improvement was noticed. With this, patient was psychologically prepared for discharge on the day of admission. Patient was also made aware how bills would be paid and how it was necessary in other for one to be discharged.

At 9:00am, MR.F. A complained of pain in his right scrotum. A nursing diagnosis was formulated as, altered body comfort (scrotal pain) related to accumulation of excess fluid in the scrotum. An objective was set to relieve patient from pain within 24hours. The following nursing interventions were carried out to meet the objective set; MR.F.A was reassured of competent nursing care, His pain level was assessed using numerical rating scale, a calm and restful environment was provided, patient was kept into a comfortable position that relieves his pain,

diversional therapies such as; watching television and interacting with patient was done, Prescribed analgesics medications were rightly administered and documented. Iv paracetamol was administered and documented. Patient's vital signs were checked and recorded at 2:00pm as follows:

Temperature- 36.3^{O}C

Pulse- 79bpm

Respiration- 20cpm

Blood pressure- 138/86mmhg

At 6:00pm, MR.F.A. complained of anxiety. A nursing diagnosis was formulated as, anxiety related to unfamiliar procedure, new environment and unknown outcome of surgery. An objective was set to relieve patient from anxiety within 2hours as evidenced by, patient demonstrating positive coping mechanism, nurse encouraging patient to ask questions and providing tactful answers. The following nursing interventions were carried out to meet the objective set; Patient was reassured of competent nursing care, patient was given answers to the questions that was asked , unfamiliar procedure was explained to patient, nurse make sure to avoid any painful and intrusive procedure, diversional therapy was provided for patient, finally wife of patient was encouraged to stay with him.

At 11:00pm, MR.F. A complained of difficulty in trying to fall asleep. A nursing diagnosis was formulated as; insomnia related to pain and change in environment. An objective was set to help patient relieved of insomnia within 24 hours. The following nursing interventions were carried out to meet the objective set; nurse minimized environmental activities and noise to enable patient to sleep, Patient was relieved of pain enabling him to sleep, adequate ventilation was

provided to help patient sleep, patient was advised against having long periods of sleep during the day.

On 1st December, 2021 at 8:00pm an evaluation of the objective set to relieve patient of anxiety within 2hours was done and goal was fully met as patient verbalized that he no longer felt anxious and a nurse observed patients relaxed expression.

Physical Preparation

Skin preparation was initiated early in the morning at the ward before he was sent to the theater. He was advised to take in light diet for supper the night before the operation and was told not to eat or drink anything after 8pm till the operation is done the following day. This was to prevent any vomiting and aspiration of gastric content during anesthesia.

He was also told what to expect after the surgery such as administration of intravenous infusions, frequent taking of vital signs and no food intake for some time until bowel sounds resume.

He was introduced to some of the patient who had undergone similar operations successfully and assurance was given to him concerning pain management such as positioning and analgesics.

Second Day of Admission (02/12/2021)

a. Day of operation

On 2nd December, 2021, MR.F.A. woke up early. He primarily related it to the change of the environment. He was mostly on his phone the rest of the night.

Before then, he was reassured and necessary measures such as dimming the lights at the wards to make sleep easier. His vital signs were checked and recorded around 7:49am as follows.

Temperature - 36.0°C

Pulse - 68bpm

Respiration- 20cpm

Blood Pressure- 138/85mmHg

Oxygen saturation- 99%

medications were served and patient was propped for the impending surgery.

The incision site was inspected for any rashes and was washed with an antiseptic lotion. The site was dried, a sterile towel applied and stabilized with an adhesive tape. One of the surgeon's visited MR. F.A. in the morning to prepare him mentally for the surgery. He spoke to him briefly and encouraged him to ask questions which he answered tactfully. MR. F A. was assisted by his wife in putting on his theatre gown. Normal saline 1liter had been set up before he was moved to the theatre by myself and two staff nurses at 9:00am on his bed. He was then handed over to the theatre team.

b. Intra operative care (surgical procedure)

The surgery performed for MR.F.A. was a hydrocelectomy. He had a unilateral hydrocele (right). The surgery was performed by DR.F.S.

Under spinal anesthesia, patient was aseptically draped.an incision was made through the median raphe and advanced through the fascia. The hydrocele was exteriorized and about 400mls of serous fluid was drained. The tunica vaginalis was excised and a pursed suture was put on it after which it was tied.

c. Immediate post-operative care

At 12:30pm, the operation was completed and patient was sent to the recovery room in a semi – conscious state. Patient was received into an operation bed.

He was put in the recovery position with the head tilted to one side and chin lifted to aid drainage of secretion from the mouth and to prevent the tongue from falling back to block the airway.

He was observed for signs of hemorrhage and shock. His wound's dressing was checked regularly for signs of bleeding. His skin was observed for paleness as well as the nail bed for capillary refill.

Patient was handed over by the theatre to us to be taken to the male surgical ward at 1:00pm. A normal saline was set up for him already as we received him. patient had been given pethidine to reduce pain after anesthesia had wear off.

His vital signs were checked and recorded at 2:00pm as follows.

Temperature - 36.2^{o}C

Pulse- 55bpm

Respiration - 14cpm

Blood Pressure – 99/67mmHg

Oxygen saturation- 98%

The vital signs were continually checked every 15 minutes for an hour and every 30 minutes until he recovered fully from anesthesia which was around 4:00pm.

The physician came and reviewed the patient around 6pm and ordered that he starts sips of water before advancing to normal diet. His vital signs were checked and recorded at 6:00pm as

Temperature- 36.2ºC

Pulse- 72bpm

Respiration- 20cpm

Blood Pressure- 136/88mmHg

Oxygen saturation- 98%

At 1:00pm, MR.F. A came out of surgery. He had an incision at the scrotum. A nursing diagnosis was formulated as; impaired skin integrity related to surgical procedure. An objective was set to maintain patients skin integrity. The following nursing interventions were carried out; patient was taken through ways he could take care of his incisional site especially not to let water enter the dressing, incisional was inspected for any form of drainage, change in color, odor. Wound of patient was also checked for rashes or anything that shows allergy for latex.

At 3:00pm, patient complained of pain at incisional site. A nursing diagnosis was formulated as; acute pain related to tissue trauma and reflex muscle spasm associated with surgery. An objective was set to help relieved patient and relative from anxiety within 48 hours. The following nursing interventions were carried out; patient was assessed for restlessness and diaphoresis, the pattern of pain for patient was assessed. That is, duration, location and onset, patient was advised to split incisional site while coughing, prescribed analgesics was served post-operatively to reduce pain. patient was managed on IM Pethidine 50mg and IV paracetamol was given and was reassured that that pain will subside with time and proper treatment.

He took just a bowl of soup for supper since he was starting with light diets. MR.F.A. was not allowed to have his bath due to the surgery and was therefore cleaned up with warm water on his bed with the assistance of his wife.

On 2nd December, 2021 at 9:00am, an evaluation of the objective set on 1st December, 2021 to relieve patient of scrotal pain within 24hours was done and goal was fully met as patient verbalized, he had been relieved of pain and nurse recorded patient's pain level of 0 using numerical rating scale.

at 11:00pm, an evaluation of the goal set on 1st December, 2021 to help patient be relieve of insomnia within 24 hours was made and goal was fully met as patient verbalized having enough rest and nurse observing patient having uninterrupted sleep at night. (8hrs)

d First day post operatively (Third day of Admission) (3/12/21)

Patient took milo with bread as breakfast. He was able to walk about in a slow pace and able to visit the wash room on his own. Patient's medications were served thus was given normal saline, paracetamol for the pain and cefuroxime to prevent any infection.

His vital signs were checked and recorded at 6:00am as:

Temperature - 36.3°C

Pulse- 86bpm

Respiration- 18cpm

Blood Pressure - 100 / 70mmHg

Oxygen saturation- 97%

At 10:00am, upon my interaction with patient, I realized that he lacked sufficient knowledge concerning wound care. A nursing diagnosis of knowledge deficit related to insufficient information on wound care was formulated to help increase patient and the relative knowledge about wound care. The following nursing interventions were carried out to help meet the objective set; patient was educated on the process in caring for wound. That is, how to clean,

cover and prevent water from entering, patient was taught how to assess for color, odor, and appearance which will guide him in knowing how the wound healing, MR.F.A and his wife tried answering a lot of questions that were asked on wound care, a clear and simple language was used in answering MR.F.A and his wife tactfully. At 1:00pm, evaluation was made and goal was fully met as patient and wife verbalized understanding of education, patient and wife making conscious effort to implement whatever information received in caring for the wound.

At 2:00pm, the surgical team came for rounds to review their cases. MR.F. A was reviewed. His sutures were intact with no evidence of hemorrhage or drainage and he had little complaint.

The physician advised that he stayed for an extra day so as to be keep under observation. The ward routine was carried out at 2:00pm. Thus, serving of medication and checking and recording of vital signs.

Vital signs were checked and recorded as follows,

Temperature- 36.5°C

Pulse - 90bpm

Respiration - 21cpm

Blood pressure - 129/85mmhg

Oxygen saturation- 97%

Ambulation was encouraged by accompanying patient out of bed and taking a walk at the ward to enhance effective circulation at 3pm.

At 4:00pm, evaluation was made and goal was fully met as patient and wife verbalized understanding of education, patient and wife making conscious effort to implement whatever information received in caring for the wound.

Patient ate rice with soup in the evening which was prepared by his wife. At 6: 00pm medication and vital signs were checked and recorded as follows:

Temperature- 36.5^{o}C

Pulse- 78bpm

Respiration- 18cpm

Blood Pressure- 100/70mmHg.

Oxygen saturation- 98%

He was served with rice ball and groundnut soup for supper. I said my goodbye to MR.F.A. and his wife as I handed him over to the night staff for continuity of care.

e. Second day post operatively (4/12/21)

On 4th December, 2021, being the second day post-operative, I visited MR.F. A in the morning. His wife was present. He had no complaints that morning as his pain has subsided and was eager to go home. His vital signs had been checked and recorded at 6:00am as:

Temperature - 37.1^{o}C

Pulse- 76bpm

Respiration- 20cpm

Blood Pressure- 120/60mmHg

Oxygen saturation- 98%

He was encouraged and assisted to care for himself as much as possible. He took rice porridge with milk and bread as breakfast. His medications were served per chart.

During ward rounds by the surgical team, MR.F. A. did not make any complains. upon general assessment, his general condition was good and the physician asked for the wound to be opened. The wound was then inspected and afterwards dressed with methylated spirit and dry dressing applied on the wound.

At 9am, an evaluation of the objective set to maintain intact skin was fully met: the skin of the wound was dry with proper edges and void of smell.

At 10:00am, an evaluation of the objective set to relieved MR.F.A. was fully met as patient verbalized less pain and patient was able to go about daily activities.

MR.F.A. together with his wife were informed that he has been discharged. He was to report for review on the 9th of December at the OPD. He was then advised not to be touching the wound and necessary preparations were made for his discharge. Patient and wife were educated on how take home medications should be taken. I helped his wife to pack their things and later escorted her to make payment at the account unit towards the discharge. The date for discharge was recorded in the discharged book. I escorted patient and wife outside the ward and said my goodbye. I came back to remove the dirty linen and disinfect the bed in preparation for another patient.

4.2 Preparation of patient / family for discharge and Rehabilitation

The preparation started on the day of admission and continued throughout his stay at the hospital.

In the morning of the admission MR.F. A, he was educated on the causes, signs and symptoms, prevention and treatment of the disease and the need to undergo surgery to prevent

complications. This was to build a trusting relationship with MR.F. A and to enable him gain knowledge and understanding regarding the condition and promote co – operation with his care.

He was advised to take enough fluid and regular moderate exercise such as walking to ensure free bowel to prevent straining and to improve circulatory and respiratory functions and also for daily dressing of wound. His wife was also instructed to provide him with nutritious and a balanced meal so as to help in wound healing.

MR.F. A and his wife were also educated on personal hygiene. He was advised to bath twice daily, clean the mouth, wash hands and cloths when dirty and also to keep the wound clean. They were educated to keep the environment clean, the bathroom and toilets also clean.

I stressed on the need to adhere to the scheduled review which was 9th December, 2021. I also advised him to prevent lifting heavy loads.

During home visit, emphasis was made on keeping the home clean always to prevent infections when patient returns home.

The importance of his medication was emphasized and the needs to avoid unprescribed drugs were also made clear to them.

4.3 Follow – up / Home Visit Continuity of Care

In reference to home visit, is the act of visiting patients in their houses and environment to see how they are feeling before after discharge. It helps to ensure proper care of patients after discharge and see the actual home situation in order to give necessary health education.

It also ensures continuity of care in the home and also helps to identify health hazards in the home and the environment and to evaluate the care rendered to him at the hospital.

There are two main types of home visits:

Routine visit which is the type where health workers move from house to house visiting patients in a selected area and selective visit is also specially planned visit where a patient with a particular condition is chosen and visited in his or her house.

The selective type was used during this care study.

First home visit: 3/12/2021

The first home visit was carried out while the patient was on admission on 3rd December, 2021. The aim of my visit was to visit to the house and to verify the information given by the patient on the day of admission, to inspect patient's environment, identify possible problems and put measures in place to prevent it. It was also to prepare the family to receive him back home.

On 3rd December, 2021, around 12pm I arrived at MR.F. A'S house with his wife at Asufufuo in Sunyani. Asufufuo was far from the hospital and the main station.

The vicinity was nice and had a proper layout. The house itself was far from the main road so we had to walk there. They had a very nice house with a big compound which had been cemented. The house was painted with iron bars on each apartment. The house had five rooms with each containing its toilet and bath and a veranda that was used as kitchens by each occupant. MR.F. A'S apartment was neat with tiled floors. I was welcomed by his wife's sister and her three kids. They were very welcoming and very easy going. I took the opportunity to look around the place as I was ushered inside. I was given a seat and offered water and some fried plantain which I declined respectfully. I informed them about the purpose of my visit and how important it was in caring for MR.F.A. I introduced myself to her sister as the nurse taken care of MR.F.A. I asked about their source of water and electricity and was informed they have a tap and polytank in the house that supplies them with water. They also had light that they paid every month to the electricity company of Ghana.

The conversation between myself and the family was not too concentrated on my patient's condition since it was physiological. I didn't want to exposed my patient much since his wife already knew about the condition.

The compound was clean and the house well ventilated with enough windows to allow in fresh air. I was introduced to the landlady and other tenants. I congratulated them in the promotion and maintenance of clean environment and encourage them to continue the good work done. I also educated them on personal hygiene and infection control and prevention. I suggested and stressed on the need for him and the whole family to take in well-balanced diet, fruit and enough fluids. Emphases were laid on his medication, avoidance of lifting heavy objects for the first one month and the need to avoid over the counter drugs.

I allowed them to ask questions and answered them to the best of their understanding. I assured them of my next visit and they were really happy to see me next time. I asked permission and left around 1:00pm. MR.F. A's wife made sure to see me off.

Second home visit (7/12/21)

The significant of this visit was to find out how my patient was doing after discharge, whether he is taking his drugs, care of the wound and also to remind him of the review day and its significance. I got there around 4pm. They were all doing very well and also happy to see me. I encouraged him to continue taking the drugs, avoid lifting of heavy objects and to make sure he visits the hospital as scheduled.

We discussed some of the issues raised when he was on admission, eating of balanced diet, more intake of fluids and fruits and avoidance of lifting heavy loads. I allowed them to ask questions and they were answered appropriately to their understanding.

After answering their questions, I told them of my next visit which was the last visit I would be paying to them. I explained termination of care to them and a need for me to terminate care after he has been declared fit by the doctor. I thanked them and bid them good-bye.

Reviews

MR.F. A reported to the hospital on the 9th December, 2021 around 7:00am. Wound was opened and inspected for healing. It has almost healed since the edges were contracting.

His vital signs checked on the 9th of December were:

Temperature- 36.9°C

Pulse- 80bpm

Respiration- 20cpm

Blood Pressure- 110/70mmHg

Oxygen saturation- 98%

The physician was satisfied with his recovery. The wound was dressed with methylated spirit and dry dressing applied on the wound. He was informed to report to hospital immediately he experiences any complications. The physician prescribed some medications for him to go home with. He was given paracetamol tablet to be taken orally for 7days for pain by the pharmacist and metronidazole to treat infection.

Third Home visit/termination of care (13th December, 2021)

This was scheduled with MR. F. A. and his wife on the day of his review. I arrived at their home around 12noon. The main motive for this visit was to ascertain the progress of the care given to MR.F.A. and also to terminate the care rendered to him

The family was ready to receive me since the visit had been scheduled. I was welcomed warmly. I asked about their health and how MR.F. A was coping. He confessed he was well and so as the family. I was offered a seat and water as custom demands. I ask MR.F. A how the wound was healing, and was confirmed by himself and his wife that it was healing properly and was clean.

MR.F. A together with his wife thanked me for my services rendered so far. They thanked me for the psychological support given to them throughout the operation and its successfulness. I also thanked them for given me the chance to use them for my learning processes. I also thanked them for their maximum cooperation that they offered. I also stressed on the need to eat a well-balanced and nutritious diet to boost their immune system. I informed them that they should always report any sign and symptom of infection to the hospital and to avoid over the counter drugs. I asked questions on the general care and the education given and clarification was then provided. I then handed over the care to his wife who was a community nurse. Permission was sort to leave and it was granted. I assured them that I will come and greet them whenever I pass by. The whole family bid me good-bye.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO MR. F.A

5.0 Introduction

In view of oxford dictionary (2020), evaluation is making a judgement about the value of something, the amount or number. Evaluation marks the final stage of the nursing process. This helps in the measurement of care rendered to the patient and the family. It helps in the comparism of the goals set for the patient and the care that was offered.

This covers the statement of evaluation, amendment of nursing care plan for partially met and unmet goals and termination of care.

5.1 Statement of Evaluation of Care

During the care of MR. F.A, objectives were set for problems identified with good nursing management and cooperation from patient and family, all objectives were fully met and patient's health condition improved.

5.1.1 MR.F. A was relieved of pain (2/12/21)

MR.F. A was Relieved of pain within 24hours on the day of admission 1st December, 2021. At 9:00am, MR.F. A complained of pain in his right scrotum. A nursing diagnosis was formulated as, altered body comfort (scrotal pain) related to accumulation of excess fluid in the scrotum. An objective was set to relieve patient from pain within 24hours. The following nursing interventions were carried out to meet the objective set; MR.F.A was reassured of competent nursing care, His pain level was assessed using numerical rating scale, a calm and restful environment was provided, patient was kept into a comfortable position that relieves his pain, diversional therapies such as; watching television and interacting with patient was done, Prescribed analgesics medications were rightly administered and documented.

On 2nd December, 2021 at 9:00am, an evaluation of the objective set on 1st December, 2021 to relieved of scrotal pain within 24hours was done and goal was fully met as patient verbalized, he had been relieved of pain and nurse recorded patient's pain level of 0 using numerical rating scale

5.1.2. MR.F. A was relieved of anxiety (1/12/21)

On the day of admission 1st December, 2021 at 6:00pm, MR.F.A. complained of anxiety. A nursing diagnosis was formulated as, anxiety related to unfamiliar procedure, new environment and unknown outcome of surgery. An objective was set to relieve patient from anxiety within 2hours as evidenced by, patient demonstrating positive coping mechanism, nurse encouraging patient to ask questions and providing tactful answers. The following nursing interventions were carried out to meet the objective set; Patient was reassured of competent nursing care, patient was given answers to the questions that was asked, unfamiliar procedure was explained to patient, nurse make sure to avoid any painful and intrusive procedure, diversional therapy was provided for patient, finally wife of patient was encouraged to stay with him. On 1st December, 2021 at 8:00pm an evaluation of the objective set to relieve of anxiety within 2hours was done and goal fully met as patient verbalized that he no longer felt anxious and a nurse observed patients relaxed expression.

5.1.3. MR.F. A was relieved of insomnia (2/12/21)

On 1st December, 2021 at 11:00pm, MR.F. A complained of difficulty in trying to fall asleep. A nursing diagnosis was formulated as; insomnia related to pain and change in environment. An objective was set to help patient relieved of insomnia within 24 hours. The following nursing interventions were carried out to meet the objective set; nurse minimized environmental activities and noise to enable patient to sleep, Patient was relieved of pain enabling him to sleep, adequate ventilation was provided to help patient sleep, patient was advised against having long

periods of sleep during the day. On 2nd December, 2021 at 11:00pm, an evaluation of the goal set on 1st December, 2021 to help patient be relieved of insomnia within 24 hours was made and goal was fully met as patient verbalized having enough rest and nurse observing patient having uninterrupted sleep at night. (8hrs)

5.1.4 MR.F. A had intact skin integrity (4/12/21)

On 2nd December, 2021 at 1:00pm, MR.F. A came out of surgery. He had an incision at the scrotum. A nursing diagnosis was formulated as; impaired skin integrity related to surgical procedure. An objective was set to maintain patients skin integrity. The following nursing interventions were carried out; patients wound was dressed on the second day using proper aseptic technique, patient was taken through ways he could take care of his incisional site especially not to let water enter the dressing, incisional was inspected for any form of drainage, change in color, odor. Wound of patient was also checked for rashes or anything that shows allergy for latex. On 4th December, 2021 at 9am, an evaluation of the objective set to maintain intact skin was fully met: the skin of the wound was dry with proper edges and had no smell.

5.1.5 MR.F.A. was relieved of incisional pain (4/12/21)

On 2nd December, 2021 at 3:00pm. A nursing diagnosis was formulated as; acute pain related to tissue trauma and reflex muscle spasm associated with surgery. The following nursing interventions were carried out; patient was assessed for restlessness and diaphoresis, the pattern of pain for patient was assessed. That is, duration, location and onset, patient was advised to split incisional site while coughing, prescribed analgesics was served post-operatively to reduce pain. On 4th December, 2021 at 10:00am, an evaluation of the objective set to relieved MR.F.A. was fully met as patient verbalized less pain and patient was able to go about daily activities.

5.1.6. MR. F.A was educated on how to care for his wound (3/12/21)

On 3rd December, 2021 at 10:00am, upon my interaction with patient, I realized that he lacked sufficient knowledge concerning wound care. A nursing diagnosis of knowledge deficit related to insufficient information on wound care was formulated to help increase patient and the relative knowledge about wound care. The following nursing interventions were carried out to help meet the objective set; patient was educated on the process in caring for wound. That is, how to clean, cover and prevent water from entering, patient was taught how to assess for color, odor, and appearance which will guide him in knowing how the wound healing, MR.F.A and his wife tried answering a lot of questions that were asked on wound care, a clear and simple language was used in answering MR.F.A and his wife tactfully. On 3rd December 2021 at 1:00pm, evaluation was made and goal was fully met as patient and wife verbalized understanding of education, patient and wife making conscious effort to implement whatever information received in caring for the wound.

5.2 Amendment of Nursing Care

Throughout patient stay on the ward, good nursing and medical management coupled with cooperation from MR.F. A and wife, all goals and objectives set were fully met. There was no amendment of any goal.

5.3 Termination of Care

Termination of nurse patient interaction is a completion of care given to the patient and family.

Patient and Family's care ended on the 13th December, 2021 which was the very day I embarked on my last home visit. This ended the interaction between the health team, Mr. F.A and his family. The preparation for termination of care started on the day of admission through discharge, review to the third home visit. On the Monday 13th December, 2021, after the review, I made my third and last home visit. I arrived at their home around 12noon. The main motive for

this visit was to ascertain the progress of the care given to MR.F.A. and also to terminate the care rendered to him

The family was ready to receive me since the visit had been scheduled. I was welcomed warmly. I asked about their health and how MR.F. A was coping. He confessed he was well and so as the family. I was offered a seat and water as custom demands. I ask MR.F. A how the wound was healing, and was confirmed by himself and his wife that it was healing properly and was clean.

MR.F. A together with his wife thanked me for my services rendered so far. They thanked me for the psychological support given to them throughout the operation and its successfulness. I also thanked them for given me the chance to use them for my learning processes. I also thanked them for their maximum cooperation that they offered. I also stressed on the need to eat a well-balanced and nutritious diet to boost their immune system. I informed them that they should always report any sign and symptom of infection to the hospital and to avoid over the counter drugs.

I asked for questions the general care and the education given and clarification was then provided. Permission was sort to leave and it was granted. I assured them that I will come and greet them whenever I pass by. The whole family bid me good-bye.

CHAPTER SIX

SUMMARY AND CONCLUSION OF THE CARE RENDERED

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation (Weller, 2014).

This is the 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

It is a brief statement of the main points of something (oxford dictionary,2020)

MR.F. A is 37-year-old, born on 4TH January, 1984. He resides at" asufufuo" a town in Sunyani District in the Bono- East Region. On 1st December, 2021 at 12:00pm, patient was admitted into male surgical ward of Sunyani regional Hospital at Sunyani. He was ambulant and came by himself. Patient complained of pain and swollen in the right scrotum. He was under the care of Dr A.I. Patient's vital signs was checked and recorded as:

Temperature - 36.2 degrees Celsius

Pulse - 92 bpm

Respiration – 17 cpm

Blood pressure - 138/93 mmHg

Oxygen Saturation - 99% (SPO2)

All these medications were prescribed for Mr. F.A. to help prevent infection, reduce pain and also to increase his level of fluid before the surgery. Laboratory investigations were carried out the day before admission. Laboratory investigation was carried out, that is FBC (FULL BLOOD COUNT)

Patient was educated on the risk's factors, clinical manifestations and both pharmacological and non-pharmacological management of hydrocele. Aside the education, patient was assisted in maintaining good personal hygiene, nutrition and passive exercises. The following medications were used in the management of patient throughout her period of hospitalization;

- iv paracetamol 1g tid x24hrs

-IM pethidine 50mg tid x 24hrs

-Iv cefuroxime 750mg tid x 24hrs

- Tap paracetamol

-Iv fluid normal saline I liter

-Iv ringers' lactate 1 liter

All these drugs were prescribed for MR. F.A to reduced pain, restore fluid volume and to prevent infection and any other complication before and after surgery. Patient presented with six problems, they include; scrotal pain, anxiety, insomnia, a break in the continuity of his skin, incisional pain and little knowledge about wound care. Nursing diagnosis were made, objectives were set and nursing interventions were carried out to solve all these problems. Patient was discharged on his fourth day of admission on the 4th December, 2021. Patient came for a review on 9th December, 2021. Upon assessment, patient looked very healthy as evidenced by his vital signs within normal range with no new complaints. Patient was complying with his medications

as prescribed without defaulting. Three home visits were made in this study. The first home visit was made on 3rd December, 2021 whilst patient was on admission, second home visit was made on 7th December, 2021 after patient was discharged home the third visit was embarked on 13th December, 2021 purposefully to terminate patient's care.

6.2 Conclusion

A successful patient and family care depend greatly on the cooperation of the patient and family members with the nurse's preparedness to help. This care study has not only broadened my knowledge on hydrocele as a condition but I have also put the knowledge and skills acquired from three-year diploma nursing course into practice. It has also helped me to improve upon my interpersonal relationship with patient. My study on MR. F.A has enabled me to understand family conception and different behaviors of people when they are sick. It has equipped me to practice individualized nursing. The study is essential because it is a form of research which helps identify certain health problems in specific areas and the necessary intervention given mainly through health educations. In brief, I really enjoyed every bit of writing this script despite the challenges involved including financial constraints and getting the needed information from patient and family. I recommend that, the idea and principle behind the adoption of the nursing process which is the main approach to the writing of patient and family care study should be accepted by all nurses to ensure total patient care.

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APPENDIX

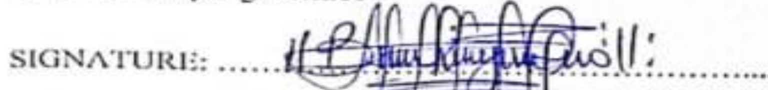
Table 6: vital signs of Mr. F.A

Date	Time	Temperature	Pulse	Respiration	Spo2	Blood Pressure
1/12/2021	10:00am	36.2°C	92cpm	17bpm	99%	138/93mmhg
	2:24pm	36.3°C	79cpm	20bpm	98%	138/86mmhg
	6:04pm	36.5°C	80cpm	20bpm	99%	12/80mmhg
	10:10pm	37.0°C	70cpm	18bpm	98%	130/80mmhg
2/12/2021	7:49am	36.0°C	68cpm	20bpm	99%	138/85mmhg
	10:00am	37.0°C	75cpm	19bpm	98%	100/70mmhg
	2:00pm	36.2°C	55cpm	14bpm	98%	99/67mmhg
	6:34pm	36.2°C	72cpm	20bpm	98%	136/88mmhg
	10:00pm	36.0°C	80cpm	20bpm	98%	110/70mmhg
3/12/2021	6:00am	36.3°C	86cpm	18bpm	97%	100/70mmhg
	10:00am	37.0°C	76cpm	19bpm	98%	120/80mmhg
	2:00pm	36.5°C	90cpm	21bpm	97%	129/85mmhg
	6:00pm	36.5°C	78cpm	18bpm	98%	100/70mmhg
	10:00pm	36.6°C	61cpm	15bpm	99%	122/85mmhg
4/12/2021	6:00pm	37.1°C	76cpm	20bpm	98%	120/60mmhg
9/12/2021	7:00am	36.9°C	80cpm	20bpm	98%	110/70mmhg

SIGNATORIES

1. **THE STUDENT NURSE.**

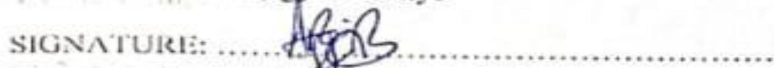
NAME: Frimpong Bernice

SIGNATURE: 

DATE: 07/10/2022.

2. **THE SUPERVISOR, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.**

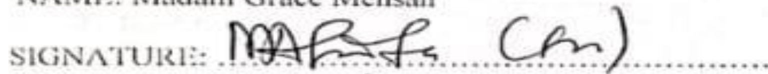
NAME: Ms. Rita Agyei Boakye

SIGNATURE: 

DATE: 07/10/2022

3. **NURSE IN-CHARGE OF MALE SURGICAL WARD, REGIONAL HOSPITAL- SUNYANI.**

NAME: Madam Grace Mensah

SIGNATURE: 

DATE: 07/10/2022

4. **THE PRINCIPAL, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.**

NAME: Monica Nkrumah

SIGNATURE:

DATE: 10/10/2022

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUM