HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT / FAMILY CENTERED CARE STUDY ON CELLULITIS

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

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PREFACE

The Patient/Family care study is a detailed write up of the care rendered to a patient and family by a final year student nurse. It entails a record of encounter between the patient, family and community on one hand and the healthcare team on the other hand, right from patient's admission until termination of care by the student nurse. The patient/family care study gives an opportunity to the student-nurse to interact with the patient in order to identify his strengths and health problems, and to put in measures to help the patient recover in good time. It exposes the student nurse to the real-world situation and experiences as he/she interact with the patient and relatives as well as with other health care providers. This prepares him/her for the professional practice ahead. The patient/family care study build on good communication skills, interpersonal relationship and research skills of the student nurse.

My reason for carrying out this patient/family care study is that, as a final year student, it is a pre requisite by the Nursing and Midwifery Council that I achieve this objective in partial fulfilment for the award of license to practice as a registered general nurse in Ghana. Also, this care study will enable me to translate my theoretical knowledge into practice in assessing, planning, implementing and evaluating nursing care. For the purpose of confidentiality, all persons referred to in this report will only be identified by their initials.

ACKNOWLEGDEMENT

All praises and thanks be to the Almighty God, the sustainer of life who gave me the strength to start and complete this care study successfully.

My sincerest gratitude is reserved for Mr. O. G. F. my care study patient. Without his consent to be studied, this care study would never have been a success. Not forgetting his family members for their commendable cooperation and support throughout the period of the study.

Exceptional thanks go to the nurse-in-charge and the nursing staff of the Males ward at Holy Family Hospital, Berekum. They gave me support and morale for this care study. The supporting staff and colleague students whom I worked with at the Males ward have not been forgotten for various manners of help.

Thanks go to my supervisor Madam Asantewaa Grace, her valuable time, patience, criticism and persistent guidance has ensured the successful completion of this care study.

My deepest gratitude goes to the principal Mrs. Monica Nkrumah and the entire tutorial staff of the Holy Family Nursing and Midwifery Training College- Berekum.

My greatest gratitude goes to my parents, their moral, spiritual and financial support has undoubtedly ensured my coming this far. They taught me the value of respect, hard work and patience.

Finally, I acknowledge and thank all authors and publishers whose works have been used as references in this care study.

INTRODUCTION

This script is about nursing care rendered to Mr. O. G. F. during the period of admission, hospitalization and after discharge. Mr. O. G. F., a 77-year-old man was admitted to the Males ward through the Out Patient Department of Holy Family Hospital, Berekum on the 12th December, 2022 at 11:10am with a diagnosis of cellulitis of the left lower limb. During our interaction, six health problems were identified and nursing diagnosis and objectives were made for each of them. On the day of discharge, all the objectives set were met. On admission, he presented fever and also had severe pain and oedema at his left lower limb. Mr. O. G. F. was discharged on 17th December, 2022. During admission, some of the treatment plan for Mr. O. G. F. were IV Clindamycin 600mg qid for three days, Tablet Paracetamol 1g tds for five days, IV Cefuroxime 750mg tds for three days and Ringers Lactate 500mls for 24hours. Patient was educated on cellulitis. On 21st December, 2022, patient reported for review as scheduled. Three home visits were embarked on. The first home visit was done while patient was still on admission on 14th December, 2022, second home visit was on the 19th December, 2022 and third home visit was on the 27th December, 2022. The care of Mr. O. G. F. and his family was terminated on the 27th December, 2022, during the third home visit when patient had fully recovered from cellulitis with oedema of the left lower limb resolved, no pain and was not warm to touch.

This report is organized into five chapters based on the nursing process phases

Chapter one deals with the assessment of Mr. O. G. F. and family. This involves collection of data about the patient to identify his problems. Data collected for assessment includes biographical data, developmental, past and present medical history, the family's medical and socioeconomic history as well as the patient's lifestyle and hobbies. An account is also given on the admission of the patient, literature review on Cellulitis as well as validation of data also discussed.

Chapter two deals with the analysis of data. A comparison is made between the signs and symptoms experienced by the patient and those obtained in literature review. Diagnostic investigations, clinical manifestations and pharmacology of drugs are analyzed in tabular form. Causes of illness, treatment and complications are also discussed. Data is analyzed to arrive at appropriate nursing diagnosis reflecting the patient's response to actual or potential health problems.

Chapter three comprises the planning phase of the nursing process and has the tabulated plan of care for the stated nursing diagnoses spanning the objective criteria, nursing orders, intervention and evaluation.

Chapter four tackles the actual implementation of the care giving summary descriptions of activities which were undertaken from the moment of first contact with the patient at the time of admission to the ward till discharge and subsequent follow up with home visit.

In chapter five, evaluation of nursing care given to the patient and her family from encounter till termination of nurse-patient relationship is discussed. A summary and conclusion then end this care study report by reviewing thematic issues that arose in the care study from admission to last home visit after discharge

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CHAPTER ONE

ASSESSMENT OF PATIENT /FAMILY

1.0 Introduction

An assessment is a critical analysis and evaluation or judgment of the status or quality of a particular condition, situation or other subjects of appraisal (Smeltzer, et al, 2010). This gives information about the patient, his family and the community characteristics. It is the first stage and a vital tool in the nursing process. Assessment can be done through observations, interviewing and investigations such as laboratory results, x-ray reports and physical examination of the patient. It includes the patient's particulars, patient/family medical and surgical history, patient's socioeconomic history, patient's developmental history, patient's lifestyle and hobbies, patient past medical and surgical history, patient present medical and surgical history. It also includes admission of patient, patient and family concept of his illness, literature review on the condition from which analysis will be made to identify the patient problems and validation of data. These help the nurse to determine the health status of the patient and his family in order to plan an effective nursing care towards recovery. All the information was gathered from the patient and his relatives, as well as the patient's e-folder.

1.1 Patient's particulars

Patient refers to a person who is receiving medical treatment in the hospital (Hornby, 2006). Particulars is also defined as information about a person, especially when officially recorded (Mcintosh, 2013).

Mr. O. G. F. is the name of my patient. He was born to Mr. O. M. and Mrs. K. Y. Z. on 21st November 1945 at Benkasa, Berekum in the Bono Region of Ghana but currently lives at Kyiribaa, Berekum with house number PLT9, BLK P. He speaks Twi and English language. He is dark in complexion and weighs about seventy-five kilograms (75kg) with height of

1.70meters. He is the second born of his parents. Mr. O. G. F's parents are farmers in Berekum and are all alive.

Mr. O. G. F. is married to Mrs. K. M. and has twelve (12) children, four (4) boys and Eight (8) girls. He is a retired headmaster of All For Christ S.H.S. Mr. O. G. F. is a National Health Insurance beneficiary. He has no physical impairments or disabilities. He is a Christian who worships at All for Christ church. His next of kin is Mr. A.S (his first born). His e-folder number at Holy family hospital, Berekum was AAB2629.

1.2 Patient / family medical and surgical history

Knowing patient's family medical history is very important because, it gives a clue on some of possible diseases that the patient can inherit from parents. Mr. O. G. F. said that aside hypertension, there is no known chronic disease such as diabetes mellitus, sickle cell anemia, asthma neither are there any communicable diseases like tuberculosis, leprosy nor any mental disorder in the family. He however revealed that, his family members occasionally suffer minor ailment such as fever, malaria, headache which are treated by self -medication (using both over-the -counter drugs and traditional medicines) but if symptoms persist, they report to hospital. Based on this information, I educated my patient and family about the effects of the use of over-the-counter drugs and urged them to seek medical care from any health center when they are suffering from any condition. Mr. O. G. F. informed me that, this is the third time he has being hospitalized at Berekum Holy Family Hospital. The two previous admissions were on account of malaria. The source of medical treatment of Mr. O. G. F. and family are both orthodox and herbal medicine. There are no known allergies and taboos in the family.

1.3 Patient socio-economic history

This comprises both social and economic status of the patient. Mr. O. G. F. is the bread winner of the family and he is supported by his wife and sometimes receive help from his eldest son. Mr. O. G. F. is a retired headmaster of All for Christ S.H.S. but engages in farming

activities. The socio-economic life of Mr. O. G. F. is quite favourable because he belongs to the middle-income group. They are able to afford a three-square meal daily. His family currently consists of himself, his wife and their twelve (12) children but still keeps in touch with his parents and other members of the extended family. His family members are well known for their enormous participation in religious activities, their kindness and generosity. In terms of religious believes he revealed that, all of his family members are Christians. The family members according to Mr. O. G. F. depend on National Health Insurance Scheme (NHIS) for medical care. There are no taboos governing the family. Mr. O. G. F. revealed that there are family values, taboos and cultural practices but they are not known to him.

1.4 Patient developmental history

Development refers to the biological, psychological and emotional changes that take place in an individual from birth until the end of adolescence as the individual progresses from dependency to increasing autonomy. Growth means the gradual increase in size of the body and its organs. (Livio, 2009). According to Mr. O. G. F. he was told by his mother that he was born spontaneously on 21st November, 1945 at his hometown in Benkasa and was delivered by traditional health attendance Mrs. A.N. without any complications. He said he was told by his mother that he was not immunized against all the six childhood killer diseases but did not suffer any of them and the mark of the vaccine was not seen on his shoulder. He said he was told he did not suffer any ailment or injury that might affect his development. Mr. O. G. F. was well breastfed by his mother for two years. He had a normal developmental milestone. He started to crawl at the nineth month. By the age of fourteen years, he exhibited characteristics of puberty such as, growing of pubic hairs, deep voice, enlargement of penis and others. He had his first sexual intercourse at age 21. Mr. O. G. F. has no physical disability and has no identifiable allergy. As specified by Jarvis (2000), Erik Erikson focused on cultural and societal influences as determinants of behaviour. Erickson was concerned with the growth of ego, the conscious,

organized, rational part of the personality. According to Erik Erikson's psychological theory, individual goes through eight (8) stages of development with their corresponding ages. Mr. O. G. F. is 77 years old so he is in Integrity versus Despair.

Completing this stage successfully leads to a strong sense of self-esteem and confidence that remains throughout life. Upon communicating with him, I found out that he had identified himself because he had a dream of poultry farm activities in future. Outwardly, he seemed shy but has a good personal and social interaction with other people.

1.5 Patient lifestyle and hobbies

Life style simply refers to the pattern of daily living that an individual develops (Weller, 2014). Mr. O. G. F. usually goes to bed around 9:00 pm and wakes around 5:30am and says his morning prayers after which he reads for 2hours. He maintains his oral hygiene with the use of yazz tooth brush and close up toothpaste which is his favourite. Afterwards, he empties his bowel and takes his bath with warm water and prepares for farm. For breakfast, patient mostly takes porridge with bread. Patient indicated that he usually takes rice and soup or Ampesi and stew for lunch around 12:00pm. Patient revealed that he usually read books or watches television on leisure times. During Saturdays, he wakes up early in the morning and goes about his normal duties. In the evening, he watches movie with the family to entertain themselves. He attends church on every Sunday. His favorite meal is Banku with okro stew. He baths twice a day and cleans the teeth twice every day. Patient has no known allergy to food or drugs. He does not have any fixated habit such as drinking, smoking, gossiping etc. Mr. O. G. F. likes everyone but does not like it when people want to abuse his right. He described himself as an introvert. My personal impression about my patient is that, he is very calm, humble and generous.

1.6 Patient's past medical history

Past medical history is a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health (MediLexicon, 2009). Mr. O. G. F. never experienced any childhood illness like whooping cough, measles, tetanus, tuberculosis, and diphtheria and has not identified any allergy to drugs, animals or insects. He revealed that he usually suffers from minor ailments such as headache and common cold which he treats with over-the-counter medications. When symptoms persist, he visits a nearby hospital or clinic. Mr. O. G. F. has been hospitalized twice already on account of malaria. He has no history of surgery.

1.7 Patient's present medical history

History of present illness is a complete, clear account of the problems prompting the patient to seek care (Bickley & Szilagyi, 2009). Mr. O. G. F. said he was in his usual state of health last Saturday (10th December, 2022) when he was chasing his grandson upon switching off the light of the hall they were playing, accidentally hit his left leg on one of the chairs at his hall so he noticed the swelling of the leg the following day but reported to the facility two days after the incident. He was apparently doing well until 12th December, 2022. The pain and swelling became unbearable so he complained to his nephew about it and reported to the Out Patient Department of Holy Family Hospital, Berekum at 9:00am on 12th December, 2022. He was seen at the consulting room 3 by Dr. G. P. and upon examination he was diagnosed with cellulitis of the left lower limb and he was subsequently admitted to the Males Ward on the same day. Swollen left lower limb was the patient chief complain but was accompanied by pains, fever and localized tenderness.

1.8 Admission of patient

On the 12th December, 2022 at 11:10am, Mr. O. G. F. was admitted to the Males ward of Holy Family Hospital, Berekum. His admission was ordered by Dr. G. P. from the OPD with a

diagnosis of cellulitis of the left lower limb. Patient was brought to the ward in a wheel chair accompanied by his nephew. His admission was confirmed by calling his name written on the e-folder card handed to me and he responded. On arrival, patient was conscious and alert. Patient and relative were welcomed to the nurse's station and patient was made comfortable in an already prepared bed with the foot end elevated with pillow, to aid circulation and to reduce pain in his edematous feet. I introduced myself to the patient and relative as a final year student at Holy Family Nursing and Midwifery Training College, Berekum and other staff present were also introduced. His card number was entered on the ward computer and further mentioning his name for response, and his admission was stated clearly there by the doctor. Patient and relatives were reassured that he was in the hands of competent staff and everything possible would be done to return him to normal. This is an attempt to allay fears and anxiety from the patient and relatives. His particulars such as sex, age, name, residential address was recorded into the admission and discharge book as well as daily census sheet. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained. National Health Insurance scheme policy was also explained to him. I introduced myself to the patient and relative as a final year student at Holy Family Nursing and Midwifery Training College, Berekum. Patient was introduced to nearby patients and was well oriented to the ward. Admission note was documented and vital signs were checked and recorded accurately as follows:

1. Temperature 38.9 degree Celsius (°C)
2. Pulse 84 beat per minute (bmp)
3. Respiration 21 cycle per minute (cpm)
4. Blood Pressure 120/90 millimeters of mercury (mmHg) and

Oxygen saturation 95%

Patient`s weight was 75kg, Tablet paracetamol 1g was given to reduce the pain and temperature. The rest of the medications were collected from the pharmacy and served as ordered. Cold malt was served to the patient to help reduce the temperature to a normal physiological level and after 3 hours patient temperature reduced to 37.60C, which showed a sign of improvement. Physical examination on the patient was performed from head to toe and no abnormalities were seen. At the time of admission, assessment revealed that patient had high body temperature, pain at the left lower limb. Patient and relatives were orientated around the ward, which involve where to find bathroom, Nurses station and he was also hinted on all hospital protocol available. He was introduced to the patient around him and was told to call for help when needed. I made him aware of items he can keep in the ward as well as those he needed during admission and visiting times. The patient was to be managed on the following plan:

1. IV Clindamycin 600mg qid for 3days
2. Tablet Paracetamol 1g tds for 5days
3. IV Cefuroxime 750mg tds for 3days
4. SC Clexane 40mg od and

Ringers Lactate 500mls for 24hours

All these medications were correctly administered as ordered.

The following diagnostic investigation were requested.

1. Full blood count (FBC).
2. Fasting blood sugar (FBS).
3. Blood for malaria parasite (MPs).
4. Doppler USG of the affected limb (left)
5. Wound swab for culture and sensitivity

I reintroduced myself to patient as a final year nursing student of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my care study. Mr. O. G. F. and his nephew were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of Diploma in Registered General Nursing. It was explained to the patient and his nephew about the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. I told them that I will visit their home while they are still on admission and also visit them when they are discharged home to continue the care being rendered. It was also made clear to the family that they have the right to withdraw from the arrangement whenever they feel to do so. Mr. O. G. F. and his relatives agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the patient; thus, they will continue the care at home once he is well. I decided to choose this patient for the study because I had been taught the theoretical aspect of cellulitis and wanted to utilize this opportunity to put theoretical knowledge into practice.

1.9 Patient concept of illness

Mr. O. G. F. did not attribute his illness to any spiritual cause in spite of his spiritual believes as a Christian. He also said that some conditions like epilepsy and other mental disorders can have spiritual implications. He believes that everyone is vulnerable to the condition. He also revealed that he does not know the exact cause of his condition. Patient also believes that, the treatment planned for him in the hospital will help treat his illness and prevent any complication.

1.10 Literature review

Anatomy and Physiology of the Integumentary System (skin). The integumentary System (skin) consists of the skin, hair, oil and sweat glands, nails and sensory receptors which play a

role in the maintenance of homeostasis. It is the largest organ in the body which act as the primary barrier in disease prevention (Hinkle & Cheever, 2014). The skin is composed of three layers: epidermis, dermis, and subcutaneous tissue.

Epidermis

The epidermis is an outermost layer of stratified epithelial cells composed predominantly of keratinocytes. This is the most superficial layer and is composed of stratified keratinized squamous epithelium. It varies in thickness, being thickest on the palms of the hands and soles of the feet. There are no blood vessels or nerve endings in the epidermis, but its deeper layers are bathed in interstitial fluid from the dermis, which provides oxygen and nutrients, and drains away as lymph. There are several layers (strata) of cells in the epidermis; from innermost to outermost they are the:

1. Stratum basal or germinativum. This is the last layer and deepest layer of the epidermis.
2. Stratum spinosum. This layer is the last but one deeper layer of the epidermis.
3. Stratum granulosum. This layer is the middle layer of the epidermis.
4. Stratum lucidum. This is the next superficial layer to the stratum corneum.
5. Stratum corneum. This is the most superficial layer of the epidermis.

Melanocytes are the special cells of the epidermis that are primarily involved in producing the pigment melanin, which colours the skin and hair. Skin colour darkens as melanin content increases. Melanin production is controlled by a hormone secreted from the hypothalamus of the brain called melanocyte-stimulating hormone. Two other types of cells are common to the epidermis: Merkel and Langerhans cells. Merkel cells are receptors that transmit stimuli to the axon through a chemical synapse. Langerhans cells are believed to play a significant role in cutaneous immune system reactions (Hinkle & Cheever, 2014)

Dermis

The dermis is tough and elastic. It is formed from connective tissue and the matrix contains collagen fibers interlaced with elastic fibers. Collagen fibers bind water and give the skin its tensile strength, but as this ability declines with age, wrinkles develop. Fibroblasts, macrophages and mast cells are the main cells found in the dermis. Underlying its deepest layer is the subcutaneous layer containing areolar tissue and varying amounts of adipose (fat) tissue. According to (Waugh & Grant, 2014). The structures in the dermis are:

1. 1.Blood vessels,
2. Sensory nerve endings,
3. Sweat glands and their ducts,
4. Hairs, erector pili muscles and sebaceous glands
5. Lymph vessels,

Subcutaneous tissue or hypodermis

The subcutaneous tissue, or hypodermis, is the innermost layer of the skin. It is primarily adipose tissue, which provides a cushion between the skin layers, muscles, and bones. It promotes skin mobility, molds body contours, and insulates the body. Fat is deposited and distributed according to the person's gender and in part accounts for the difference in body shape between men and women (Smeltzer et al., 2010).

Functions of the Skin

According to Hinkle and Cheever, (2014) the following are the functions of the skin,

1. Protection: The skin covering most of the body is no more than 1 mm thick, but it provides very effective protection against invasion by bacteria and other foreign matter.

2. Sensation: The receptor endings of nerves in the skin allow the body to constantly monitor the conditions of the immediate environment. The primary functions of the receptors in the skin are to sense temperature, pain, light touch, and pressure.

3. Fluid Balance: The stratum corneum, the outermost layer of the epidermis, has the capacity to absorb water, thereby preventing an excessive loss of water and electrolytes from the internal body and retaining moisture in the subcutaneous tissues.

4. Temperature Regulation: The body continuously produces heat as a result of the metabolism of food, which produces energy. This heat is dissipated primarily through the skin.

5. Vitamin Production: Skin exposed to ultraviolet light can convert substances necessary for synthesizing vitamin D (cholecalciferol). Vitamin D is essential for preventing osteoporosis and rickets, a condition that causes bone deformities and results from a deficiency of vitamin D, calcium, and phosphorus.

6. Immune Response Function: Research has confirmed a definite action of Langerhans cells in facilitating the uptake of immunoglobulin E (IgE)-associated allergens.

Definition of Cellulitis

According to Ministry of Health [MOH] (2014), Cellulitis is a diffuse inflammation of the soft tissue under the skin. Usually, it follows an infected wound or prick by a pin, nail, thorn, insect bite or cracks between the toes. Diabetes mellitus may be a predisposing factor. Cellulitis is a spreading infection caused by some anaerobic bacteria including Streptococcus pyogenic and Clostridium perfringens that enter through a break in the skin. Their spread is facilitated by the formation of enzymes that break down the connective tissue that normally isolates an area of inflammation. If untreated, the bacteria may enter the blood causing septicemia (Waugh & Grant, 2014)

Cellulitis is an infection of the deep dermis of the skin by beta-hemolytic streptococci. It is most common on the lower legs and there may be associated with lymphangitis and lymphadenitis (Kumar & Clark, 2017).

Causes

The MOH (2014) identified bacterial infection by Streptococcus pyogenic (the commonest Cause) and Staphylococcus aureaus as the causes of cellulitis. Waugh and Grant (2014) shared similar views that, Cellulitis is caused by some aerobic pyrogenes or Clostridium perfringens, diabetes mellitus, insect bites and stings, cracks or peeling skin between toes, surgical wound infection injury or trauma (pin or needle prick) and intravenous drugs injections.

Pathophysiology

Cellulitis occurs when an entry point through normal skin barriers allows bacteria to enter and release their toxins in the subcutaneous tissues. The acute onset of swelling, localized redness, and pain is frequently associated with systemic signs of fever, chills, and sweating. The redness may not be uniform and often skips areas. Regional lymph nodes may also be tender and enlarged (Hinkle & Cheever, 2014).

Clinical Manifestation

As specified by MOH (2014) the following are the signs and symptoms of cellulitis;

1. Pain
2. Fever
3. Malaise
4. Reddening or darkening of the overlying skin
5. Swelling of affected part
6. Localized tenderness
7. Localized warmth
8. Enlarged and tender regional lymph nodes
9. Underlying pus
10. Offensive wound

Investigations

The MOH (2014) outlined the following diagnostic investigations for cellulitis

1. Full blood count (FBC)
2. Fasting blood glucose (FBG)
3. Wound swab for culture and sensitivity, if discharging pus

Medical Treatment

Treatment objectives

Ministry of Health, Ghana (2014) stated that the treatment objectives are;

1. To relieve pain
2. To control the infection
3. To treat predisposing condition(s)

Pharmacological treatment

The pharmacological treatments recommended by Ministry of Health; Ghana (2014) include;

1. Antipyretic e.g., Paracetamol, Route; Orally, Adults 500 mg -1 g 6 to 8 hourly, Children 6-12 years; 250-500 mg 6 to 8 hourly, 1-5 years; 120-250 mg 6 to 8 hourly and 3 months-1 year; 60- 120 mg 6 to 8 hourly
2. Antibiotics e.g. Amoxicillin plus Flucloxacillin Amoxicillin, Route; Orally, Adults 500 mg -1 g 6 to 8 hourly, Children 6-12 years; 250 mg 6 hourly for 7 days, 1-5 y ears; 125 mg 6 hourly for 7 days, < 1 year; 62.5 mg 6 hourly for 7 days Plus Flucloxacillin, Route; Orally, intramuscular and intravenous injection Adults 250-500 mg 6 hourly for 7 days, Children > 10 years; 250-500 mg 6 hourly for 7 days, 2- 10 years; 125-250 mg 6 hourly for 7 days, < 2 years; 62.5-125 mg 6 hourly for 7 days
3. Analgesics and anti-inflammatory e.g. Ibuprofen, Route; Orally Adult: Initially 300–400 mg 3–4 times a day; increased if necessary up to 600 mg 4 times a day; maintenance 200–400 mg 3 times a day, may be adequate.

Surgical Treatments

The surgical treatment for Cellulitis is incision and drainage of the pus for those that suppurate and debridement for cellulitis with slough in the wound as well as careful wound care after the surgical procedure MOH (2014).

Nursing Management

The MOH (2014) stated the following nursing management;

1. Clean and dress any open wound.
2. Rest and elevate the affected part if possible

Hinkle and Cheever (2014) added the following nursing interventions; Position, Rest and Sleep

1. Ensure bed rest in a peaceful environment. Patient should be made comfortable always to reduce the impact of pain.
2. Client is best nursed in a supine position with the affected limb slightly elevated with a pillow to help reduce oedema.
3. Measures were put in place to ensure that client sleeps well eg: client took warm bath, soiled bed linen was changed and client environment was noise free.
4. All nursing interventions should be carried out in well-ventilated and noise free environment.

Preoperative preparation

1. Reassure patient and relatives to allay fear and anxiety.
2. Let patient be aware that surgery will relieve him out of the pain he is experiencing.
3. Explain all procedures to patient, educate patient on the condition to build upon his knowledge and answer accurately all question asked by patient and relatives.
4. Explain the signing of consent form to patient and the family members to give consent for surgery.
5. Set up intravenous fluid to replace fluid loss and promote adequate renal functioning.
6. Serve all preoperative drugs prescribed by the physician.

7. Monitor vital signs.

8. Educate patient and relatives on the need of personal hygiene.

Post-operative management

1. Reassure patient after gaining full consciousness after a successful surgery to allay fear and anxiety.

2. Monitor and record vital signs of the patient which includes Temperature, Respiration, blood pressure and oxygen saturation and report if there is any deviation from the normal.

3. Assess the incisional site for bleeding and report if any.

4. Serve all postoperative medications prescribed by the physician.

5. Ensure good ventilation.

6. Serve postoperative IV fluid to the patient.

7. Ensure personal hygiene.

Medication

1. All prescribed drugs should be administered ensuring that it is the right drug, given through the right route, to the right person at the right time.

2. Observe for any side effects of the drug and ask patient to voice out any abnormality noticed after taking the drug.

3. All administered medications with any side effect (if present) should be documented and reported.

Personal Hygiene

1. Ensure proper hygiene methods such as bathing at least twice daily and brushing of the teeth or cleaning the mouth daily.

2. Dirty clothing and linen should be changed.

3. The hands and feet should be well cared for by ensuring that nails are clean and tidy, by washing and combing.

4. Care should be taken when bathing or cleaning the affected area to avoid inflicting pain.

5. All used items during all nursing cares taken must be discarded or decontaminated appropriately.

Nutrition

1. A well balanced meal should be provided containing carbohydrates, protein, vitamins, fats and oil, roughages and minerals.

2. Food should be extra rich in vitamins especially vitamin C and protein to help boost the immune system and facilitate healing.

3. Roughages as well as proper intake of fluids should be ensured to help prevent constipation due to limitation in activities and movement of client.

4. Ensure adequate intake of diets which are easily digestible and absorbable e.g., fruit juice to prevent constipation or GI abnormalities.

Observation

1. Patient's vital signs should be checked and recorded accurately (temperature, pulse, respiration, blood pressure). This aids to assess the progress of the client.

2. Patient's level of pain is also assessed so that measures may be taken to reduce it.

3. The client's level of activity is also assessed so that the necessary help may be rendered.

4. Therapeutic and other effects of drugs are also assessed for response to treatment.

5. Weight of client must be assessed and compared to the normal weight of the client to detect deviation from normal.

6. Circumference and length of the affected limb should be measured on daily bases and compared to the unaffected one to detect the degree of abnormality.

Psychological Care

1. Reassure patient and family that the client is in the hands of competent staff and that proper medical care is available for complete recovery.

2. Allow client as well as her family members to voice out their worries and ask questions, their worries should be addressed and questions answered as honestly as possible.

3. Engage patient in friendly interactions to aid comfort and relaxation at the hospital this also promotes cooperation and rapport establishment.

4. Engage the patient in diversional therapy such as watching of television and explain any procedure before carrying it out. This helps reduce anxiety and pain.

Elimination

1. Due to reduced activity and bed rest, patient may experience constipation thus intake of roughages, fruits and fluids should be encouraged to aid free bowel movement.

2. In case of vomiting, a vomits bowl should be made available to the patient. Vomitus should be observed for its characteristics and abnormalities and recorded.

3. Bed pan must be served when necessary.

4. Encourage patient to take copious fluids.

Patient and Family Education.

1. Advice patient and family to ensure personal and environmental hygiene (bathing and brushing the teeth daily, keeping the surroundings clean, wearing of clean clothing and proper well-fitting shoes.

2. Educate on protective measures for the skin such as application of lotions and skin cream to prevent cracking of the skin, wearing of comfortable shoes to prevent athletes' foot, wearing appropriate protective equipment during work and sports.

3. In case of a break in skin, it should be cleaned carefully and covered with a clean material.

4. Dog bites and bites from other animals should be reported to the hospital for the necessary treatment.

5. Meals should also be well balanced with a lot of vitamins to boost immunity and facilitate healing.

6. Educate patient on the need for proper intake of drugs and the importance of review.

Complications

1. Bone infection (Osteomyelitis). This is an infection of the bone. Wounds are very likely to become infected. This can result in a very dangerous deep abscess that can also infect the bone.

2. Meningitis (if its peri-orbital). This can occur if the bacteria get inside the central nervous system.

3. Sepsis. If the bacteria reach the bloodstream, the person has higher risk of developing sepsis.

4. Tissue necrosis (gangrene). This refers to the death of tissue due to either lack of blood flow or a serious bacterial infection and since cellulitis can result in serious bacterial infection it has the tendency to result in tissue necrosis if left untreated.

Preventions.

The MOH (2014) outlined the following preventions of cellulitis.

1. Keep skin moist with lotions or ointments to prevent cracking.

2. Wear shoes that fit well and provide enough room for your feet.

3. Avoid contact with corrosive substances that can cause break to skin

4. Learning how to trim your nails to avoid harming the skin around them.

5. Whenever you have a break in the skin; clean wound with water and soap, apply an antibiotic cream or ointment every day and cover with a bandage and change it every day until a scar forms, watch for redness, pain, drainage or other signs of infections.

Wound Care

Wound should be dressed as ordered by the doctor and strict aseptic techniques must be ensured

1.11 validation of data.

Validation is the extent to which a measure, indicator, or a method of data collection possesses the quality of being sound or true as far as it can be judged (Weller, 2014). The information for this study was gathered from Mr. O. G. F, his relatives, nurses and medical records, personal

observation and laboratory investigations. To prevent doubt and misinterpretation of information, they were cross-checked with Mr. O. G. F. and relatives. The literature reviewed also confirmed. This indicated that the data collected was valid since there were no contradictions.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis is a statistic that measures difference among group means and uses a statistical technique to equate the groups under study in relation to another given variable (Weller, 2014). Analysis of data is the second phase of the nursing process, which involves careful comparison of the patient's problems or the information gathered from patient and relatives with standards and then putting these problems in order of priorities to plan for the care of the patient and family (Delaune & Ladner, 2010). This section covers the under listed areas;

1. Comparison of data with standards,
2. Patient and family's strengths,
3. Patient and family health problems,
4. Nursing diagnosis

2.1 Comparison of data with standards

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

2.1.1 Diagnostic Investigation/Test.

The following are list of investigations which were carried out on Mr. O. G. F. during his period of hospitalization

1. Full blood count (FBC).

2. Fasting blood sugar (FBS).

3. Blood film for malaria parasites (MPs).

4. Doppler USG of the affected limb

5. Wound swab for culture and sensitivity

Table 1: Comparison Of Diagnostic Tests Done To Literature Review.

Diagnostic Test outlined in Literature Review.	**Test Carried out on patient.**
1. Full Blood count.	**1.** Full Blood count was done.
2. Fasting Blood Sugar check.	**2.** Fasting Blood Sugar check was done.
3. Wound swab for culture and sensitivity test.	**3.** Wound swab for culture and sensitivity was not done
4. Blood film for malaria parasites was not in literature review.	**4.** Blood film for malaria parasite was done.
5. Doppler USG of the affected limb	**5.** Doppler USG of the affected limb(left) was done

Blood film for malaria parasite test (MPs) was done which is not among literature. This was because patient was manifesting some of the signs and symptoms of malaria aside cellulitis. Hence this was to serve as a differential diagnose for cellulitis. From the table one can conclude that Mr. O. G. F. was rightly diagnosed since most of the diagnostic tests outlined in literature review were carried out on him.

2.1.2 Causes of patient's illness

With references to the literature review, cellulitis is caused by Streptococcus pyogenes, Staphylococcus aureus, Clostridium perfringens, diabetes mellitus, insect bites and stings, cracks or peeling skin between toes, surgical wound infection and injury or trauma (pin or needle prick). In the case of Mr. O. G. F, his condition could be as a result of trauma of which micro- infections like Streptococcal or Staphylococcal infection gained entry into his skin. However, culture and sensitivity test were not carried out to see the organism.

Table 2: Clinical Features Of Mr O. G. F. Compared To Literature Review

Clinical Features in Literature Review	Clinical Features Exhibited by Patient
1. Pain.	1. Patient complained of pain at the left lower limb.
2. Fever.	2. Patient experienced fever (38.9^0C).
3. Malaise.	3. Patient complained of malaise.
4. Reddening or darkening of the overlying skin.	4. Reddening or darkening of the overlying skin of the left lower limb
5. Swelling of the affected parts.	5. Swelling of the left lower limb was seen.
6. Localized tenderness.	6. Patient complained of localized tenderness.
7. Headache.	7. Patient complained of headache.
8. Nausea and vomiting.	8. Patient experienced nausea and vomiting.
9. Warmth over the site.	9. Patient left lower limb was warm to touch.
10. Offensive wound.	10. There was wound present but not offensive
11. Enlarged and tender regional lymph nodes.	11. Enlarged and tender regional lymph nodes were not present.

The above comparison indicate that my patient condition is truly cellulitis since most of his exhibited signs and symptoms appeared in the literature review. Mr. O. G. F. complained of headache which is not among literature but care was planned to relieve him of the symptom.

Table 3: Results Of Diagnostic Investigations Carried Out On Mr. O. G. F.

Date	Specimen	Investigation	Result	Normal values	Interpretations	Remarks
12/12/2022	Blood	**Full blood count** RBC	4.11[10^6/ul]	2[10^3/ul]	Normal	No treatment given
		Haemoglobin level	12.9g/dl	12.3-18.0g/dl	Normal	No treatment given
		WBC	5.22[10^3/ul]	3.00- 8.50[10^3/ul]	Result within normal range	Antibiotics such as Clindamycin 600mg qid for 3days were prescribed for the patient.
		Neutrophils	5.04[10^3/ul]	1.50- 7.00[10^3/ul]	Result within normal range	Antibiotics were prescribed for the patient.
		Platelet count	307.0[10^3/ul]	150- 400[10^3/ul]	Result within normal range	No treatment was given.
12/12/2022	Blood	**Fasting Blood Sugar** (FBS)	4.3mm/l	4.1-6.2mm/l	Result within normal range	Patient was educated on his nutritional status.
12/12/2022	Blood	Malaria RDT	Negative	No malarial parasites should be present.	Patient was not suffering from malaria.	Patient was educated to sleep in a treated mosquito net.
13/12/22		Doppler USG of the left lower limb			Deep Vein Thrombosis was absent	Patient's affected limb was elevated on a slide wooden board

Table 4: Treatment Given To Mr. O. G. F. Compared With That Of Literature Review.

Treatment as in literature review.	**Treatment given to my patient**.
1. Antipyretic e.g.: Paracetamol	1. Tablet Paracetamol was given.
2. Antibiotics e.g.: Ciprofloxacin, Clindamycin, Cefuroxime.	2. Patient was given: IV Cefuroxime and IV Clindamycin.
3. Analgesics and Anti-inflammatory e.g.: paracetamol, diclofenac.	3. Patient was given: Tablet paracetamol.
4. Surgery (Incision and Drainage).	4. No surgical treatment was given to the patient.

From the above Table, it is indicative that treatments given to patient were in line with the literature and that helped in the full recovery of MR. O. G. F.

2.1.3 Medical Treatment Given to the Patient

Treatment refers to the mode of dealing with a patient or disease (Weller, 2014). According to clinical manifestation presented by MR. O. G. F., the following medical treatment were prescribed and administered:

1. IV Clindamycin 600mg qid for 3days (12/12/2022)
2. Tablet Paracetamol 1g tds for 5days (12/12/2022)
3. IV Cefuroxime 750mg tds for 5days (12/12/2022)
4. Ringers Lactate 500mls for 24hours (12/12/2022)
5. Capsules Clindamycin 300mg qid for 3days (15/12/2022)

Table 5:1 Pharmacology Of Drugs Administered To Mr. O. G. F.

Date	Drug	Standard Dosage/ Route of Administration	Dosage/ Route of Administration on Given to Patient.	Classification	Desired Effect	Actual Action observed	Side Effect/ Remark
12/12/21 **15/12/21**	IV Clindamycin Capsules Clindamycin	**Dosage**; Adult: 150–300 mg every 6 hours; **Route** Orally, Intramuscular, intravenously **Dosage**; Adult: 150–300 mg every 6 hours; **Route:** Orally, Intramuscular, intravenously.	**Dosage** 600mg qid for 3days **Route** Intravenously **Route/Dosage:** Oral route 300mg qid 3days	Antibacterial (Lincosamides)	To prevent infection and interfere with cell replication	Bacteria that caused patient's cellulitis were controlled	Jaundice, diarrhoea, abdominal discomfort, nausea and vomiting. Patient did not experience any of these symptoms

Table 5:2 Pharmacology Of Drugs Administered To Mr. O. G. F. Cont'd

Date	Drug	Standard Dosage/ Route of Administration	Dosage/ Route of Administration on Given to Patient.	Classification	Desired Effect	Actual Action observed	Side Effect/ Remark
12/12/21	Tablet Paracetamol	**Dosage:** 0.5- 1g every 4-5 hours; maximum 4g per day **Route** Orally, Rectal and Intravenously	**Dosage:** 1g tid x 5days **Route** Orally	Antipyretic/ Analgesic	To reduce pains and fever.	Patient had a reduction in pain and experienced decreased in temperature	Acute generalized exanthemata's pustulosis, Malaise, skin reaction, Haematological reaction, allergic Reaction and liver damage following overdose. Patient experienced no side effect

Table 5:3 Pharmacology Of Drugs Administered To Mr. O. G. F. Cont'd

Date	Drug	Standard Dosage/ Route of Administration	Dosage/ Route of Administration on Given to Patient.	Classification	Desired Effect	Actual Action observed	Side Effect/ Remark
12/12/21	Cefuroxime	**Dosage:** 750 mg every 6–8 hours **Route** Orally and Intravenously	**Dosage:** 750mg TDS for 5days **Route** Orally	Antibiotics (Cephalosporins)	To kill or prevent the growth of bacteria	Bacteria that caused patient's cellulitis were controlled	Black, tarry stools, chest pain, general feeling of tiredness, blistering, peeling or loosening of skin. Patient experienced no side effect

Table 5:4 Pharmacology Of Drugs Administered To Mr. O. G. F. Cont'd

Date	Drug	Standard Dosage/ Route of Administration	Dosage/ Route of Administration on Given to Patient.	Classification	Desired Effect	Actual Action observed	Side Effect/ Remark
12/12/21	Ringer's Lactate Infusion	**Dosage**: Depends on clinical condition of patient. **Route**: Intravenously	**Dosage**:.500mls for 24 hours **Route**: intravenously.	An Isotonic crystalloid solution	Increases blood pH and replaces fluid loss.	Patient was hydrated.	Hives and itching, swelling of the eyes, face, or throat, coughing, sneezing, or difficulty in breathing. None was observed.

2.1.4 Complications

With reference to the complications listed in the literature review such as; septicaemia, necrotizing fasciitis, large abscess and gangrene. MR. O. G. F. exhibited no complications throughout the period of hospitalization which resulted in his early recovery. Patient did not develop any complications because of the early seeking of medical help and prompt treatment given to him throughout his period of hospitalization.

2.2 Patient / family strengths

The strength of patient and the family involves what can be done on their part to facilitate the work of health care providers in providing holistic care to promote recovery. (Gulanick &Myers, 2014). The following strengths were observed in my patient and family during their period of hospitalization

1. Though patient was having fever (38.9^{0}C), he could tolerate antipyretic medication such as paracetamol, cold bath and cold drink. (12/12/22).
2. Despite the pain in the left lower limb, patient could move his leg with assistance. (12/12/22).
3. Patient was willing to participate in wound care activities. (12/12/22).
4. Though patient had poor appetite, he could eat half of each meal served. (13/12/22).
5. Though patient had insomnia, he could sleep for two hours during the day and four hours at night. (13/12/22).
6. Patient was able to express intensity and aggravation factors associated with his headache (14/12/22).

2.3 Patient / family's health problems

Problem refers to a situation or person that needs attention and needs to be dealt with. (Mclntosh. 2013). In respect to the health status of MR. O. G. F. there were some identifiable needs which were supposed to be solved in order to restore health and comfort for my patient.

These problems were identified based on the interview and observation which I made from the patient throughout the period of hospitalization

1. Patient had fever (38.9^{0}C) (12/12/22).

2. Patient had pain in the affected limb (Left lower limb) (12/12/22).

3. Patient had wound on the left lower limb. (12/12/22).

4. Patient complained of poor appetite. (13/12/22).

5. Patient was unable to sleep well. (13/12/22).

6. Patient had headache (14/12/22).

2.4 Nursing diagnosis

Nursing diagnosis is a clinical judgment concerning a human response to health conditions/ life processes, or vulnerability for that response, by an individual, family, group, or community (Herdman & Kamitsuru, 2014). This is identified based on the analysis made on patient assessment being carried out.

1. Hyperthermia (38.9^{0}C) related to ongoing inflammatory process (12/12/22).

2. Impaired comfort related to painful swollen left lower limb. (12/12/22).

3. Impaired skin integrity(wound) related to break in skin continuity. (12/12/22).

4. Risk for imbalanced nutrition (less than body requirement) as evidenced by poor appetite. (13/12/22).

5. Disturb sleep pattern related to pain at the left lower limb (13/12/22).

6. Headache related to infectious process of cellulitis. (14/12/22).

CHAPTER THREE.

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the third step of the nursing process which includes the formulation of guidelines that establish the proposed course of nursing action in the resolution of nursing diagnoses and the development of the client's plan of care (Delaune & Ladner, 2010). The patient's care plan is written based on the data collected which is translated into nursing diagnosis. This will help meet the patient's needs, thereby eliminating or minimizing patient problems.

3.1 Objective / Outcome Criteria

1. Patient's body temperature will fall within normal range in 24hours as evidenced by;

a. Nurse recording a temperature of within normal range (36.2-37.2^{o}C).

b. Patient verbalizing that he is not warm to touch.

2. Patient will be relieved of pain within 48hours as evidenced by;

a. Patient verbalizing reduction of pain at the affected limb.

b. Nurse observing reduction in swelling on the affected limb.

3. Patient wound will be cared for throughout period of hospitalization as evidenced by:

a. Patient coping in wound care activities

b. Nurse performing wound care for patient.

4. Patient's normal nutritional status will be maintained throughout period of hospitalization as evidenced by:

a. Nurses observing patient eating more than half of his meals served.

b. Patient verbalizing increase in appetite.

5. Patient will regain normal sleep pattern within 48 hours as evidence by;

a. Nurse observing patient sleeping at least 8hours during night and 2 hours in the day time. b. Patient verbalizing that he slept soundly.

6. Patient will be relieved of headache within 8 hours as evidenced by:

a. Patient verbalizing that the headache has subsided.

b. Nurse observing patient experiencing increased level of comfort.

Table 6:1 Nursing Care Plan For Mr. O. G. F.

Date/ time	Nursing diagnosis	Objective/ outcome criteria	Nursing orders	Nursing intervention	Date/ time	Evaluation	Sign
12/12/22 11:20am	Hyperthermia (38.9^0C) related to ongoing inflammatory process.	Patient's body temperature will fall within normal range in 24hours as evidenced by; 1. Nurse recording patient's temperature within the range of 36.2-37.20C. 2. Patient verbalizing that he is not warm to touch.	1. Monitor vital signs. 2. Serve patient with cold drinks. 3. Ensure proper ventilation. 4. Encourage patient to wear light clothes 5. Administer prescribed anti-inflammatory and anti-pyretic.	1. Patient's body temperature, pulse, respiration and blood pressure were monitored and recorded. 2. Cold drink (malt) was served to patient 3. Ventilation was ensured by opening nearby windows and turning on ceiling fans. 4. Patient was encouraged to remove tight clothes and was made to put on loose clothes. 5. Paracetamol 1g was administered as ordered	13/12/22 11:20am	Goal fully met as patient recorded a temperature of 36.8^0C and Mr. O. G. F. verbalized his body is not warm to touch.	A. S

Table 6:2 Nursing Care Plan For Mr. O. G. F. Cont'd

Date/ time	Nursing diagnosis	Objective/ outcome criteria	Nursing orders	Nursing intervention	Date/ time	Evaluation	Sign
12/12/22 11:35am	Impaired comfort (pain) related to swollen left lower Limb.	Patient will be relieved of pain within 48hours as evidenced by; 1. Patient verbalizing reduction of pain at the affected limb. 2. Nurse observing reduction in swelling on the affected limb.	1. Reassure the patient. 2. Assess patient's level of pain. 3. Employ diversional therapy 4. Apply cold compress on the swollen limb. 5. Administer the prescribed pain killers as ordered.	1. Patient and family were reassured that with available management, patient's pain will be relieved. 2. Patient's level of pain was assessed using numerical paining rating scale. 3. Patient was engaged in conversation with wife, nurses and other patients. 4. Cold compress was applied on swollen limb to reduce swelling and pain. 5. Tablet Paracetamol 1g was administered as ordered.	14/12/22 11:35am	Goal fully met as patient verbalized reduction of pain at the affected limb and nurse observed a reduction in swelling on the affected limb	A. S

Table 6:3 Nursing Care Plan For Mr. O. G. F. Cont'd

Date/ time	Nursing diagnosis	Objective/ outcome criteria	Nursing orders	Nursing intervention	Date/ time	Evaluation	Sign
12/12/22 3:20pm	Impaired skin integrity (wound) related to break in skin continuity.	Patient wound will be cared for throughout period of hospitalization as evidenced by: a. Patient coping in wound care activities b. Nurse performing wound care for patient.	1. Reassure patient and family. 2. Assess patient's wound. 3. Explain to patient and relative about wound care procedure. 4. Educate patient on personal hygiene and wound care 5. Perform wound care for patient. 6. Administer prescribed antibiotics.	1. Patient and family were reassured of being in the hands of competent health team. 2. Patient's wound was assessed on damaged tissues, exudates, color and odour. 3. Wound care procedure was explained to patient and relative. 4. Patient and relative were educated on hand washing, skin cleansing and wound care. 5. Patient's wound was cared for and dressed aseptically. 6. Prescribed IV Clindamycin 600mg was administered to patient.	17/12/22 9:00am	Goal fully met as patient coped in wound care activities and nurse performed wound care for patient.	A. S

Table 6:4 Nursing Care Plan For Mr. O. G. F. Cont'd

Date/ time	Nursing diagnosis	Objective/ outcome criteria	Nursing orders	Nursing intervention	Date/ time	Evaluation	Sign
13/12/22 8:05am	Risk for imbalanced nutrition (less than body requirement) as evidenced by poor appetite.	Patient's normal nutritional status will be maintained throughout hospitalization as evidenced by: 1. Nurses observing patient eating more than half of his meals served. 2. Patient verbalizing increase in appetite	1. Reassure patient and family. 2. Plan diet with patient and care taker 3. Encourage patient to maintain oral hygiene. 4. Serve patient meal small but in a frequent interval. 5. Stay and encourage patient to eat.	1. Patient and family were reassured of being in the hands of competent health team. 2. Diet was planned with patient and care taker with pawpaw and pineapples being added to his meals. 3. Patient was encouraged to perform oral hygiene twice daily to boost appetite. 4. Fufu was served in bits, attractively and at regular frequencies. 5. Patient was encouraged to eat his meal served.	17/12/22 8:05am	Goal fully met as patient ate more than half of his meals served and also verbalized an increase in his appetite.	A. S

Table 6:5 Nursing Care Plan For Mr. O. G. F. Cont'd

Date/ time	Nursing diagnosis	Objective/ outcome criteria	Nursing orders	Nursing intervention	Date/ time	Evaluation	Sign
13/12/22 9:00am	Disturb sleep pattern related to pain at the Left lower limb.	Patient will regain normal sleep pattern within 48 hours as evidence by; 1. Nurse observing patient sleeping at least 8 hours during night and 2 hours in the day time. 2. Patient verbalizing that he slept soundly	1. Reassure patient and family. 2. Encourage patient to take warm bath 3. Restrict visitors to allow time for patient to sleep. 4. Ensure proper ventilation in the patient room 5. Administer prescribed analgesics as ordered.	1. Patient was reassured to allay any fears arising from his inability to sleep. 2. Patient was encouraged to take a warm before going to bed. 3. Visitors were not allowed to distract patient during sleep. 4. Proper ventilation was ensured in the patient room to enhance sleeping. 5. Tablet Paracetamol 1g was administered to reduce pain.	15/12/22 9:00am	Goal fully met as patient slept at least 8hours during night and 2 hours in the day time and also patient verbalized that he slept soundly during his hours of sleep.	A. S

Table 6:6 Nursing Care Plan For Mr. O. G. F. Cont'd

Date/ time	Nursing diagnosis	Objective/ outcome criteria	Nursing orders	Nursing intervention	Date/ time	Evaluation	Sign
14/12/22 9:30am	Headache related to infectious process of cellulitis.	Patient will be relieved of headache within 8 hours as evidenced by: a. Patient verbalizing that the headache has subsided. b. Nurse observing patient experiencing increased level of comfort.	1. Reassure patient and family. 2. Assess patient and relative's pain 3. Explain to patient the reasons for the headache and the available management. 4. Nurse patient in a calm environment. 5. Employ diversional therapy. 6. Administer prescribed analgesics.	1. Patient and family were reassured that with available management, patient's headache will be relieved. 2. Patient's pain was assessed using pain rating scale (0-10) and patient rated 6. 3. Patient was told the headache is as a result of bacteria and the drugs given will relieve the headache. 4. Patient was nursed in a calm environment by restricting visitors and activities carried out without interruption. 5. Patient was engaged in conversation with other patients and television was switched on to entertain patient. 6. Tablet paracetamol 1g was administered to patient.	14/12/22 5:30am	Goal fully met as patient verbalized that there is decrease in headache and nurse observing patient experiencing increased level of comfort.	A. S

CHAPTER FOUR.

IMPLEMENTATION OF PATIENT/FAMILY CARE

4.0 Introduction

Implementation, the fourth step in the nursing process, involves the execution of the nursing plan of care derived during the planning phase of the nursing process. It involves completion of nursing activities to accomplish predetermined goals and to make progress toward achievements of specific outcomes (Delaune & Ladner, 2010).

4.1 Summary of actual nursing care

The actual nursing care rendered to Mr. O. G. F. and his family started on the day of admission, 12th December, 2022 to the time care was terminated on 27th December, 2022. The management of patient and his family was planned to meet their physiological, emotional, spiritual and physical needs. Whiles on admission, routine nursing actions, for example, oral care and medication administration were done and the necessary documentations were also carried out. The summary of care was written on daily bases as follows:

4.1.1 First day of admission (12th December, 2022)

On the 12th December, 2022, at 11:10am, Mr. O. G. F. was admitted to the Males ward of Holy Family Hospital, Berekum. His admission was ordered by Dr. G. P. from the OPD with a diagnosis of cellulitis of the left lower limb. Patient was brought to the ward in a wheel chair accompanied by his nephew. His admission was confirmed by calling his name written on the e-folder card handed to me and he responded. I also entered his card number on the ward computer and further mentioning his name for response, and his admission was stated clearly there by the doctor. On arrival, patient was conscious and alert. He was made comfortable in an already prepared bed with the foot end elevated with pillow, to aid circulation and to reduce pain in his oedematous feet. Patient and relative were reassured that he was in the hands of competent staff and everything possible would be done to promote his recovery. This is an

attempt to allay fears and anxiety from the patient and relatives. His particulars such as sex, age, name, residential address were recorded into the admission and discharge book as well as daily census sheet. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained. National Health Insurance scheme policy was also explained to him. I introduced myself to the patient and relative as a final year student at Holy Family Nursing and Midwifery Training College, Berekum. Vital signs were checked and recorded accurately as follows:

Temperature - 38.9^{o}C

Pulse - 84bmp

Respiration - 21cpm

Blood Pressure - 120/90mmHg

Oxygen saturation - 95%

Patient weight was - 75kg

Tablet paracetamol 1g was given to reduce the pain and temperature. The rest of the medications were collected from the pharmacy and served as ordered. Cold malt was served to the patient to help reduce the temperature to a normal physiological level and after 3 hours patient temperature reduced to 37.6^{o}C, which showed a sign of improvement. Physical examination on the patient was performed from head to toe and no abnormalities were seen. At the time of admission, assessment revealed that patient had high body temperature, pain at the left lower limb. Patient and relatives were orientated around the ward, which involve where to find bathroom, Nurses station and he was also hinted on all hospital protocol available. He was introduced to the patient around him and was told to call for help when needed. I made him aware of items he can keep in the ward as well as those he needed during admission and visiting times. The patient was to be managed on the following plan;

1. IV Clindamycin 600mg qid for 3days

2. Tablet Paracetamol 1g tds for 5days

3. IV Cefuroxime 750mg tds for 3days

4. Ringers Lactate 500mls for 24hours and

SC Clexane 40mg od

The following diagnostic investigation were requested already at the OPD.

1. Full blood count (FBC).

2. Fasting blood sugar (FBS).

3. Blood for malaria parasite (MPs).

I reintroduced myself to patient as a final year nursing student of the Holy Family Nursing and Midwifery Training College, Berekum, who would like to take him and his family for my care study. Mr. O. G. F. and his relatives were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfillment towards the award of Diploma in Registered General Nursing. I explained to the patient and his relatives the concept of the patient/family care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event. I told them that I will visit their home while they are still on admission and also visit them when they are discharged home to continue the care being rendered. I also made it clear to the family that they have the right to withdraw from the arrangement whenever they feel to do so. Mr. O. G. F. and his relative agreed to my request and promised to offer me the necessary information and assistance. I then expressed my gratitude to them. Discharge planning was initiated with the patient; thus, they will continue the care at home once he is well. I decided to choose this patient for the study because I had been taught the theoretical aspect of cellulitis and wanted to utilize this opportunity to put theoretical knowledge into practice.

At 11:20 am, per the patient temperature a nursing diagnosis, hyperthermia (38.9) related to ongoing inflammatory process was formulated and objective was set to reduce the temperature

to normal range within 24hours. The following interventions were carried out to ensure a reduction in his temperature; antipyretics such as tablet paracetamol 1g was administered to reduce the temperature, cold malt was served, patient's body temperature, pulse, respiration and blood pressure were monitored and recorded., he was covered with a light cloth and nearby fans were switched on and windows opened to ensure good ventilation.

At 11:35am, the nursing diagnosis of impaired comfort related to painful swelling of left lower limb was formulated for problem of severe pains of the left lower limb identified during the assessment. Nursing interventions such as reassurance of patient was done, patient's level of pain was assessed using numerical pain rating scale, and elevation of the affected limb using pillow, application of cold compress to reduce pain and swelling and administration of medication such as paracetamol ordered were carried out.

2:00pm vital signs were checked and documented. Prescribed medications were also administered as ordered. Patient took rice and vegetable stew for lunch.

At 3:20pm the nursing diagnosis of impaired skin integrity (wound) related to break in skin continuity was formulated for problem of wound at the left lower limb. An objective was therefore set to care for patient's wound throughout period of hospitalization. Nursing interventions carried out were as follows; Patient and family were reassured of being in the hands of competent health team, patient's wound was assessed on damaged tissues, exudates, color and odor, wound care procedure was explained to patient and relative, patient and relative were educated on hand washing, skin cleansing and wound care, patient's wound was cared for and dressed aseptically, prescribed IV Clindamycin 600mg was administered to patient. He was monitored until I handed him over to the night shift staffs at 7:30pm

4.1.2 Second day of admission (13th December, 2022)

On the second day of admission, at 7:00am I went to the ward to continue with my nursing care for Mr. O. G. F., his morning vital signs had already been checked at 6am and recorded as follows; Temperature 36.7^{0}C, Pulse 70bpm, Respiration 17cpm and Blood pressure 130/70 mmHg. As part of the diagnostic investigation patients fasting blood sugar was checked in the morning at 6:20am and it was recorded as 4.3mmol/L indicating Mr. O. G. F. is not diabetic. During the ward rounds at 7:40am, Dr. A. B. attended to Mr. O. G. F. and the plan was to continue his medications. At 8:00am, patient had his breakfast which was Hausa porridge with milk and bread, he was able to consume less than half of the porridge and bread. Based on my observation, I conducted a nursing assessment on patient and it was realized that patient had a poor nutritional status. This was evident as patient and his relatives attested to the fact that patient is able to consume less than half of food he is been served with.

At 8:05am a nursing diagnosis was formulated as, risk for imbalanced nutrition: less than body requirements due to his poor appetite. As such, an objective was to help him attain and maintain adequate nutrition throughout the period of hospitalization. The following nursing actions were implemented; Patient and family were reassured of being in the hands of competent health team, diet was planned with patient and care taker with pawpaw and pineapples being added to his meals, patient was encouraged to perform oral hygiene twice daily to boost appetite, fufu was served in bits, attractively and at regular frequencies, patient was encouraged to eat his meal served.

At 9:00am, information gathered from the night nurses indicated that patient was unable to have adequate sleep throughout the night. I enquired from the patient why he was unable to sleep adequately and he stated that it was because of the pain at the affected site hence the nursing diagnosis of disturb sleep pattern related to pain at the affected limb was formulated and objective was set to help patient regain his normal sleep pattern within 48 hours and patient

verbalizing that he slept soundly. The following nursing interventions were carried out; patient was reassured to allay any fears arising from his inability to sleep, patient was encouraged to take a warm bath before going to bed, visitors were not allowed to distract patient during sleep, proper ventilation was ensured in the patient room to enhance sleeping, tablet Paracetamol 1g was administered to reduce pain.

At 11:20 am, I evaluated the objective set to help reduce the patient's body temperature to normal and goal was fully met as his temperature recorded was 36.8^{0}C and patient verbalizing that he is not warm to touch.

Patient was served with rice and stew as lunch in the afternoon. At 2:00 patient vital signs were checked and recorded. Afternoon prescribed medications were served to the patient. Patient was made comfortable in bed.

At 6:00 patient vital signs were checked and recorded as follows; Temperature,36.4^{0}C, Pulse 73bpm, Respiration 19cpm, Spo2 98%, Blood pressure 120/80mmHg. Evening medications were also served to the patient. Patient then went to take his bath. I handed over to the night shift nurses to continue with the patient care and departed at 7:30pm

4.1.3 Third day of admission (14th December, 2022)

On the third day of admission, patient was fairly well, he brushed his teeth, had his bath and emptied his bowel which assisted by his nephew. Report from the night nurses read that he was able to sleep well upon the measures put in place. Vital signs checked and recorded at 6:00am read as follows: temperature 36.50C, Pulse 73bpm, Respiration 19cpm and Blood Pressure 120/80mmHg. Due medications were served. Patient was served with porridge and koose for breakfast. At 9:22am patient was reviewed and plan was to continue all medications.

At 9:30am patient was engaged in an interaction and it was realized that patient had headache. The nursing diagnosis formulated was headache related to infectious process of cellulitis. An objective was set to relief patient of headache within 8 hours. Interventions carried out were; Patient and family were reassured that with available management, patient's headache will be

relieved, patient's pain was assessed using pain rating scale (0-10) and patient rated 6, patient was told the headache is as a result of bacteria and the drugs given will relieve the headache, patient was nursed in a calm environment by restricting visitors and activities carried out without interruption, patient was engaged in conversation with other patients and television was switched on to entertain patient, tablet paracetamol 1g was administered to patient.

At 11:35am, objective set to relieve patient of pain was evaluated and goal was fully met as; patient verbalized reduction of pain at the affected limb and nurse observed a reduction in swelling on the affected limb.

Due medications were administered at 2pm to the patient and afternoon vital signs were checked and recorded. Patient was made comfortable in bed.

At 2:05pm, I left for my first home visit. I met Mr. O. G. F. son in which we had interactions for about one and half hours and returned to continue my care to Mr. O. G. F.

At 5:30pm, objective that was set to relief patient of headache within 8 hours was fully met as patient verbalized that there is decrease in headache and nurse observing patient experiencing increased level of comfort.

At 6:00pm, vital signs were checked and recorded. Patient took his supper which was yam and beans stew, it was observed that patient was able to eat more than two- third of food served. Patient was made comfortable in bed after evening vital signs were checked and recorded as in appendix. Due medications were served and he slept around 10:30pm.

4.1.4 Fourth day of admission (15th December, 2022)

Patient on this day said he had a sound night with little pain at the affected limb. He observed his personal hygiene needs and vital signs checked and recorded as follows; Temperature 36.4^0C, Pulse 80bpm, Respiration 21cpm and Blood Pressure 120/70mmHg. He was reassured that everything necessary will be done in caring for him. Bed linens were straightened to provide comfort, medications (analgesics and antibiotics) were administered as ordered and recorded. His breakfast was attractively served and encouraged to eat at 7:30am before ward

rounds. At 8:00am, doctor came for ward rounds and patient expressed his happiness about the sudden reduction in pain that made him had a sound sleep on the previous night. On ward rounds, no new orders were made but to continue treatment.

At 9:00am, I evaluated the set objective to restore patients sleep pattern to normal within 48 hours and goal was fully met as; patient slept at least 8 hours during night and 2 hours in the day time and also patient verbalized that he slept soundly during his hours of sleep. All routine nursing actions were carried out and documented for references and to ensure quality care as well. We later had conversation regarding his work and activities that will promote his health. Patient was served with rice ball and ground nut soup as his lunch food and encouraged to eat to promote healing. At 2:00pm patient vital signs were checked and recorded. Due medications were also administered to the patient as ordered. Patient was then made comfortable in bed. Patient took his bath around 5:30pm. At 6:00 Patient vital signs were checked and recorded as in appendix and all due medications were served to the patient. I then handed him over to the night shift Nurses to continue the care rending to him. Patient slept around 10:20pm. I then departed to my home.

4.1.5 Fifth day of admission (16th December, 2022)

Patient on this day said he had a sound night with little pain at the affected limb. He observed his personal hygiene needs and vital signs checked and recorded as follows; Temperature 36.3^0C, Pulse 79bpm, Respiration 17cpm and Blood Pressure 120/70mmHg. At 8:00am doctor came for ward rounds and patient expressed his happiness about the sudden reduction in pain that made him had a sound sleep on the previous night. On ward rounds, no new orders were made but to continue treatment. All routine nursing actions were carried out and documented for references and to ensure quality care as well. After all these, patient/family was informed about his possible discharge the next day as said by doctor and he was very happy about that. We later had conservation regarding his work and activities that will promote his health. Patient

was made comfortable in bed after evening medications were served and he slept around 10:20pm.

4.1.6 Day of discharge / sixth day of admission (17th December, 2022)

Patient woke up feeling strong and better. Report from night nurses indicated that patient was able to sleep well. I greeted patient, he responded with a cheerful facial expression. I was Inquisitive enough to ask patient why he has put up a smiley face. Upon asking, patient said that he feels grateful to have special nursing care rendered to him over the past few days since he was admitted. His morning vitals had already been checked and recorded at 6:00am as; Temperature 36.4^{0}C, Pulse 86bpm, Respiration 21cpm and Blood Pressure 130/80mmHg.

Due medications were administered. Patient had Hausa porridge and bread as breakfast and he was able to consume majority of the porridge and bread.

During routine ward rounds, patient was discharged since his condition was stable and he had no complains. His relative was informed and the bills were assessed to be paid.

An evaluation of the objective set to ensure patient attain and maintain adequate nutrition within hospitalization period was done at 8:05am and goal was achieved as the nurse observed that patient was able to eat more than half of his meal served and patient verbalized an increase in appetite. At 9:00am, an evaluation of the objective set to care for patient wound throughout period of hospitalization was done and goal was fully met as patient coped in wound care activities and nurse performed wound care for patient.

An amount of seventy- five Ghana Cedi's for medications which was not covered by National Health Insurance Scheme was paid. Patient was educated on the need to eat food containing high fibre like whole grains, the entire essential food nutrients, for example protein, vitamins and irons, as well as maintaining good personal hygiene.

Patient was discharged on capsules clindamycin 300mg qid for 7days and tablet paracetamol 1g tds for 7 days. Patient was informed to come for review on 21st December, 2022 at the main

Out Patient Department. The need to continue with medications was emphasized and review date was stretched on. General assessment revealed that patient fever, pain and swollen limb were reduced and also well hydrated before leaving. Patient and the family bid the ward inmates and staff goodbye. I accompanied patient and relatives to the road side, where they boared a tricycle known as "pragya".

4.2 Preparation of patient / family for discharge and rehabilitation

Preparation for discharge commenced from the time of admission at the hospital, at11:20 am on 12th December, 2022 till the last day of hospitalization, 17th December, 2022.

The patient and family were informed that staying in the hospital was for a temporal period of time and they would continue the care at home once patient is stable. Education of patient and family on the causes, clinical features, treatment and management of cellulitis was reemphasized. This was aimed at helping the patient and relatives in the provision of adequate care. Prior to patient discharge, health education was given to the patient and relative on the importance of personal hygiene. Patient was encouraged to take in food rich in the essential food nutrients especially iron such as "kontomire", garden eggs, plantain and others. A great emphasis was made on the need to continue with medication and to report to the hospital if any problem does occur. Patient was informed to come for review on Wednesday 21st December, 2022. Necessary documents were recorded into the admission and discharge book as well as the ward state. Assessment of patient bills were made with the help of National health insurance scheme and paid GH¢ 75.00 for medications that were not covered by the NHIS.

4.3 Follow up / home visit / continuity of care

Home visit is a visit made by a health professional to a patient's home, usually with face-to-face contact between the health professional and the patient, less commonly between health professional and the patient's family. Home visits were done before and after patient's discharge. It is friendly but a purposeful visit to patient home. Health educations were given

and the need for the prevention of complication was reemphasized. It provided a good account on the causes and predisposing factors of patient's illness.

4.3.1 First home visit (14th December, 2022)

My first home visit was made on 14/12/2022, thus; the third day of admission to Kyiribaa about 4km journey from Holy Family Hospital, Berekum. It was agreed to visit their home on this day, while patient was on admission. On the day of admission as I explained to him that it is a requirement and part of the care. The purpose of this visit was to assess the home environment of my patient and to give appropriate health educations to his family before his discharge on general cleanliness and safeguard methods to prevent themselves from injury. I left Holy Family Hospital, Berekum at 2:05pm and safely arrived at my patient's house at around 2:30pm with patient's Son. I was warmly welcomed, offered a comfortable seat and water as tradition demands. I was asked of my mission so I introduced myself to them as a final year nursing student as said above and the need for the visit. My patient lives in a five-bedroom house built with blocks and roofed with aluminum sheets with kitchen. During my interactions with his son, he revealed to me that their place of convenience was not a problem because there was a toilet about 100 meters away from the house. Refuse disposal site is about 200 meters away from the house and source of water from a tap at the house. I also realized that water containers were covered. No health facility was identified nearby. Based on the above findings, I reinforced on the need to continue to cover water containers and also food to prevent contamination. The need to ensure proper ventilation and hand washing with soap before eating and after visiting toilet was also stressed on. Mr. O. G. F. condition; the causes, signs and symptoms, management and prevention were explained to them. They were also encouraged to continue good refuse disposal to prevent environmental pollution and breeding of mosquitoes. They were therefore reassured that Mr. O. G. F. will soon get well and be discharged home. Finally, they were encouraged to ask questions and answers were provided

in simple terms to enhance their understanding. I thanked them for their hospitality and they thanked me too. I left the house around 3:20pm.

4.3.2 Second home visit (19th December, 2022)

This visit was made on 19/12/2022 at 10:30am, as it was scheduled with the patient and the family to pay them a second visit. The purpose of the visit was to assess whether there is improvement in the condition of the patient. On arrival, patient's parents, sisters and friends were all waiting to receive and welcome me. I made enquiries about their health which they responded positively. On assessment the environment was neat and they were commended for that. The importance of taking drugs as ordered was reinforced to patient and family. Education on good nutrition was stressed on to help protect patient and family from any diseases. I reminded him of the review date which will on 21st December, 2022 and the need for the review. Patient and family were thanked for their cooperation and permission was sought to leave. I promised them of another visit which will be my last. Mr. O. G. F. escorted me to the roadside where I bordered a "pragyia" from Kyiribaa to Berekum town.

4.3.3 Day of review (21st December, 2022)

On Wednesday, 21st December, 2022 patient was met at the Out-Patient Department of Holy Family Hospital at 9:00am looking cheerful and lovely as noted from facial expression with his nephew. The vital signs checked and recorded as follows; Temperature 36.0^{o}C, Pulse 75bpm, Respiration 22cpm, Sp02 99% and Blood pressure 120/70mmHg. After vital signs patient was taking to surgical OPD which is room 3. Upon assessment by the doctor, Mr. O. G. F. was healthy. Patient did not make any complains. The doctor inspected the site and it was very much improved since the edema was no more as well as the darkened area. He was told not to hesitate to report to the hospital if should he encounter any health problem. He was encouraged to eat more of fiber-rich diets like cereals and iron rich diets. He was also encouraged to practice personal and environmental hygiene to protect himself from getting

diseases. Patient was assured of a third home visit. I then accompanied the patient and his nephew to the gate where they picked a tricycle popularly known "pragyia" to their house.

4.3.4 Third home visit (27th December, 2022)

The main reasons for conducting the third home visit were to: assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care. On the said date, I set off early on Tuesday afternoon around 2:30pm with a tricycle popularly known "pragyia". I got to Kyiribaa around 02:50pm. Patient and relatives were doing well as they looked cheerful and had no complains. The environment was tidy as there were no rubbish nor stagnant water around. I handed over patient to his relatives to continue with care at home after giving her enough education since there was no health facility around. Mr. O. G. F's relatives commended me for good work done and accepted to continue the care of Mr. O. G. F. at home. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick rather than relying on self-medication. After interacting with patient and family for a while, I reemphasized the health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship with patient and family, I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave. There was no separation anxiety as patient and the relatives had enough psychological preparations from the day of admission till discharge but it was still difficulty bidding them farewell. I terminated my care and thanked them for their cooperation which made my study a success. Again, patient and his relatives expressed their gratitude by showing how grateful they were to me for the support and care given to them. I eventually sought permission to leave and bid them the final farewell. I board pragyia to Berekum town at 4:50pm

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Hinkle & Cheever, 2014). The chapter gives

information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to my patient and family.

5.1 Statement of evaluation

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

5.1. Patient was relieved of hyperthermia (13/12/22)

On the day of admission thus; 12/12/22, at 11:20am patient had fever hence the nursing diagnosis hyperthermia ($38.9^{0}C$) related to ongoing inflammatory process was formulated. The following interventions were carried out to ensure a reduction in his temperature; antipyretics such as tablet paracetamol 1g was administered to reduce the temperature, cold malt was served, he was covered with a light cloth and nearby fans were switched on then windows opened to ensure good ventilation. On 13/12/22 at 11:20am, objective that was set to reduce patient temperature was evaluated and goal was fully met as; nurse recording patient temperature of 36.8^{0} C and patient verbalized that he is not warm to touch.

5.1.2. Patient was relieved of pain at left lower limb (14/12/22)

On 12/12/22, at 11:35am patient complained of severe pains at the affected limb hence the nursing diagnosis of impaired comfort related to painful swollen of left lower limb was formulated. Nursing interventions such as assessment of the level of pain, provision of comfortable bed to promote rest, elevation of the affected limb using pillow to enhance venous return in other to reduce oedema, application of cold compress to reduce pain and swelling and administration of medication as ordered were carried out.

On 14/12/22 at 11:35am, objective set to relieve patient of pain within 48 hours was evaluated and goal was fully met as; patient verbalized reduction of pain at the affected limb and nurse observed a reduction in swelling on the affected limb

5.1.3. Patient was relieved of headache (14/12/22)

On 14/12/22 at 9:30am patient was engaged in an interaction and it was realized that patient had headache. The nursing diagnosis formulated was headache related to infectious process of cellulitis. An objective was set to relief patient of headache within 24 hours. Interventions carried out were; Patient and family were reassured that with available management, patient's headache will be relieved, patient's pain was assessed using pain rating scale (0-10) and patient rated 6, patient was told the headache is as a result of bacteria and the drugs given will relieve the headache, patient was nursed in a calm environment by restricting visitors and activities carried out without interruption, patient was engaged in conversation with other patients and television was switched on to entertain patient, tablet paracetamol 1g was administered to patient.

On 14/12/22 at 5:30am, objective that was set to relief patient of headache within 8 hours was fully met as patient verbalized that there is decrease in headache and nurse observing patient experiencing increased level of comfort.

5.1.4. Patient normal sleep pattern was restored (15/12/22)

On 13/12/22, Information from the night nurses indicated that patient was unable to have adequate sleep throughout the night. I enquired from the patient why he was unable to sleep adequately and he stated that it was because of the pain at the affected site hence the nursing diagnosis of disturb sleep pattern related to pain at the affected limb was formulated at 9:00am and objective was set to help patient regain his normal sleep pattern within 48 hours. The following nursing interventions were carried out; patient was reassured not to worry about other issues aside his sickness to stimulate sleep, all due nursing activities were grouped and carried out at once to allow time for rest and sleep as well as restriction of visitors to prevent

disturbance and promote sleep, ward environment was kept calm and quite to allow enough rest and sleep, prescribed medications (analgesics) were served as ordered to relieve pain and swollen limb, warm bath was performed to induce sleep and elevation of the affected limb to reduce swelling and pain when in bed.

On 15/12/22 at 9:00am, I evaluated the set objective to restore patients sleep pattern to normal within 48 hours and goal fully met as; patient slept at least 8hours during night and 2 hours in the day time and also patient verbalized that he slept soundly during his hours of sleep.

5.1.5. Patient appetite was restored (17/12/22)

On 13/12/22, I conducted a nursing assessment on patient and it was realized that patient had a poor nutritional status. This was evident as patient and his relatives attested to the fact that patient is able to consume only one-third of food he is been served with. At 8:05am a nursing diagnosis was formulated as, risk for imbalanced nutrition (less than body requirements) related to his poor appetite. As such, an objective was to help him attain and maintain adequate nutrition during the period of hospitalization. The following nursing actions were implemented; mouth care to stimulate appetite, planning his diet with him and the family were done, diet was served attractively and he was encouraged to eat.

On 17/12/22, an evaluation of the objective set to ensure patient attain and maintain adequate nutrition within hospitalization period was done at 8:05am and goal was achieved as; Nurse observed that patient was able to eat more than half of his meals served and patient verbalized an increase in appetite.

5.1.6. Patient wound was cared for (17/12/22)

On 12/12/22 at 03:20pm, wound was identified at the left lower limb during the assessment. Nursing diagnosis of impaired skin integrity (wound) related to break in skin continuity was

formulated. An objective was therefore set to care for patient's wound throughout period of hospitalization. Nursing interventions carried out were as follows; patient and family were reassured of being in the hands of competent health team, patient's wound was assessed on damaged tissues, exudates, color and odor, wound care procedure was explained to patient and relative, patient and relative were educated on hand washing, skin cleansing and wound care, patient's wound was cared for and dressed aseptically, prescribed IV Clindamycin 600mg was administered to patient.

On 17/12/22 at 9:00am, an evaluation of the objective set to care for patient wound throughout period of hospitalization was done and goal was fully met as patient coped in wound care activities and nurse performed wound care for patient.

5.2 Amendment of the nursing care plan

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

5.3 Termination of care

I set off early on Tuesday 27th December, 2022 afternoon around 2:30pm with a tricycle popularly known "pragyia". I got to kyiribaa around 02:50pm. Patient and relatives were doing well as they looked cheerful and had no complains. The environment was tidy as there were no rubbish nor stagnant water around. I handed over patient to his relatives to continue with care at home after giving them enough education since there was no health facility around. Mr. O. G. F. and his relatives commended me for good work done and accepted to continue the care of Mr. O. G. F. at home. I however stressed on the importance of regular check-ups and to seek prompt medical attention whenever they fall sick and rather than relying on self-medication. After interacting with patient and family for a while, I reemphasized on health educations that had been given to them already. Since it happened to be my last day of therapeutic relationship

with patient and family, I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. It was a moment to remember when I told them of my intention to leave. There was no separation of anxiety as patient and the relatives had enough psychological preparations from the day of admission till discharge but it was still difficulty bidding them farewell. I terminated my care and thanked them for their cooperation which made my study a success. Again, patient and his wife expressed their gratitude by showing how grateful they were to me for the support and care given to them. I eventually sought permission to leave and bid them the final farewell. I board pragyia to Berekum at 4:50pm.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

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

6.1 Summary

Mr. O. G. F., a 77-year-old man was admitted to the Males ward through the Out Patient Department of Holy Family Hospital, Berekum on the 12th December, 2022 at 11:10am with a diagnosis of cellulitis of the left lower limb. During our interaction, six health problems were identified and nursing diagnosis and objectives were made for each of them. On the day of discharge, all the objectives set were met. On admission, he presented fever and also had severe pain and edema at his left lower limb. Mr. O. G. F. was discharged on 17th December, 2022. During admission some of the treatment plan for Mr. O. G. F. were IV Clindamycin 600mg qid for three days, Tablet Paracetamol 1g tds for five days, IV Cefuroxime 750mg tds for three days and Ringers Lactate 500mls for 24hours. Patient was educated on cellulitis. On 21st December, 2022, patient reported for review as scheduled. Three home visits were embarked on. The first home visit was done while patient was still on admission on 14th December, 2022, second home visit was on the 19th December, 2022 and third home visit was on the 27th December, 2022. The care of Mr. O. G. F. and his family was terminated on the 27th December, 2022, during the third home visit when patient had fully recovered from cellulitis with edema of the left lower limb resolved, no pain and was not warm to touch.

6.3 Conclusion

The study has equipped me with knowledge on how to care for a patient as an individual. Through this study, I have been able to put into practice actual and holistic nursing care as has been learnt theoretically. The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (family) relationship as well as broadened my knowledge on cellulitis, its prevention, management and treatment. It has also helped me to practice my skills acquired in the classroom theoretically. It has deepened my relationship with patients, families and the people in a given community as a whole. It is my recommendation that all students are given the opportunity to embark on the patient/family care study to implement the nursing process in order to render individualized comprehensive care to patients/families. In brief, I really enjoyed every bit of writing this script despite the challenges encountered.

APPENDIX

Table 7: Vital Signs Of Mr O. G. F.

DATE	TIME	TEMPERATURE (0C)	PULSE (Bpm)	RESPIRATION (Cpm)	BLOOD PRESSURE (mmHg)
12/12/22	11:10am	38.9	84	21	130/70
	2:00pm	37.6	80	19	120/70
	6:00pm	37.3	78	22	120/80
	10:00pm	37.4	79	20	120/90
13/12/22	6:00am	36.7	82	17	130/70
	10:00am	36.4	78	18	120/80
	2:00pm	36.6	80	20	120/70
	6:00pm	36.4	81	19	120/80
	10:00pm	36.8	86	22	120.80
14/12/22	6:00am	36.5	75	19	120/80
	10:00am	36.4	78	23	110/70
	2:00pm	36.2	80	21	120/70
	6:00pm	36.6	81	19	130/70
	10:00pm	36.3	77	18	120/80
15/12/22	6:00am	36.4	80	21	120/70
	10:00am	36.2	76	20	130/70
	2:00pm	36.4	84	19	120/80
	6:00pm	36.6	82	20	120/80
	10:00pm	36.1	79	18	110/70

Table 7:1 Vital Signs Of Mr O. G. F. Continued

DATE	TIME	TEMPERATURE (0C)	PULSE (Bpm)	RESPIRATION (Cpm)	BLOOD PRESSURE (mmHg)
16/12/22	6:00am	36.3	81	17	120/70
	10:00am	36.2	85	18	110/60
	2:00pm	36.7	81	21	120/80
	6:00pm	36.8	83	18	120/80
	10:00pm	35.9	79	17	120/70
17/12/22	6:00am	36.4	86	21	110/70

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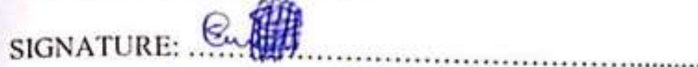

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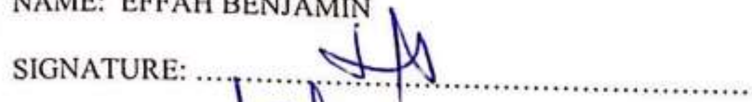

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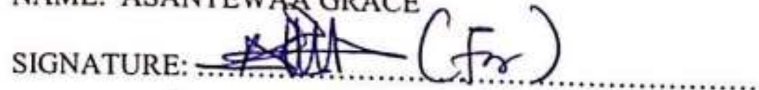

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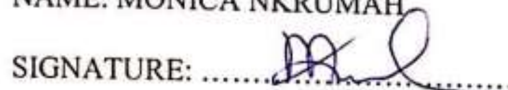

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