HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A PATIENT /FAMILY CARE STUDY ON CELLULITIS

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

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PREFACE

Patient/Family care study is a detailed account of nursing care rendered to a patient and his or her family within a specific period of time. The interaction between the patient, his or her family, the community and the health team comprise of planning, implementation and evaluation of the care given to the patient to meet his or her physiological, spiritual, and socio-economic needs.

The patient and family care study helps the student nurse to identify patient and family problems so as to be able to formulate appropriate interventions. This enables the student nurse to look into the disease condition to be able to put to use the theoretical knowledge and practical skills acquired to provide holistic nursing care including health education to the patient and family.

The study utilizes the nursing process, which is a systemic approach to nursing care taken to care for a sick individual and comprises of assessment, diagnosis, planning, implementation and evaluation of all care rendered to patient and her family to ensure an effective nursing care.

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.

The patient and family care study has helped me gain practical experience and gain in-depth knowledge about the care of patients with cellulitis.

The challenge I experienced was not difficult in getting to my patient's house during the first home visit because I got there through the help of my patient's father who accompanied me safely to the house.

Finally, the patient and family care study is part of the final assessment of the student nurse by the Nursing and Midwifery Council of Ghana for partial fulfillment for the award of certificate in Registered General Nursing students. Initials were used to protect the confidentiality of the patient and family.

ACKNOWLEDGEMENT

I would like to thank the Almighty God for seeing me through all these years and for giving me the strength to complete this work successfully.

I would also like to express my profound gratitude to the Principal of the Holy Family Nursing and Midwifery Training College, Berekum, Monica Nkrumah, for being a source of guidance and motivation.

This study would not have been successful without the directions and constructive criticisms of my supervisors, Ms. Rita Agyei Boakye and Mr. Alhassan Ibrahim who equipped me with the knowledge and guidelines whilst writing this care study and all the tutors of Holy Family Nursing and Midwifery Training College, Berekum, for their supports and the pieces of advice they gave me throughout this study.

My heartfelt gratitude goes to Mr. N.O. and his family for being approachable, cooperative and for spending their time in answering all the questions asked, which meant so much for the completion of this study. I am also grateful to the Nurse-in-Charge and staffs of the Males Ward at Holy Family Hospital, Berekum.

Furthermore, I would like to extend my appreciation to my parents for their unending emotional, moral, spiritual and financial support throughout the period of this study. I would like to express a hand of appreciation to all Diploma 22s and SPGs.

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Lastly, I am very grateful to all the publishers and authors whose books I used during the course of my study.

INTRODUCTION

Virginia Henderson defined nursing as, “the unique function of the nurse is to assist the individual sick or well, in the performance those activities contributing to health or its recovery (or peaceful death) that he or she would perform unaided if he or she had the necessary strength, will or knowledge. And to do this in such a way as to help him or her gain independence as rapidly as possible”.

This comprehensive study was carried out on Mr. N. O. , a eighteen year old man with the diagnosis of cellulitis of the right lower limb. He was admitted to the male medical ward of the Holy Family Hospital, Berekum on the 26th November, 2021 and discharged on the 1st December, 2021. On admission patient was managed on IV Clindamycin 300mg qid for 3days, Tablet Paracetamol 1g tid for 5days, IV Ciprofloxacin 400mg bid for 3days, Tablet Diclofenac 50mg tid for 5days, Ringers Lactate 500mls tds for 24hours. Full blood count (FBC), fasting blood sugar (FBS), blood for malaria parasite (MPs) were the investigations carried on my patient.Three (3) home visits were made, during admission, after discharge and after review. Six (6) problems were identified during the period of hospitalization.

I decided to write about this condition because it is one of the common diseases in Ghana and knowing how to manage this condition will help to alleviate the complications arising from it. Through the various nursing interventions, management, laboratory investigations and drug therapy, Mr. N. O. was able to recover fully without any complication.

Good interpersonal relationship was built between the patient/family and my on the first day of admission. The patient care study ended on the 20th December, 2021.

On discharge, he had normal temperature, able to eat well and very excited and energetic. There was no pain and no complication. According to the nursing process, the study has been divided into six chapters as follows;

1. Assessment of patient and family which involves collection of data about the patient/family and their community

2. Analysis of data which gives the detailed and scientific study of all data gathered from patient/family.

3. Planning for patient/family care which deals with the plan of care that was rendered to the patient/family.

4. Implementation of patient/family care deals with how the care that was planned for patient/family was implemented.

5. Evaluation of care rendered to patient/family which involves evaluation of goals that were set up for the patient care.

6. Summary and Conclusion of the care study which includes summary of the care rendered to the patient/family.

Contents

LIST OF TABLES

CHAPTER ONE

ASSESSSMENT OF PATIENT /FAMILY

1.0 INTRODUCTION

An assessment is a critical analysis and evaluation or judgment of status or quality of a particular condition, situation or other subject 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. N. O. is 18 years old man who hails from Berekum in the Bono Region of Ghana. He was born on 6th February 2003. He speaks Twi and English language. Mr. .N.O. acquired his basic education at T- Kwart School of excellence in Berekum and currently a second year student at Berekum Presbyterian Senior High school. Mr. N.O. is a National Health

Insurance beneficiary. He has no physical impairments or disabilities. He is a Christian who worships with Dwankobea church. He comes from and currently reside in Brenyekwa a suburb of Berekum in Bono region of Ghana. Mr. N.O.'s parents are Traders in Berekum and are all alive. He is dark in complexion and weighs seventy five kilogram (75kg) with a height of 1.70meters. His next of kin is Mr. A.A (his father). He is a fourth born of seven children. His e-folder number at Holy family hospital Berekum was 10177/18.

1.2 PATIENT / FAMILY MEDICAL AND SURGICAL HISTORY

Knowing patient's family medical history is very essential because, it gives a clue on some of possible diseases that the patient can inherit from parents. Mr. N.O. said that, there is no known chronic disease such as hypertension, 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. N. O. informed me that, this is the third time he has being hospitalized at Berekum Holy Family Hospital. The two previous admission were on account of malaria and cellulitis on his left leg of which he had surgery done. The source of medical treatment of Mr. N. O. 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. N. O. has a very good relationship and cohesion with his family. Socially, the family is not noted for smoking or drinking alcohol. He revealed that most of his family members are into farming and trading. Family members are always ready and willing to support each other in times of financial hardships. Mr. N.O. currently solely depends on his parents for financial support. 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. N.O. depend on National Health Insurance Scheme (NHIS) for medical care. There are no taboos governing the family. The socioeconomic status of Mr. N. O. `s family is quite favorable because they belongs to the middle income group. They are able to afford three square meals daily.

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. N.O. he was told by his mother that he was born spontaneously at the Berekum Holy Family in the Bono Region of Ghana without any complications. He said he was told by his mother that he was immunized against all the six childhood killer diseases and for that matter did not suffer any of them. He said he was told he did not suffer any ailment or injury that might affect his development. He was well breastfed by the mother for two years. She had a normal developmental milestone. He started to crawl at the ninth 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. Mr. N. O. 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 behavior. Erickson was concerned with the growth of ego, the conscious, organized, rational part of the personality. He described eight stages of ego development that encompass the life span. Each stage is characterized by a distinct conflict, or crisis, relating to the person's physiologic maturation and to what society expects of a person at that age. In respect to my patient's age and psychosocial behavior, He falls in the middle adulthood group where there is conflict between identities versus role confusion. This stage occurs during adolescence between the ages 12 and 18yrs. According to Erik Erikson, during this stage of developmental task, adolescents explore their independence and develop a sense of self. Mr. N.O. exhibited such traits whiles on admission.

1.5 PATIENT LIFESTYLE AND HOBBIES

Life style simply refers to the pattern of daily living that an individual develops (Weller, 2014). Mr. N. O. usually goes to bed around 9:00 pm and wakes up at 3am and says his morning prayers after which he learns for 2hours. He maintains his oral hygiene with the use of yazz tooth brush and close up tooth paste which is his favorite. After that he fetches water from nearby borehole, empties his bowel and takes his bath with warm water and prepares for school. For breakfast, patient mostly takes porridge with bread and sometimes "milo" drinks with bread. Patient indicated that he usually takes rice and stew or Ampesi and stew for lunch. Patient revealed that he usually plays football or table tennis which are his favorite games on leisure times. During Saturdays, he wakes up early in the morning and goes about his normal duties. He washes his clothes and goes to the market place to help his parents on selling. During Saturday 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 occasionally takes Tampico as his favorite drink. 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. 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. N. O. 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. My patient has been hospitalized twice already on account of malaria and cellulitis respectively. He has undergone one surgery on his left leg on account of cellulitis.

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. N.O. said he was apparently doing very well until 20th November, 2021. According to Mr. N. O., he woke up and found the right lower limb swollen and painful. The pain and swelling became unbearable so he complained to his parents about it and reported to the Out Patient Department of Holy Family Hospital, Berekum at 9:00am on 26th November 2021. He was seen at the consulting room 3 by Dr. G. and upon examination he was diagnosed with cellulitis of the right lower limb and he was subsequently admitted to the Males

Ward on the same day. Swollen right lower limb was the patient chief complain but was accompanied by pains, chills, fever and dizziness.

1.8 ADMISSION OF PATIENT

On the 26th November 2021, Mr. N. O. was admitted to the Males ward of Holy Family Hospital, Berekum. His admission was ordered by Dr. G. from the OPD with a diagnosis of cellulitis of the right lower limb. Patient was brought to the ward in a wheel chair accompanied by his mother and his elderly sister. 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 edematous feet. 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.

Vital signs were checked and recorded accurately as follows:

1. Temperature 38.9oC
2. Pulse 84bmp
3. Respiration 21cpm

4. Blood Pressure 120/90mmHg
5. 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 alvaro was served to the patient to help reduce the temperature to a normal physiological level and after 3 hours patient temperature reduced to 37.6^0C, 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 right 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 300mg qid for 3days
2. Tablet Paracetamol 1g tid for 5days
3. IV Ciprofloxacin 400mg bid for 3days
4. Tablet Diclofenac 50mg tid for 5days
5. Ringers Lactate 500mls tds for 24hours

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. N. O. and his mother 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 mother 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. N. O. and His mother 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. N. O. 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 colors the skin and hair. Skin color 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 9 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. 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 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

According to MOH (2014), 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.

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. N. O., his relatives, nurses and medical records, personal observation and laboratory investigations. To prevent doubt and misinterpretation of information, they were cross-checked with Mr. N. O. 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.

A**. Diagnostic Investigation/Test.**

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

1. Full blood count (FBC).
2. Fasting blood sugar (FBS).

3. Blood film for malaria parasites (MPs).

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.

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. N. O. was rightly diagnosed since most of the diagnostic tests outlined in literature review were carried out on him.

Causes of Patient's Condition

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. N. O. his condition could be as a result of micro- infections like Streptococcal or Staphylococcal infection which gained entry into his skin. However, culture and sensitivity test were not carried out to see the organism.

Table 2: CLINICAL FEATURES OF MR. N. O. COMPARED WITH THOSE IN THE LITERATURE REVIEW

Clinical Features in Literature Review	Clinical Features Exhibited by Patient
1. Pain.	1. Patient complained of pain at the Right lower limb.
2. Fever.	2. Patient experienced fever (38.90C).
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 Right lower limb.
5. Swelling of the affected parts.	5. Swelling of the Right 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 Right lower limb was warm to touch.
10. Offensive wound.	10. There was no wound present.
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.

Table 3: RESULTS OF DIAGNOSTIC INVESTIGATIONS CARRIED OUT ON PATIENT.

Date	Specimen	Investigation	Result	Normal values	Interpretations	Remarks
26/11/2021	Blood	RBC	4.11[10^6/ul]	2[10^3/ul]	Normal	No treatment given.
26/11.2021	Blood	Hemoglobin level	12.9g/dl	12.3-18.0g/dl	Normal	No treatment given.
26/11/21	Blood	WBC	5.22[10^3/ul]	3.00-8.50[10^3/ul]	Result within normal range	Antibiotics such as Clindamycin 300mg qid for 3days were prescribed for the patient.
26/11/ 2021	Blood	Neutrophils	5.04[10^3/ul] 1.50-	1.50-7.00[10^3/ul]	Result within normal range	Antibiotics were prescribed for the patient.
26/11/21 2021	Blood	Platelet count	307.0[10^3/ul]	150-400[10^3/ul]	Result within normal range	No treatment.
26/11/ 2021	Blood	FBS	4.3mm/l	4.1-6.2mm/l	Result within normal range	Patient was educated on his nutritional status.
27/11/2021	Blood	Malaria RDT	Negative		Patient was not suffering from malaria.	Patient was educated to sleep in a treated mosquito net.

Table 4: TREATMENT GIVEN TO PATIENT COMPARED WITH THAT OF LITERATURE REVIEW.

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

Medical Treatment Given to the Patient

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

1. IV Clindamycin 300mg qid for 3days.
2. Tablet Paracetamol 1g tid for 5days.
3. IV Ciprofloxacin 400mg bid for 3days.
4. Tablet Diclofenac 50mg tid for 5days.
5. Ringers Lactate 500mls tds for 24hours.

Table 5: PHARMACOLOGY OF DRUGS ADMINISTERED TO PATIENT

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration on Given to Patient.**	**Classification**	**Desired Effect**	**Actual Action observed**	**Side Effect/ Remarks**
26/11/21	Paracetamol	0.5- 1g every 4-5 hours; maximum 4g per day **Route** Orally, Rectal and Intravenously.	**Dosage** 1g tid x 5days **Route** Orally	Anti-pyretic/ 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, Hematological reaction, allergic Reaction and liver damage following overdose. Patient experienced no side effect

Table 5: **PHARMACOLOGY OF DRUGS ADMINISTERED TO PATIENT CONTINUED**

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration on Given to Patient.**	**Classification**	**Desired Effect**	**Actual Action observed**	**Side Effect/ Remarks**
26/11/21	Ciprofloxacin	**Dosage** 400mg IV every 12hours 500mg orally every 12hours	**Dosage** 400mg bid for 72hours **Route** Intravenously	Fluor quinolone	It is active against many Gram-negative bacteria. It functions by inhibiting DNA gyrase, and a type II topoisomerase, topoisomerase IV, necessary to separate bacterial, thereby inhibiting cell division.	Bacteria that caused patient's cellulitis were controlled.	Diarrhea, dizziness, headache, stomach, nausea and vomiting. None of these were exhibited by the patient

Table 5: **PHARMACOLOGY OF DRUGS ADMINISTERED TO PATIENT CONTINUED**

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effects/ Remark**
26/11/21	Diclofenac	Dosage 50mg orally 2 or 3times a day; 75mg orally 2times a day; 100mg orally once a day Maximum dose; 150mg daily	Dosage 50mg orally tid for 5days	Anti-inflammatory (Non-steroidal anti-inflammatory / analgesic)	It inhibits Cyclooxygenase II of prostaglandin synthesis to antagonize the process of inflammation.	Patient was relieved from pain	Increased blood pressure, headache, stuffy nose, indigestion, nausea and vomiting, dizziness, drowsiness. None of these were exhibited by the patient.

Table 5: **PHARMACOLOGY OF DRUGS ADMINISTERED TO PATIENT CONTINUED**

Date	**Drug**	**Dosage/ Route of Administration (Literature)**	**Dosage/ Route of Administration Given to Patient**	**Classification**	**Desired Effect**	**Actual Action Observed**	**Side Effect/ Remarks**
27/11/21	Clinda mycin	**Dosage**; Adult: 150–300 mg every 6 hours; **Route** Orally, Intramuscular, intravenously	**Dosage** 300mg qid for 3days **Route** Intravenously	Antibacterial (Lincosamides)	It is active against Gram-positive cocci, including streptococci and penicillin-resistant staphylococci. It is well concentrated in bone and excreted in bile and urine	Bacteria that caused patient's cellulitis were controlled	Abdominal discomfort, Anaphylactic reactions, Antibiotic associated colitis, Diarrhea None of these side effects were observed.

Table 5: **PHARMACOLOGY OF DRUGS ADMINISTERED TO PATIENT CONTINUED**

Date	**Name of Drug**	**Standard Dosage and Route of Administration According to Literature**	**Dosage and Route of Administration to Patient**	**Classification**	**Desired Effect**	**Actual Effect of the Drug Observe**	**Side Effect**
26/11/21	Ringers Lactate	**Dosage** Amount depends on patient's fluid and electrolyte level as well as doctor's prescription. **Route** Intravenously.	**Dosage** 500mls for 24hours **Route** Intravenously	An Isotonic crystalloid solution	For fluid and electrolyte replacement	Patient was well hydrated.	Allergic reactions such as swelling of the eyes, sneezing, difficulty breathing. None of these was evident in the patient.

Complications

With reference to the complications listed in the literature review such as; septicemia, necrotizing fasciitis, large abscess and gangrene. Mr. N. O. 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 (38.90C), he could tolerate antipyretic medication such as paracetamol, cold bath and drink. (26/11/21).
2. Despite the pain in the Right lower limb, patient could move his leg with assistance. (26/11/21).
3. Despite his state of anxiousness, patient was able to express his fears and worry. (26/11/21).
4. Though patient had poor appetite, he could eat half of each meal served. (27/11/21).
5. Though Mr. N. O. had insomnia, he could sleep for two hours during the day and four hours at night. (27/11/21).
6. Patient expressed interest in knowing more about his condition by asking question. (28/11/21).

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. N. O. 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 (38.9^0C) (26/11/2021)
2. Patient had pain in the affected limb (Right lower limb) (26/11/2021).
3. Patient was anxious. (26/11/21).
4. Patient complained of poor appetite. (27/11/21).
5. Patient was unable to sleep well. (27/11/2021).
6. Patient had less knowledge of his current disease condition (28/11/2021)

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 (38.90C) related to ongoing inflammatory process. (26/11/21).
2. Impaired comfort related to painful swollen right lower limb. (26/11/21).
3. Anxiety related to unknown outcome of the disease condition. (26/11/21).
4. Risk for imbalanced nutrition(less than body requirement) as evidenced by poor appetite. (27/11/21).
5. Disturb sleep pattern related to pain at the right lower limb. (27/11/21).

6. Deficient knowledge related to patient's lack of exposure to sources of information on the disease condition and treatment regimen. (28/11/21).

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 36.2-37.2oC.

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 will be relieved of anxiety within 24 hours as evidenced by:

a. Patient relating freely with nurses and other patients.

b. Nurse observing patient showing cheerful facial expression.

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 have adequate knowledge on her condition within period of hospitalization as evidenced by;

a. Patient and relatives being able to provide correct answers to questions posed to them.

b. Nurse observing that patient and relatives practice knowledge gained on cellulitis.

Table 6: NURSING CARE PLAN FOR MR. N. O.

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
26/11/21 At 03:55pm	Hyperthermia (38.90C) 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. Vital signs were monitored. 2. Cold drink (alvaro) was served. 3. Ventilation was ensured by opening nearby windows and turning on ceiling fans. 4. Patient was encouraged to wear clothes made of cotton. 5. Paracetamol 1g was administered as ordered.	27/11/21 At 03:55pm	Goal fully met as patient recorded a temperature of 36.80C and Mr. N. O. verbalized his body is not warm to touch.	B. S.

Table 6: NURSING CARE PLAN FOR MR. N. O. CONTINUED

Date and Time	**Nursing Diagnosis**	**Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	**Sign**
26/11/21 At 3:59pm	Impaired comfort (pain) related to swollen Right 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. Elevate the swollen limb. 4. Apply cold compress on the swollen hand. 5. Administer the prescribed pain killers as ordered.	1. Patient was reassured to allay fear and anxiety. 2. Patient's level of pain was assessed using numerical paining rating scale. 3. Swollen limb was elevated on a pillow. 4. Cold compress was applied on swollen limb to reduce swelling and pain. 5. Paracetamol and diclofenac were administered as ordered.	28/11/21 At 3:59pm	Goal fully met as patient verbalized reduction of pain at the affected limb and nurse observed a reduction in swelling on the affected limb	B. S.

Table 6: NURSING CARE PLAN FOR MR. N. O. CONTINUED

Date and Time	**Nursing Diagnosis**	**Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date and Time**	**Evaluation**	**sign**
26/11/21 At 7:20pm	Anxiety related to unknown outcome of the disease condition (cellulitis).	Patient will be relieved of anxiety within 24 hours as evidenced by; 1. Patient relating freely with nurses and other patients. 2. Nurse observing patient showing cheerful facial expression.	1. Reassure patient and family. 2. Orientate patient and family around the ward and its environment. 3. Introduce other health team members to patient and family. 4. Encourage patient to clarify any doubt.	1. Patient and family were reassured of competent nursing care. 2. Orientation was done for patient and family to familiarize with the environment and reduce their level of anxiety. 3. Health team was introduced to patient and family members to increase their hopes of competent care. 4. Patient was encouraged to clarify her doubts about her recovery.	27/11/21 At 7:20pm	Goal fully met as patient related freely with nurses and other patients and showed cheerful facial expression	B.S.

Table 6: NURSING CARE PLAN FOR MR. N. O. CONTINUED

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	sign
27/11/21 At 08:05am	Risk for imbalanced nutrition (less than body requirement) as evidenced by poor appetite.	Patient's normal nutritional status will be maintained during hospitalization as evidenced by: 1. Nurses observing patient eating more than half of his meals served. 2. Patient verbalizing increase in appetite	1. Plan diet with patient and care taker 2. Do oral care. 3. Serve patient meal small but in a frequent interval. 4. Stay and encourage patient to eat. 5. Reassure patient.	1. Diet was planned with patient and care taker with pawpaw and pineapples being added to his meals. 2. Oral care was done to boost appetite. 3. Fufu was served in bits, attractively and at regular frequencies. 4. Patient was encouraged to eat his meal served. 5. Patient was reassured to allay fear and anxiety on his appetite.	01/12/21 At 08:05am	Goal fully met as patient ate more than half of his meals served and also verbalized an increase in his appetite.	B. S.

Table 6: NURSING CARE PLAN FOR MR. N. O. CONTINUED

Date and Time	Nursing Diagnosis	Objective/Outcome criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
27/11/21 At 9am	Disturb sleep pattern related to pain at the Right lower limb.	Patient will regain normal sleep pattern within 48 hours as evidence by; 1. Nurse observing patient sleeping at least 8hours during night and 2 hours in the day time. 2. Patient verbalizing that he slept soundly.	1. Encourage patient to take warm bath 2. Restrict visitors to allow time for patient to sleep. 3. Ensure proper ventilation in the patient room to enhance sleeping. 4. Administer prescribed analgesics as ordered. 5. Reassure patient.	1. Patient was encouraged to take a warm before going to bed. 2. Visitors were not allowed to destruct patient during sleep. 3. Proper ventilation was ensured in the patient room. 4. Tablet Paracetamol 1g and Tablet diclofenc 50mg was administered to reduce pain. 5. Patient was reassured to allay any fears arising from his inability to sleep.	29/11/21 At 9am	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.	B. S.

Table 6: NURSING CARE PLAN FOR MR. N. O. CONTINUED

Date and Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date and Time	Evaluation	Sign
28/11/21 At 09:30am	Deficient knowledge related to patient's lack of exposure to source of information on the disease condition.	Patient will have adequate knowledge on his condition within period of hospitalization as evidence by; 1. Patient and relatives being able to provide correct answers to questions posed to them. 2. Nurse observing that client and relatives practice knowledge gained on cellulitis.	1. Reassure patient and family. 2. Assess patient level of knowledge on the condition. 3. Educate patient and relatives on the condition. 4. Allow patient to ask question and answer tactfully.	1. Patient and family were reassured that all the necessary information about the condition will be made known to them. 2. Patient level of knowledge on the condition was assessed by asking him questions on the condition. 3. Patient and family was educated on the causes, manifestation treatment and prevention of cellulitis. 4. Questions were asked by the patient and were answered tactfully.	01/12/21 At 09:30am	Goal fully met as patient and family provided correct answers to questions posed to them and knowledge gained on cellulitis were practiced by patient and family.	B. 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 achievement of specific outcomes (Delaune & Ladner, 2010).

4.1 SUMMARY OF ACTUAL NURSING CARE.

The actual nursing care rendered to Mr. N. O. and his family started on the day of admission, 26th November, 2021 to the time care was terminated on 23rd December, 2021. 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 (26TH NOVEMBER, 2021).

On the 26th November 2021, Mr. N. O. was admitted to the Males ward of Holy Family Hospital, Berekum. His admission was ordered by Dr. G. from the OPD with a diagnosis of cellulitis of the right lower limb. Patient was brought to the ward in a wheel chair accompanied by his mother and his elderly sister. 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 edematous feet. Patient and relatives was 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 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 was checked and recorded accurately as follows:

6. Temperature 38.9oC
7. Pulse 84bmp
8. Respiration 21cpm
9. Blood Pressure 120/90mmHg
10. 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 alvaro was served to the patient to help reduce the temperature to a normal physiological level and after 3 hours patient temperature reduced to 37.6oC, 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 right 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 300mg qid for 3days
2. Tablet Paracetamol 1g tid for 5days
3. IV Ciprofloxacin 400mg bid for 3days
4. Tablet Diclofenac 50mg tid for 5days
5. Ringers Lactate 500mls tds for 24hours

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. N. O. and his mother 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 mother 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. N. O. and His mother 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.

At 3:55pm 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 alvaro was served, vital signs were monitored, he was covered with a light cloth and nearby fans were switched on and windows opened to ensure good ventilation.

At 3:59pm, the nursing diagnosis of impaired comfort related to painful swelling of right lower limb was formulated for problem of severe pains of the right lower limb identified during the assessment. Nursing interventions such as reassurance of patient was done, assessment of the patient's pain was done, and elevation of the affected limb using pillow, application of cold compress to reduce pain and swelling and administration of medication such as paracetamol and diclofenac ordered were carried out.

Evening vital signs were checked and documented. Prescribed medications were also administered as ordered.

At 07:20pm, I went to my patient to interact with him, patient manifested a feeling of apprehension as he was not cooperating. So, I asked patient to verbalize his fears with regards to his stay in the ward. He then revealed to me that he was anxious because he does not know the

outcome of the disease process and its management. Nursing diagnosis was made as anxiety related to unknown outcome of disease condition (cellulitis) and unfamiliar environment. An objective was therefore set to relieve patient of anxiety within 24 hours. Nursing interventions carried out were as follows; patient and family were reassured, orientation was done for patient and family, health team was introduced to patient and family members. Patient was then encouraged to clarify his doubts by asking questions.

He was monitored until I handed him over to the night shift staffs at 8:00pm.

4.1.2 SECOND DAY OF ADMISSION (27TH NOVEMBER, 2021).

On the second day of admission, at 7:00am I went to the ward to continue with my nursing care for Mr. N. O., his morning vital signs had already been checked at 6am and recorded as follows; Temperature 36.70C, 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. N. O. is not diabetic. During the ward rounds at 7:40am, Dr. A. attended to Mr. N. O. 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 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 and he was reassured to allay fears and anxiety arising from his inability to eat.

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 not to be 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, reassured to allay fears anxiety arising from his inability to sleep and elevation of the affected limb to reduce swelling and pain when in bed. 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 03:55pm, 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 36.80Cand patient verbalizing that he is warm to touch.

At 6:00 patient vital signs were checked and recorded as follows; Temperature,36.4C, 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.

At 07:20pm, I evaluated the objective that was set to help relieve patient of anxiety and goal was fully met as nurse observed patient related freely with nurses and other patient and showed cheerful facial expression. I finally handed over to the night shift nurses to continue with the patient care and departed.

4.1.3 THIRD DAY OF ADMISSION (28TH NOVEMBER, 2021).

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 mother. 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 less knowledge on his condition (Cellulitis). The nursing diagnosis formulated was Deficient knowledge related to patient's lack of exposure to sources of information on the disease condition. An objective was set to help patient and family gain adequate knowledge on cellulitis within the period of hospitalization. Interventions carried out were; Patient and family were reassured that all the necessary information about the condition will be made known to him, patient`s level of knowledge on the condition was assessed, patient was educated on condition and questions were asked by the patient. 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. N. O. Father in which we had interactions for about one and half hours and returned back to continue my care to Mr. N. O.

At 3:59pm, 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. 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.

I then handed him over to the night shift nurses to continue the nursing care to the patient.

4.1.4 FOURTH DAY OF ADMISSION (29TH NOVEMBER.2021).

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 36.40C, 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 rounds. At 8:00am doctor came for rounds and patient expressed his happiness about the sudden reduction in pain that made him had a sound sleep on the previous night. On 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 8hours 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 conservation 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 enhance 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 (30TH NOVEMBER, 2021).

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 36.30C, Pulse 79bpm, Respiration 17cpm and Blood Pressure 120/70mmHg.

At 8:00am doctor came for rounds and patient expressed his happiness about the sudden reduction in pain that made him had a sound sleep on the previous night. On 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 (1ST DECEMBER, 2021).

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 36.40C, Pulse 86bpm, Respiration 21cpm and Blood Pressure 130/80mmHg.

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

At 9:30am, objective that was set to help patient and family gain adequate information about his condition was evaluated and goal was fully achieved as; Patient and family provided correct answers to questions posed to them and knowledge gained on cellulitis were summarized by patient and family. During routine ward rounds, patient was discharged since his condition was stable and he had no complains. His Mother was informed and the bills were assessed to be paid. An amount of seventy- three 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 fiber like whole grains, the entire essential food nutrients, for example protein, vitamins and irons, as well as maintaining good personal hygiene. Mr. N. O. was discharged on tablet clindamycin 300mg qid for 7days and tablet paracetamol 1g tds for 7 days. Patient was informed to come for review on 8th December, 2021 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.

4.2 PREPARATION OF PATIENT/FAMILY FOR DISCHARGE AND REHABILITATION.

Preparation for discharge commenced from the time of admission at the hospital, at 03:50pm on 26th November, 2021 till the last day of hospitalization, 1st December, 2021. The patient and family were informed that staying in the hospital was for a temporal period of time. Education of patient and family on the causes, clinical features, treatment and management of cellulitis were 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 1st December, 2021. 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. Patient belongings were packed and I accompanied them to the house as I had arranged with them.

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 (28TH NOVEMBER, 2021).

My first home visit was made on 28/11/2021, thus; the third day of admission to Breynkwa about 3km 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 Father where 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 father, 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. N, O.'s 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. N. O. 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 (6TH DECEMBER, 2021).

This visit was made on 06/12/2021 at 10:30am, as it was scheduled with the patient and the family to pay them a second visit. 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 8th December, 2021 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. Patient's father escorted me to the roadside where I bordered a "pragyia" from Brenyekwa to Berekum town.

4.3.3 DAY OF REVIEW (8TH DECEMBER, 2021).

On Wednesday, 8th December, 2021 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 mother. The vital signs checked and recorded as follows; Temperature 36.0oC, 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. N. O. 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 he should 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 mother to the gate where they picked a tricycle popularly known "pragyia" to their house.

4.3.4 THIRD HOME VISIT (20TH DECEMBER, 2021).

The main reason for conducting the third home visit were to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen and finally terminate care. On the said date, I set off early on Monday afternoon around 2:30pm with a tricycle popularly known "pragyia". I got to Breynkwa 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 mother to continue with care at home after giving her enough education since there was no health facility around. Mr. N. O.'s mother commended me for good work done and accepted to continue the care of Mr. N. O. 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 mother 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 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.

1. **Patient was relieved of hyperthermia (27/11/21).**

On the day of admission thus; 26/11/2021, at 3:55pm patient had fever hence the nursing diagnosis hyperthermia (38.90C) 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 alvaro were served, he was covered with a light cloth and nearby fans were switched on then windows opened to ensure good ventilation. On 27/11/2021 at 03:55am, objective that was set to reduce patient temperature was evaluated and goal was fully met as; Nurse recording Patient temperature of 36.6 ^{0}C and patient verbalized that he is not warm to touch.

2. **Patient was relieved of anxiety (27/11/21).**

On 26/11/2021 at 07:20pm, I went to my patient to interact with him, patient manifested a feeling of apprehension as he was not cooperating. So, I asked patient to verbalize his fears with regards to his stay in the ward. He then revealed to me that he was anxious because he does not know the outcome of the disease process and its management. Nursing diagnosis was made as anxiety related to unknown outcome of disease condition. An objective was therefore set to relieve patient of anxiety within 24 hours. Nursing interventions carried out were as follows; Patient and family were reassured, orientation was done for patient and family, health team was introduced to patient and family members. Patient was then encouraged to clarify his doubts by asking questions.

On 27/11/2021at 07:20pm, I evaluated the objective that was set to help relieve patient of anxiety and goal fully met as Patient related freely with nurses and other patients and showed cheerful facial expression.

3. **Patient was relieved of pain at right lower limb (28/11/21)**.

On 26/11/2021, at 3:59pm patient complained of severe pains at the affected limb hence the nursing diagnosis of impaired comfort related to painful swollen of right 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 edema, application of cold compress to reduce pain and swelling and administration of medication as ordered were carried out.

On 28/11/2021 at 03:59pm, 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.

4. **Patient normal sleep pattern was restored (29/11/21).**

On 27/11/2021, 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 be 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 29/11/2021 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. **Patient appetite was restored (01/12/21).**

On 27/11/2021, 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 01/12/2021, 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.

6. **Patient and family gained knowledge on cellulitis (01/12/21).**

On 28th November, 2021 at 9:30am, patient and mother were engaged in an interaction and it was realized that patient and mother had less knowledge on patient's condition (Cellulitis). The nursing diagnosis formulated was Deficient knowledge related to patient's lack of exposure to sources of information on the disease condition. An objective was set for to help patient and family gain adequate knowledge on cellulitis within the period of hospitalization. Interventions carried out were; Patient and family was reassured that all the necessary information about the condition will be made known to him, patient level of knowledge on the condition was assessed, patient was educated on condition and questions were asked by the patient.

On 1st December, 2021 at 9:30am, objective that was set to help patient and family gain adequate information about his condition was evaluated and goal was fully achieved as; Patient provided correct answers to questions posed to them and Knowledge gained on cellulitis were practiced by 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. N. O. 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 Monday 20th December, 2021 afternoon around 2:30pm with a tricycle popularly known "pragyia". I got to Breynkwa 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 mother to continue with care at home after giving her enough education since there was no health facility around. Mr. N. O.'s mother commended me for good work done and accepted to continue the care of Mr. N. O. 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 mother 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. N. O. an 18-year-old man was admitted to the Males ward through the Out Patient Department of Holy Family Hospital, Berekum on the 26th of November, 2021 at 03:50pm with the diagnose of cellulitis of the right 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 discharged all the objectives set were met. On admission, he presented fever and also had severe pain, edema at his right lower limb. Mr. N.O. was discharged on 1st December, 2021. During admission some of the treatment plan for Mr. N.O. were IV Clindamycin 300mg qid for three days, Tablet Paracetamol 1g tid for five days, IV Ciprofloxacin 400mg bid for three days. Patient was educated on cellulitis. On the 8th December, 2021 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 28th November, 2021, second home visit was on the 6th December, 2021 and third home visit was on the 20th December, 2021. The care of Mr. N. O. and his family was terminated on the 20th December, 2021, during the third home visit when patient had fully recovered with edema of the right 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 N. O

DATE	TIME	TEMPERATURE (^{0}C)	PULSE (Bpm)	RESPIRATION (Cpm)	BLOOD PRESSURE (mmHg)
26/11/21	3:50PM	38.9	84	21	120/90
	6:00PM	37.6	80	20	120/70
	10:00PM	37.3	78	22	120/80
27/11/21	6:00AM	36.7	70	17	130/70
	10:00AM	36.6	72	18	120/80
	2:00PM	36.6	76	20	120/70
	6:00PM	36.4	73	19	120/80
	!0:00PM	36.8	78	22	120.80
28/11/21	6:00AM	36.5	73	19	120/80
	10:00AM	36.4	76	20	110/70
	2:00PM	36.2	80	21	120/70
	6:00PM	36.6	78	19	120/70
	!0:00PM	36.3	76	18	120/80
29/11/21	6:00AM	36.4	80	21	120/70
	10:00AM	36.2	76	20	130/70

	2:00PM	36.4	74	19	120/80
	6:00PM	36.6	76	20	120/80
	!0:00PM	36.1	71	18	110/70
30/11/21	6:00AM	36.3	79	17	120/70
	10:00AM	36.2	72	18	110/60
	2:00PM	36.7	81	21	120/80
	6:00PM	36.8	79	18	120/80
	!0:00PM	35.9	75	17	110/70
1/12/21	6:00AM	36.4	86	21	130/30

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SIGNATORIES

THE STUDENT NURSE

NAME : BOAKYE SAMUEL

SIGNATURE: .....

DATE: 04/10/2022

THE NURSE-IN-CHARGE OF MALES MEDICAL WARD (HOLY FAMILY HOSPITAL, BEREKUM).

NAME: OWUSU KOFI BISMARK.....

SIGNATURE: .....

DATE: 04/10/2022.....

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

NAME: MS. AGYEI BOAKYE RITA

SIGNATURE: .....

DATE: 04/10/2022.....

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

NAME: MS. MONICA NKRUMAH

SIGNATURE: .....

DATE: 05/10/2022

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