HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE BEREKUM

A PATIENT/FAMILY CENTERED CARE STUDY ON PERITONITIS

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A PATIENT/FAMILY CENTERED CARE STUDY ON PERITONITIS SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILLMENT FOR THE AWARD OF THE LICENSE TO PRACTICE AS A REGISTERED GENERAL NURSE.

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PREFACE

Virginia Henderson (1960-1964) defined nursing as assisting the individual whether sick or well in the performance of those activities contributing to health or peaceful death that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such way to help him gain independence as rapidly as possible.

Nursing care has evolved from just caring for the sick and the dying, to an era of assisting people who seek health guidance and counseling, as well as promoting the health of individuals, their families and the entire community. There has also been an extension of care to the sick person's family and community, at large, in all aspects of health care. The Patient/family care study is a detailed account of nursing care rendered to the Patient and family to meet their needs. The study is designed to give a comprehensive nursing care to both patient and family from the time of admission till when patient is finally discharged to go home, as well as follow-ups or home visits for continuity of care, hence care study has become mandatory for every final year student offering the Registered General Nursing (Diploma) programme. This is a pre-requisite for the partial fulfillment for the award of license to practice as a Registered General nurse by the Nursing and Midwifery Council (NMC) for Ghana. The study also involves the nursing process which involves assessment of patient/ family, planning of care to be rendered, implementing the plan and evaluating care rendered to patient/ family. The patient and family care study helps to broaden the scope of knowledge of the student nurse. It helps the student nurse to put his theoretical knowledge and skills acquired through training together to give a comprehensive care to patient and family. The patient and family care study also enhances the interpersonal relationship of the student nurse as he constantly communicates with the patient, relatives, friends and other health team in the various units of the hospital to provide comprehensive care

of the patient. For the purpose of confidentiality and security reasons, my patient's identity will not be disclosed; hence Miss S.Y. will be used to represent my patient's name throughout the script.

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Again, I am also grateful to my lovely mother Mrs. Grace Kyere and my brothers Bernard Kwasi Nkrumah and Augustine Yeboah for the financial, emotional, psychological and spiritual support throughout my education. I say God richly bless you and replenish whatever you lost through your support and encouragement. My profound gratitude also goes to RGN 22 class and all my friends, not forgetting my roommates and loved ones. Finally, my thanks go to the authors from whose books information was extracted. May God richly bless you all.

INTRODUCTION

This script entails a patient/family care study written on Miss S.Y., a 29 year old woman. She hails from Asotiano, a town in the Dormaa East district in the Bono Region. She was admitted the 9th November, 2021 with diagnosis of Peritonitis. She spent ten days at the hospital and throughout her stay in the hospital, she had treatment and care geared towards complete recovery. On admission Miss S.Y presented with headache, nausea, abdominal pain and chills. Her vital signs were checked and recorded as temperature 38.4^0c, pulse 144bpm, respiration 21cpm and BP 130/80mmHg. Interventions were put in place to reduce the rise in patient's body temperature. The following laboratory test were ordered and carried out on Miss S.Y. blood film for malaria parasites, blood for full blood count, human immunodeficiency (HIV) screening, blood urea nitrogen and creatinine. Metronidazole injection 5mg/ml in 100ml, Diclofenac suppository 100mg bid x 10 days, Metronidazole 400mg tid x 1/52, Ciprofloxacin 500mg bid x 1/52, Dextrose saline 2L x 24hrs, Ringers Lactate 1L x 24hrs, IV Paracetamol 1G tid x 24hrs and Vitamin C 100mg tid x 14 days were prescribed for her.

With proper medical and nursing care Miss S.Y. was discharged on 18th November, 2021 without any severe complication. Three home visits were embarked on and patient was handed over to community health nurse. First visit was embark on the 10th November, 2021, second home visit 22nd November, 2021 and third home visit 28th November, 2021.
This script is written, organized and compiled into six (6) chapters for easy reading and understanding.

Chapter one deals with the assessment of patient and family. Assessment in this chapter gives a general overview of the patient's particulars, family medical and surgical history, family socio-

economic history, patient's developmental history, patient's concept of illness, obstetric history, patient's lifestyle and hobbies and patient's past and present medical and surgical history, admission of patient, literature review and validation of data.

Chapter two entails data analysis. Analysis of data is the statistic that measures difference among group means and uses a statistical technique to equate the groups under study in relation to another given variable. Here, there is a comparison between the results of the investigations carried out and the normal values to detect any abnormality from normal.

Chapter three deals with the planning the care for patient and family where a nursing care plan is drawn and was used in the management of Miss S.Y.

Chapter four of this study is the implementation phase of the nursing process involves carrying out the proposed plan of nursing care. It involves a summary of the actual nursing interventions rendered, preparation of patient for discharge and follow-up visits.

The fifth chapter is about the evaluation of care rendered to patient and family. The chapter also gives information about the amendment of nursing goals and the termination of the care rendered to patient and family.

The final chapter is the summary and conclusive part of the care rendered to the patient.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

Assessment involves the gathering of information about the health status of the patient, analysis and synthesis of the data and the making of clinical nursing judgment (Weller, 2014). Assessment is the first stage and a vital tool in the nursing process. Assessment can be done through observation, interviewing and investigations such as laboratory results, x-ray reports and physical examination of the patient. It entails 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 illness and literature review on the condition from which analysis will be made to identify the patient problems and validation of data. This information gives the health team the idea about patient/family problems and will serve as foundation upon which appropriate nursing intervention will be established and implemented for the speedy recovery of the patient.

1.1 Patient's Particulars

According to the Macmillan English Dictionary (2016), patient particulars are the information in details about someone. They include patient's name, age, weight, height, patient's name and others.

Patient's name is Miss S.Y. She was born on Sunday, 8th November, 1992 at Asotiano. She is 29 years of age. She comes from Asotiano, a town in the Dormaa East district in the Bono Region. She stays at Domfete, a suburb of Berekum in the Bono Region of Ghana. Her house number is DF/65. She is single. She attends the Church of Methodist at Domfete. Madam P.Y is her next of kin. She completed Sunyani Senior High School. She speaks both English and Asante Twi which is her mother tongue. She is a trader. She has a son. She is an Akan by tribe. She was born to Mr. K.P and Mrs. A.S. She is the 4th born of 5 children. She is fair in complexion. She weights 55kg. She has no physical impairment. She is a beneficiary of the National Health Insurance Scheme (NHIS). Her folder number at Holy Family Hospital, Berekum is 11904/11.

1.2 Family's Medical and Surgical History

Family medical history is a record of the relationships among family members along with their medical histories. It focuses on the impact of psychosocial, ethnic, and cultural background on a person's health. Information is obtained on both paternal and maternal sides of family (Smeltzer, Bare, Hinkle, & Cheever, 2014).

There is no known hereditary disease like sickle cell, diabetes mellitus, hypertension, asthma or epilepsy in the family. There is no communicable disease like measles, diphtheria and tuberculosis in the family. She said she had lost her grandfather who died a natural death but both her parents and her grandmother are all alive and they are living in good health. There is no history of mental illness in the family. Patient has never been hospitalized. The source of treatment for patient's family is orthodox. They sometimes use herbal medicine. They use Over the Counter drugs for the treatment of minor disorders like headache, fever, etc. Patient and

family were educated to desist from buying unprescribed drugs and they were encouraged to always visit the hospital when sick. Patient/family have no known allergies.

1.3 Family's Socio-Economic History

Socio economic history presents a profile of the patient/family's social and personal world (Park, 2013). It includes; family relationship/social cohesion, support systems, religious activity, source of medical care/financing (NHIS), parent employment, occupational hazards and income levels and wealth of family as well as traditions, norms, values, taboos and cultural practice.

According to patient, she lives peacefully with other members of the family and people within her community. She takes care of her family without support. Her source of income is gained from trading. All her family members are beneficiaries of the National Health Insurance Scheme (NHIS). According to patient, she earns about three thousand Ghana Cedis annually. She is a Christian. Patient conforms to all the traditions and taboos governing the community she lives in. Patient's family is financially stable. This is because they can provide for themselves their needs and donate to the needy.

1.4 Patient's Developmental History

Development refers to the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014). Maturation is the process of development in which an individual matures or reaches full functionality (Weller, 2014). Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2014).

According to patient she was delivered per Vaginum at Asotiano with the help of a community midwife. She was delivered on Sunday, 8th November, 1992. On examination it was realised that patient had the Bacille Calmette Guerin (BCG) injection scar on her right arm indicating that she was immunized with the BCG vaccine. She was vaccinated with all the childhood immunization. It was verified by cross-checking her health record book.

According to patient, she started sitting when she was six months then started walking at one year. At one and half years she was able to notice her mother and close relatives. She was able to say ‘mama’ and ‘dada’. She had her milk teeth at six months. Patient was fed with water and breast milk. This is because her parents had no knowledge about practicing exclusive breastfeeding. She did not have any childhood disease. Puberty is the time in life when a boy or girl becomes sexually mature. It is a process that usually happens between ages 10 and 14 for girls and ages 12 and 16 for boys (Shriver, 2018). According to patient, she had her menarche at the age of sixteen. Her breast development and pubic hairs grew within the same year. According to patient, she wanted to become a teacher in the future but could not achieve her aspirations due to financial problems.

According to Erikson’s theory of psychosocial development (1959), there are eight distinct stages with each possible result, thus success or failure personality. The stages are;

Trust vs. Mistrust (birth to 18 months)

Autonomy vs. Shame and Doubt (2 to 3 years)

Initiative vs. Guilt (3 to 5 years)

Industry vs. Inferiority (6 to 11 years)

Identity vs. Confusion (12 to 18 years)

Intimacy vs. Isolation (19 to 40 years)

Generativity vs. Stagnation (40 to 65 years)

Integrity vs. Despair (65 to death)

Patient by age 29years is classified under the sixth stage that is “Intimacy versus Isolation”. This is the sixth of eight stages of Erik Erikson’s theory of psychosocial development.

Intimacy versus isolation is the sixth stage of Erikson's Theory of Psychosocial Development, present during young adulthood (19 and 40 years). During this crucial period, people develop relationships with one another, learn how to resolve conflicts, and form bonds. Learning how to build strong emotional bonds with others helps an individual cultivate a support system. Erickson points out the importance of a focus on the development of strong emotional bonds with others, as vital in helping one to feel secure in themselves and the world. The intimacy versus isolation stage highlights a human desire to want to form intimate bonds, as having significant positive effects as opposed to being socially isolated. Erikson said that we must have a strong sense of self before we can develop successful intimate relationships. Adults who do not develop a positive self-concept in adolescence may experience feelings of loneliness and emotional isolation.

It was realized that patient was in the Intimacy stage of the psychosocial development. This is because she had a strong bond with her family members and was involved in everything that took place in her family.

1.5 Obstetric History

Patient is gravid one (1) para one (1). She delivered per Vaginum without any complication with the help of a Registered Midwife at Holy Family Hospital, Berekum. She had her menarche when she was sixteen years. She still has her menstrual periods every month. According to patient, she never suffered from any Sexual Transmitted Infections (STIs) such as gonorrhoea, syphilis, HIV/AIDS, among others. She has not also suffered from any breast conditions like breast cancer, mastitis and breast engorgement.

1.6 Patient's Lifestyle/Hobbies

Patient wakes up around 5:00am daily. She brushes her teeth with tooth brush and tooth paste. She takes warm bath every morning. She empties her bowel twice daily and empties the bladder whenever necessary. She normally takes porridge and bread in the morning. She normally prepares fufu and soup or banku and okro stew for supper. However, she prefers banku and okro stew to other foods. She drinks water frequently. She usually baths her son and sends him to school and leaves house for work around 8:00am and comes back around 4:30pm. She goes to work on all days of the week except Saturdays and Sundays. On Saturdays, she goes to the farm. She takes supper around 6:00pm with her son. She takes warm bath, watches television for a while and prays before she sleeps. She goes to church every Sunday. She likes listening to gospel music, listening to preaching and watching television. She also enjoys healthy relationships. On observation and interaction patient is an extrovert. She is a very kind woman who is able to address any issue that confronts her with the best of her ability.

1.7 Patient past Medical History

Past medical history is a detailed summary of a person's past health. Past medical history is a narrative or record of past events and circumstances that are relevant to a patient's current state of health. Among such information are childhood illness, allergies, accident and injury, physical disaster due to illness, medical check-up (Suzanne C. Smeltzer, 2014).

Patient had no childhood illness like measles, whooping cough, diphtheria and other disease during infancy through adolescence to adulthood. She has no allergy to drugs, insects, etc. She has not had any accident before but she has suffered minor injuries such as cuts from knives when cooking. She has not been hospitalized before. Patient has no physical disability.

1.8 Present Medical History

It gives information about when signs and symptoms started, how often problem occurs, activity which aggravate pain and the symptoms associated with the chief complaint. The history of present illness is usually a chronological description of the progression of the patient's present illness from the first and symptom to the present (Cardiology, 2019)

Patient was well until 8th November, 2021 when she started experiencing headache, nausea, abdominal pain and chills. She went to Asotiano clinic and was referred to Holy Family hospital, Berekum for further treatment. She reported to Holy Family hospital, Berekum on 9th November, 2021 at the Accident and Emergency Unit. Patient was referred to the surgical team for further treatment.

1.9 Admission of the Patient

Admission of the patient is the process of allowing a person to stay at the hospital for observation, investigation and treatment of the disease he/she is suffering from (Kart, 2018).

Patient was admitted into the surgical ward of Holy Family Hospital, Berekum per ambulation accompanied by a student nurse and a relative (sister) on 9th November, 2021 around 9:30am with the diagnosis of Peritonitis. They were welcomed to the nurses' station and seats were offered to them. Patient was made comfortable in an admission bed already prepared. On admission she complained headache, nausea, abdominal pain and chills. On examination and observation, she was conscious and alert. She looked anxious. Patient had a high body temperature. Patient was made comfortable in bed and her vital signs were checked and recorded as follows;

Temperature	38.4 degree Celsius
Pulse	144 beats per minute
Respiration	21 cycles per minute
Blood Pressure	130/80mmHg

Due to the increased in body temperature (38.4^{o}c), measures were taken to reduce patient's temperature. The measures include; patient was tepid sponged with tepid water, 1g of IV paracetamol was administered to patient, closed windows were opened and patient's temperature was rechecked which reduced to 37.5^{o}c.

Patient and relative were introduced to the staff nurses present and were assured of the competence of the health workers (nurses, doctors) who were going to take care of her throughout her stay at the hospital. The following information was obtained: patient's name, age,

religion, address and allergies. The particulars taken were then entered into the admission and discharge book and in the daily ward state. Patient's relatives were orientated to the ward annexes and ward routines explained to them. I introduced myself to patient and relatives as a final year student nurse of Holy Family Nursing and Midwifery Training College, Berekum, who would like to use her family and herself for my care study. Patient and her family were informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of a license to practice as a Registered General Nurse. I explained to patient and family 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 and will visit their home while still on admission and when she is been discharged home. Patient and family agreed to my request and promised to offer me the necessary information and assistance. Patient and relatives were congratulated on such a decision since doing so showed a mark of a welcoming gesture. Hospital policies regarding visiting periods and payment of bills were explained.

She was managed on the following prescribed medications:

1. Metronidazole injection 5mg/ml in 100ml
2. Diclofenac suppository 100mg bid x 10 days
3. Metronidazole 400mg tid x 1/52
4. Ciprofloxacin 500mg bid x 1/52
5. Dextrose saline 2L x 24hrs
6. Ringers Lactate 1L x 24hrs
7. IV Paracetamol 1G tid x 24hrs
8. Vitamin C 100mg tid x 14 days

The following diagnostic investigations were already requested and done for the patient;

1. Blood film for malaria parasite.
2. Blood for Full Blood Count
3. Blood Urea Nitrogen and Creatinine
4. Human Immunodeficiency (HIV) screening

Patient was used for the care study because I wanted to gain more knowledge about the condition (Peritonitis) that is the causes, clinical manifestation, the diagnostic investigations, medical, surgical, nursing management and the complications associated with it.

1.10 Patient's Concept about Illness

Patient and Family concept of illness is the understanding retained in the mind, from experience, reasoning or imagination about patient illness (Park, 2013). It provides information about patient perception of his or her illness, cause of illness, concern about illness/fear, expectation about treatment in the hospital, etc.

Patient and relative did not know the actual cause of the illness. She did not attribute her illness to any spiritual cause. They believed that, it was just a disease and she will be cured with prayers and through medical intervention

1.11 Literature Review.

Anatomy and Physiology of the Peritoneum

The peritoneum is the largest serous membrane of the body. It is a closed sac, containing a small amount of serous fluid, within the abdominal cavity. It is richly supplied with blood and lymph vessels and contains many lymph nodes. It provides a physical barrier to local spread of infection

and can isolate an infective focus such as appendicitis, preventing involvement of other abdominal structures (Waugh & Grant, 2016). It has two layers;

a) The parietal peritoneum, which lines the abdominal wall

b) The visceral peritoneum, which covers the organs (viscera) within the abdominal and pelvic cavities.

The parietal peritoneum lines the anterior abdominal wall.

The two layers of peritoneum are in close contact and friction between them is prevented by the presence of serous fluid secreted by the peritoneal cells, thus the peritoneal cavity is only a potential cavity. In male, the peritoneal cavity is completely closed but in the female the uterine tubes open into it and the ovaries are the only structures inside.

The arrangement of the peritoneum is such that the organs are invaginated into the closed sac from below, behind and above so that they at least partly covered by the visceral layer, and attached securely within the abdominal cavity. This means;

a) Pelvic organs are only covered on their superior surface.

b) The stomach and intestines, deeply invaginated from behind, are almost completely surrounded by peritoneum and have a double fold (the mesentery) that attaches them to the posterior abdominal wall. The fold of peritoneum enclosing the stomach extends beyond the greater curvature of the stomach, and hangs down in front of the abdominal organs like an apron. This is the greater omentum which stores fat that provides both insulation and a long term energy store.

c) The pancreas, spleen, kidneys and adrenal glands are invaginated from behind but only their anterior surfaces are covered and are therefore retroperitoneal structures (lies behind the peritoneum)

d) The liver is invaginated from above and is almost completely covered by peritoneum, which attaches it to the inferior surface of the diaphragm.

e) The main blood vessels and nerves pass close to the posterior abdominal wall and send branches to the organs between folds of peritoneum. (Waugh & Grant, 2016)

DEFINITION OF PERITIONITIS

Peritonitis is inflammation of the peritoneum which is a serous membrane lining the abdominal cavity and covering the viscera. The peritoneal cavity, is the space between the parietal and visceral layers, contains a film of sterile fluid which envelopes most of the abdominal organs. Usually, it is a result of bacterial infection; the organisms come from diseases of the GI tract or, in women, from the internal reproductive organs (eg, fallopian tube). (Suzanne C. Smeltzer, 2014)

Causes/Aetiology

1. External sources such as abdominal injury or trauma (e.g. gunshot wound, stab wound) penetrating the peritoneal cavity causing the leakage of content into the peritoneum to cause inflammation.
2. Inflammation of an organ leading to localized or generalized peritonitis for example ruptured appendicitis, ruptured diverticulitis.
3. Closed abdominal injury causing ruptures of an organ for example spleen, liver.

4. Escape of gastrointestinal content or content of another organ leading to generalized peritonitis e.g. perforated peptic ulcer, rupture gall-bladder. That is if a portion of these organs becomes diseased and their walls infected, these infections may spread to the serous covering coat which becomes inflamed.
5. Bacterial invasion for example. *E.coli, Staphylococcus aureus, Streptococcus* causing inflammation of the peritoneum and may also occur secondary to fungal or mycobacterial infection. These organisms come from diseases of the GI tract or in women, from the internal reproductive organs (e.g. fallopian tube)
6. Chemical reaction caused by bile, pancreatic juice, gastric or intestinal secretions.
7. Abdominal surgical procedures and peritoneal dialysis. (Hinkle & Cheever, 2014)

Pathophysiology

Peritonitis is caused by leakage of content from the abdominal organs into the abdominal cavity usually as a result of inflammation, infection and ischemia, trauma or tumour perforation. Bacteria proliferation occurs. Oedema of the tissues results, and exudation of fluid develops in a short time. Fluid in the peritoneal cavity becomes turbid with increasing amount of proteins, white blood cells, cellular debris and blood. The immediate response of the intestinal tract is hyper motility soon followed by paralytic ileus with an accumulation of air and fluid in the bowel (Suzanne C. Smeltzer, 2014). Peritonitis is most often caused by introduction of an infection into the otherwise sterile peritoneal environment through organ perforation, but it may also result from other irritants, such as foreign bodies, bile from a perforated gall bladder or a lacerated liver, or gastric acid from a perforated ulcer. Women also experience localized peritonitis from an infected fallopian tube or ruptured ovarian cyst. Patients may present with an

acute or insidious onset of symptoms, limited and mild disease or systemic and severe disease with septic shock (Daley, 2019).

Clinical features

1. The patient may be febrile as the symptoms become more severe and the general condition of the patient deteriorates from lack of sleep, toxaemia and fluid and electrolyte disturbances.
2. Diffuse type of abdominal discomfort because the portion behind the muscles of the anterior abdominal wall and in front of those on the posterior abdominal wall is richly endowed with nerve endings. Irritation of this portion gives rise to pain at the site at which it is stimulated.
3. Nausea and vomiting as a result of disturbance of the chemoreceptor trigger zone.
4. Abdominal tenderness and rebound pain when abdomen is touched because of accumulation of fluid in the peritoneum.
5. The patient may experience shock due to excessive fluid loss which is mainly plasma, water and electrolyte.eg there may be signs and symptoms of shock such as restlessness, cold clammy skin, hypotension etc.
6. Increased pulse rate, the pulse is usually rapid, irregular and of poor value and shallow respiration as a result of the reduction in the blood volume.
7. Abdominal muscular rigidity. The pain and the rigidity will give way to painless distension of the abdomen
8. Fever and chills due to the infection.
9. Abdominal resonance and tympani on percussion due to the accumulation of fluid in the peritoneal cavity.
10. Anorexia due to general malaise and vomiting.

11. Altered bowel movement due to decreased peristalsis or absence of bowel sound. The patient may have constipation or diarrhea. (Hinkle & Cheever, 2014)

Diagnostic investigations

The type of test used to help diagnose a disease or condition (National Cancer Institute, 2017)

1. Radiography of the chest and abdomen for the presence of free gas in the peritoneal cavity, dilated loose of bowel, urinary calculi and perforated ulcer.
2. Laboratory investigation of urine for the presence of red blood cells and pus
3. Electrocardiography to exclude coronary infarction as a cause of abdominal pain.
4. Peritoneal aspiration may reveal the presence of bile, pus or blood
5. Plain x-ray of the abdomen to show the perforated organ.
6. Computerized tomography scans of the abdomen to visualize the peritoneum.
7. Hemoglobin level estimation to rule out anemia
8. White blood cells count will be elevated to confirm the presence of infection.
9. Full blood count for leukocytosis and haemoconcentration.
10. Serum electrolyte which are particularly to be disturbed in vomiting.
11. History from patient and signs and symptoms to aid in diagnosis.

Specific Medical Management

Medical management is an umbrella term that encompasses the use of IT for health, disease, care and case management function. Specific management is the particular treatment used for specific conditions (Gartner, 2018).

1. Nil per-os to rest the bowel.

2. Rehydration by the use of intravenous fluid such as ringer's lactate, normal saline, dextrose saline to correct fluid and electrolyte imbalances and treat shock
3. Medication such as;
    a) Antibiotics example, intravenous ciprofloxacin to counteract the infection
    b) Antibacterial example, metronidazole, gentamycin to reduce infection.
    c) Analgesics/Antipyretics such as paracetamol to control pain and reduce body temperature.
    d) Hematinic are also given to correct anemia such as multivitamin and vitamin B complex to boost patient's appetite and in severe cases blood transfusion may be given to counteract shock and replace protein loss in the inflammatory exudates.

Surgical Intervention

A surgical intervention (laparotomy) is performed when complication such as intestinal perforation or haemorrhage into the bowel sets in. The perforated bowel is sutured (simple closure of the perforation). An intraperitonial lavage is done with saline water and all pus and faecal material are suctioned. The operation is done under general anesthesia.

Nursing Management

Nursing management consists of the performance of leadership functions of governance and decision making within organizations employing nurses (Nursing management, 2022)

The goals of nursing management are to minimize complication and to give supportive care.

Preoperative Management

Period of time that constitutes the surgical experience; includes the preoperative, intraoperative, and postoperative phases of nursing care (Suzanne C. Smeltzer, 2014)

Psychological Preparation on Care;

1. Patient/ family are reassured to gain their cooperation and to allay their fears and anxiety. This also makes them comfortable and relaxed.

2. The surgical procedure should be explained to patient and the purpose of the surgery. Patient and relatives should be encouraged to ask any questions bordering them and express their fears.

3. It should be made known to the patient that, following surgery she will be able to live a normal life without restrictions.

4. Introduce other patient with successful surgery done to the patient and explain surgical procedures to them.

5. The informed consent form is given to the patient to either sign or thumbprint in the presence of the nurse and family after explanation of the surgery.

6. Assist patient to develop a positive but realistic behavior towards the procedure.

7. Assure patient of support from staff and clear all misconceptions

8. Inform patient and relatives what to expect after surgery e.g. Presence of drainage tubes, monitors, infusion lines and bags, catheter etc.

9. Address patient's pain concerns by informing him that, post-operative analgesics will be used to manage post-operative pain that follows recovery from anaesthesia.
10. Orientate patient to theatre environment and equipment.
11. Depending on patient's religion, spiritual leader may be called upon to speak with patient.

Physiological Preparation

1. This consists of all the activities that are performed to establish a base line data, detect abnormalities, correct imbalance and determine the fitness of the patient for surgery.

These include the following;

a. Grouping and cross matching
b. Full blood count
c. Blood for Blood Urea Nitrogen (BUN) urinalysis
d. Blood for sugar level
e. Clotting time

2. An intravenous line should be connected to correct any fluid and electrolyte imbalances if present. Intravenous infusions as prescribed and administered to prevent dehydration and correct electrolyte imbalances.
3. Intake and output chart should be monitored.
4. If anaemia is present, blood is transfused.

5. Any other medication prescribed is administered. Antibiotics may be prescribed as a microbial cover and should be administered accordingly.

6. The effects and side effects of medications should be observed and report any findings for immediate solution.

Physical Preparation

1. Patient should be assisted and encouraged to take care of the body (bathing, toe and finger nails, the hair and her clothing as well as oral toileting) should be maintained so as to prevent infections and improve a sense of well-being.

2. The bed linen should be clean.

3. Attend to patient's elimination needs, offer bed pans or urinals each time the patient asked for assistance.

4. The supra-pubic area and the abdominal wall is prepared according to the hospitals policy.

5. Urethral catheter is passed and connected to a urine bag to keep the bladder empty.

6. The patient's items such as beads, necklace, earrings, hair pins, prosthesis, bracelets and dentures are removed.

7. The patient is advised to avoid intake of food or drink before the operation

8. Nasogastric suction is required to empty the stomach and to rest the bowel. It should be inserted before the operation to decompress the abdomen and left in place for intra operative and post-operative use.

Patient's Education

1. Patient should be given a thorough education on the need for post-operative exercises e.g. deep breathing and coughing exercises.
2. Patient should be taught to perform these exercises as it enhanced early recovery, improves muscle tone and improve the physical well-being of the patient.
3. Answers should be provided in simple language without the use of technical terms.
4. Patient should be taught to adhere all medication regimen be given.
5. Patient should be taught to keep wound clean.

Post-Operative Management

1. When patient is in the theatre, post-operative bed is prepared to receive the patient.
2. A vital signs tray, resuscitation equipment such as oxygen cylinder, ambu bag, suction machine, drip stand, and blankets are all made ready at the bedside of the patient for use in case of emergency.
3. Immediately the patient is brought into the ward, a quick assessment is made on the level of consciousness, patency of the airway and the operated site before the patient is received into bed.

Position

1. Immediately patient recovers from anesthesia, she is placed in the semi fowler's position to ease breathing and to prevent aspiration of secretions and vomitus or the patient is placed in a position ordered in the post-operative notes.

2. Patient's safety must be maintained by the use of side rails, the bed in a lowered position and other soft restrains if necessary.

3. Patient is assigned to a bed closer to the nurses' station for close monitoring and observation.

Observations/Monitoring

1. The level of consciousness is assessed as well as patency of the airway.

2. Vital signs which include temperature, pulse, respiration and blood pressure are carefully monitored every 15 minutes for the first hour, 30 minutes for one hour, hourly for the next 2 hours and then 4 hourly until the patient's condition stabilized.

3. Signs of respiratory distress which may signal haemorrhage, obstruction and/or shock are also monitored.

4. The incision site is also monitored for bleeding.

5. Intake and output should be monitored to know the amount taken in and excreted to detect fluid and electrolyte imbalance.

Nutrition

1. Intravenous fluids should be administered as prescribed after which sips of water followed by fluid diet.
2. As condition improves, the diet should be planned with the patient.
3. Light to normal diet should be served attractively to enhance good nutritional status.
4. All diet should be well balanced and rich in all nutrients as well as roughages to prevent the incidence of constipation, promote general growth, provide energy and enhance speedy recovery.
5. Assess for adequate hydration such as moist mucous membrane and good skin turgor.

Relief of Pain

1. Pain and discomfort levels should be assessed using a pain rating scale.
2. The patient should be assisted to assume a comfortable position to help reduce pain.
3. Ensure a noise free environment .All nursing activities should be done at a goal.
4. Warm baths should be encouraged to subside pain.
5. Divertional therapy should be used to divert her mind off the pain e.g. watching of television.
6. Prescribed analgesics such as Diclofenac, paracetamol should be administered as ordered to reduce the pain.

Wound Care

1. The wound should be observed for signs of bleeding. Look out for bleeding and signs and symptoms of internal bleeding.
2. Reinforce dressing if there is bleeding and report to the surgeon.
3. The wound should be observed for wound infection which is characterized by complains of pain, redness and oedematous wound edges.
4. Dressing should be changed frequently and wound dressing should be carried out aseptically on the 3rd day or as prescribed by the surgeon.
5. Alternate stitches are removed aseptically as ordered by the surgeon.
6. The patient should be educated to keep the wound dry and avoid touching it with the hands in order to prevent wound infection.
7. Patient is encouraged to take in high protein diet with enough vitamins especially vitamin C to promote wound healing and repair of worn out tissues.

Patient's Education

1. The patient is educated to support the abdomen during coughing, deep breathing and change position frequently to help reduce pain.
2. Patient is educated on the need to maintain both personal and environmental hygiene to reduce the risk of infection.
3. Teach patient to take prescribed medications and observe any side effects.

4. Educate patient on the need for follow-up visits.

Complications of Peritonitis

1. Septicemia
2. Intestinal obstruction
3. Intestinal perforation
4. Shock
5. Pelvic abscess
6. Severe toxaemia**.**

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 given by the patient was found to be true. To confirm this, patient and relatives were asked the same question for a couple of times and same answers were obtained.

The clinical features presented by patient and diagnostic investigation conducted, with the data collected from her mother with much emphasis on the literature review, confirmed that she was suffering from peritonitis. All data collected were valid and free from errors or basis.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis of data is the 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, Bailliere's Nurses' Dictionary, 2014). Data analysis has multiple facets and approaches, encompassing diverse techniques, under a variety of names in different business, science and social domain. Analysis simply means examination of something in order to interpret or explain it (Elizabeth, 2013). The second phase of the nursing process deals with breaking down of data collected into components and comparing facts gathered with standards.

2.1 Comparison of Data with Standard

Comparison is the consideration or estimation of the similarities or dissimilarities between two things (Barber, 2019). This is comparing the data collected with that of the standards. The following data will be compared with standards;

Diagnostic test/ investigations

Causes

Treatments

Clinical manifestation

Complications

A. Diagnostic Investigations/Tests

It is simply defined as specimen identification of a condition, disease, disorder, or problem by systematic analysis of the background or history, examination of the signs or symptoms, research or test results, and investigation of the assumed or probable causes (Elizabeth, 2013). The following investigations were carried out on patient to aid in the diagnosis and treatment;

1. Blood film for malaria parasite.
2. Blood for Full Blood Count
3. Blood Urea Nitrogen and Creatinine
4. Human Immunodeficiency (HIV) screening

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

Diagnostic Investigation in Literature.	**Diagnostic Investigations carried out of Patient**
1. Clinical manifestation	1. Patient experienced the clinical manifestation
2. Full blood count	2. Full blood count was done for patient
3. Radiography of the chest and abdomen	3. Radiography of the chest and abdomen was not done
4. Urine for the presence of red blood cells and pus	4. Urine for the presence of red blood cells and pus was not conducted

5. Electrocardiography to exclude coronary infarction	5. Electrocardiography to exclude coronary infarction was not conducted
6. Peritoneal aspiration	6. Peritoneal aspiration was not conducted
7. Plain x-ray of the abdomen	7. Plain x-ray of the abdomen was not conducted
8. Computerized tomography scans of the abdomen	8. Computerized tomography scans of the abdomen was not conducted
9. Hemoglobin level estimation	9. Hemoglobin level estimation was conducted
10. White blood cells count	10. White blood cells count was conducted

Diagnosis for patient's condition (peritonitis) was made based on the clinical manifestation she exhibited and the laboratory investigations obtained.

Table 2: Results of Diagnostic Investigation

Date	Specimen	Investigation	Results	Normal Values	Interpretation	Remarks
9/11/2021	Blood	Blood film for malaria parasites	Negative	No malaria parasites should be present.	Negative means there is no presence of malaria parasites	No treatment was given.
9/11/2021	Blood	**Full Blood Count**				
		WBC	23.39 x 10^3/uL	3.00 - 8.50 x 10^3/uL	WBC level is above normal range	No treatment given
		RBC	4.02 x 10^6/uL	4.0 - 5.50 x 10^6/uL	RBC level is normal values.	No treatment given
		MCV	79.4fL	80 – 100fL	MCV level is slightly below normal values	No treatment given
		Hemoglobin estimation	12.2g/dL	Males: 11-18g/dl Female:11-15g/dl Children:14-16g/dl	Hemoglobin level is within normal values.	No treatment given

Results of Diagnostic Investigation continue

Date	Specimen	Investigation	Results	Normal Values	Interpretation	Remarks
9/11/2021	Urine	**BUE and Creatinine**				
		Chloride	107.7 mmol/L	98 – 107 mmol/L	Chloride level (107.7mmol/L) were slightly above normal value	No treatment given
		Creatinine	73.24 umol/L	60 – 120 umol/L	Creatinine level (73,24mmol/L) is within normal level value	No treatment given
		iCa	1.61 mmol/L	1.10 – 1.40mmol/L	iCa level (1.61mmol/L) were above normal value	No treatment given
		Potassium	3.85 mmol/L	3.5 – 5.3 mmol/L	Potassium level (3.85mmol/L)were within normal value	No treatment given
		Sodium	142.2 mmol/L	135 – 148 mmol/L	Sodium level (142.2mmol?L) were within normal value	No treatment given
9/11/2021	Blood	Human Immunodeficiency (HIV) screening	Negative	No Human Immunodeficiency Virus should be found in the blood.	Negative means there is no presence of HIV	No treatment was given.

B. Cause of patient's conditions

Cause of a condition is an event, usually a bad event, that brings about an effect or result (George & Merriam, 2017).

With reference to the causes of peritonitis in the literature review, patient's condition was due to the leakage of fecal content from the perforated appendix into the abdominal cavity or the peritoneum.

C. Treatment given to patient

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

Treatment for peritonitis as indicated in the literature review includes;

1. Nil per-os to rest the bowel.
2. Rehydration by the use of intravenous fluid such as ringer's lactate, normal saline, dextrose saline to correct fluid and electrolyte imbalances and treat shock
3. Medication such as;
    A. Antibiotics example, intravenous ciprofloxacin (fluoroquinolones) to counteract the infection
    B. Antibacterial example, metronidazole, gentamycin to reduce infection.
    C. Analgesics/Antipyretics such as NSAID e.g Diclofenac and paracetamol to control pain and reduce body temperature.
    D. Hematinic are also given to correct anaemia such as multivitamin and vitamin B complex to boost patient's appetite and in severe cases blood transfusion may be given to counteract shock and replace protein loss in the inflammatory exudates.

4. Gastric decompression by nasogastric tube suctioning to rest the gastrointestinal tract.

5. Surgery

Based on the clinical manifestations presented and laboratory investigations conducted the following treatment were prescribed and administered to patient.

1. Metronidazole injection 5mg/ml in 100ml
2. Diclofenac suppository 100mg bid x 10days
3. Metronidazole 400mg tid x 1/52
4. Ciprofloxacin 500mg bid x 1/52
5. Dextrose saline 2L x 24hrs
6. Ringers Lactate 1L x 24hrs
7. IV Paracetamol 1G tid x 24hrs
8. Vitamin C 100mg tid x 14 days

Table 3: Comparison of Treatment Administered to Patient with Literature Review.

Treatment stated in Literature	**Treatment Administered to Patient**
1. Antibiotics a. Penicillins b. Cephalosporin c. Ciprofloxacin d. Metronidazole	1. Antibiotics; a. Tab ciprofloxacin was given b. Injection and tablet metronidazole were given
2. Analgesics a. Paracetamol b. NSAID's eg. Diclofenac c. Aspirin	2. IV paracetamol and suppository diclofenac were given
3. Hematinic	3. Vitamin C was given

4. Intravenous Fluid a. Normal saline b. Ringer lactate c. Dextrose saline	4. Ringer's lactate and Dextrose saline were given
5. Nil per-os	5. Patient was told avoid anything by mouth
6. Gastric decompression	6. Gastric decompression was not prescribed
7. Surgery	7. Laparotomy was done for patient

With reference to the literature review of drug treatment, patient was treated with most of the drugs Metronidazole injection, Diclofenac suppository, Tablet metronidazole, Tablet ciprofloxacin, Dextrose saline, Ringers Lactate, IV Paracetamol and Vitamin C. This shows that patient's treatment was in line with the treatment of peritonitis as indicated in the literature review.

Table 4: Pharmacology of Drugs/Conservative Treatment Given To Patient.

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES	REMARKS
9/11/21	Metronidazole	**Dosage**: Adult dosage: 500-750mg 5mg/ml in 20ml intravenously. Adult dosage: Oral suspension 500mg and 1g Children dosage: 35-50mg per kilogram body weight **Route:** orally, intravenously	Intravenously: 5mg/ml in 100ml Orally: 400mg tid x 1/52	Antibacterial	Kills protozoa and active against anaerobic bacteria	Infection subsided	Metallic taste, dry mouth, diarrhoea and numbness.	No side effect was experienced
9/11/21	Diclofenac	**Dosage:** Adult dosage: 75mg-150mg Children dosage: 25-35mg per kilogram body weight **Route:** Rectally	Suppository 100mg bid x 10 days	Non-Steroidal Anti-Inflammatory Drug	Inhibits inflammation and relieves pain	Pain was relieved	Peptic ulceration, headache, pruritus, oedema.	No side effect was experienced

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES	REMARKS
9/11/21	Ciprofloxacin	**Dosage:** Adult: 500 mg bd Paediatrics: 10mg/kilogram bd **Route:** orally, intravenously	500mg bid x 1/52	Fluoro-quinolones	It inhibits relaxation of DNA; inhibits DNA gyrase in susceptible organisms; promotes breakage of double stranded DNA.	Bacterial infection were treated	Dizziness, drowsiness and insomnia	No side effect was experienced
9/11/21	Ringers lactate solution	**Dosage:** Amount depends on patient's fluid and electrolyte level and age as well physician's prescription **Route**: Intravenously	1L x 24 hours Intravenously	Isotonic solution	To correct and maintain electrolyte	Patient became strong and there was no sign of dehydration	Fluid overload, Thrombophlebitis	No side effect was experienced

DATE	DRUG	DOSAGE/ ROUTE OF ADMINISTRATION (LITERATURE)	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO PATIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT/ REMEDIES	REMARKS
9/11/21	Intravenous Dextrose	Depends on the age, weight, and clinical condition of the patient	2Litre x 24hrs intravenously	Glucose replacement	It maintain glucose concentration in the body and release of energy	Patient's glucose level was maintained.	Venous irritation, thrombophlebitis.	No side effect was experienced
9/11/21	Paracetamol	**Dosage:** Adult dosage: 650-1000mg every 6-8hours Children dosage; 10-15mg/kg body weight every 4-6hours. **Route:** Orally, Rectal, I.V.	1G tid x 24hrs intravenously	Analgesic, anti-inflammatory and anti-pyretic.	To relieve pain and fever by inhibiting prostaglandin synthesis in the nervous system.	Pain and fever reduced gradually.	Dark urine, clay- colored stools, breathing difficulties and liver toxicity.	No side effect was experienced
9/11/21	Vitamin C	**Dosage:** Adult dosage: 70-150mg daily Children dosage: 15-50mg/kg body weight **Route:** Orally, intravenously, intramuscularly	100mg tid x 14days Orally	Water-soluble vitamin	To prevent and treat scurvy and for those whose absorption of orally ingested is uncertain eg: pregnant women.	It boost patient's immune system	Stomach cramps, nausea, heartburns, headache	No side effect was experienced

D. Clinical manifestation

The table below indicates the comparison of clinical manifestation exhibited by patient with literature review.

Table 5: Comparison of Clinical Manifestation with Standards

Clinical Manifestation According Literature Review	Clinical Manifestation Exhibited by Patient
1. Fever	1. Patient had fever
2. Abdominal discomfort	2. Patient had abdominal discomfort
3. Nausea	3. Patient had nausea
4. Vomiting	4. Patient did not vomit
5. Abdominal tenderness and rebound pain	5. Patient did not have abdominal tenderness
6. Shock	6. Patient did not experience shock
7. Increased pulse rate	7. Patient had increased pulse rate
8. Abdominal muscular rigidity	8. Patient had abdominal muscular rigidity
9. Anorexia	9. Patient had anorexia
10. Altered bowel movement	10. Patient did not have altered bowel movement

From the table, it is evident that patient suffered peritonitis since she exhibited most of the clinical manifestations in the literature review.

E. Complication

With reference to the literature review, the complications of septicaemia, Intestinal obstruction, Intestinal perforation, shock, pelvic abscess and severe toxaemia. Patient did not experience any of these complications.

2.2 Patient/Family strengths

Strength is the ability to do things that need lot of physical or mental effort (Elizabeth, 2013). Patient and family strengths refers to the resources that can enable them to cope with stressful conditions leading to patient's recovery. These involve the activities that contribute to the well-being of patient and her family as well as her speedy recovery.

The following were identified during assessment of patient and her family;

1. (9/11/21) Patient could verbalize location of the pain
2. (9/11/21) Patient could tolerate tepid bath.
3. (9/11/21) Patient could eat 6-10 teaspoons of porridge served.
4. (9/11/21) Patient asked questions about the condition.
5. (12/11/21) Patient was willing to learn about the condition and treatment regimen.
6. (12/11/21) Patient knew how to keep the operative site clean.

2.3 Patients health problems

Problem is defined as a situation, person that needs attention and needs to be dealt with or solved (Elizabeth, 2013). These are the problems or factors that affect the patient physically, mentally, socially and spiritually that can hinder her speedy recovery.

The following problems were identified;

1. (9/11/21) Patient complains of abdominal pains.
2. (9/11/21) Patient had high body temperature (38.4^0C).
3. (9/11/21) Patient complains of loss of appetite.
4. (9/11/21) Patient was anxious about outcome of surgery.
5. (12/11/21) Patient lacked information about peritonitis and its treatment regimen.
6. (12/11/21) Patient had a wound.

2.4 Nursing Diagnoses.

According to NANDA International, 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, 2018). These nursing diagnoses were formulated based on the health problems that were identified on patient.

1. (9/11/21).Altered body comfort (abdominal Pain) related to irritation in the peritoneum.
2. (9/11/21) Thermoregulation imbalance (38.8^0C) related to infective process of peritonitis.

3. (9/11/21) Imbalance nutrition less than body requirement related to inadequate dietary intake as evidenced by poor appetite for food.
4. (9/11/21) Anxiety related to impending surgery.
5. (12/11/21) Knowledge deficit related to lack of information about peritonitis and its treatment regimen.
6. (12/11/21) Risk for infection as evidenced by surgical incision of body tissues.

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2014). Planning involves writing of the nursing care plan. It is the third phase of the nursing process. Nursing diagnosis is used to formulate a plan on how the patient will be cared for. Planning includes setting of priorities, goals, objectives/outcome criteria and outlining the care strategies in the nursing care plan. In writing the plan of care, objectives/outcome criteria must tally with nursing diagnosis and must be arranged in order of priority.

3.1 Objectives /Outcome Criteria for Patient/Family Care

After priorities of the nursing diagnosis have been established, goals and nursing action appropriate for attaining the goals are identified. The patient and family are included in the establishment of goals for the nursing actions. Outcome criteria and statements that describe specific, observable and measurable responses of the patient. They determine whether the goals have been achieved and they are essential tools in evaluation.

The following are nursing objectives and outcome criteria formulated for patient/family care;

Preoperative Objectives

1. Patient would be relieved of pain within 24hours as evidenced by
    a. Patient verbalizing that the intensity of pain has reduced using the pain rating scale.
    b. Nurse observing patient in a relaxed and comfortable posture.

2. Patient's body temperature will reduce to normal range (36.2^{o}C – 37.2^{o}C) within 24 hours of hospitalization as evidenced by;
    a. Patient verbalizing that fever has subsided.
    b. Nurse recording normal values of temperature (36.2^{o}C – 37.2^{o}C).
3. Patient would regain her normal nutritional pattern throughout the period of hospitalization evidenced by;
    a. Patient verbalizing she has regained her appetite
    b. Nurse observing patient consume ¾ of every meal served
4. Patient would be relieved of anxiety within 24hours as evidenced by;
    a. Patient verbalizing that she is no longer anxious about the surgery.
    b. Nurse observing patient cooperate with care and appears relaxed.

Post-operative objectives.

5. Patient will gain adequate knowledge about the disease and its treatment regimen within 12 hours of hospitalization as evidenced by;
    a. Patient verbalizing understanding of the condition and its postoperative expectations
    b. Nurse observing patient adhere to the treatment regimen
6. Patient will be protected from infection throughout period of hospitalization as evidenced by;
    a. Patient being able to identify interventions to reduce potential risk of infection.
    b. Nurse maintaining safe aseptic techniques at all time.

Table 6: Nursing Care Plan for Miss S.Y and Family

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
9/11/21 At 10:00am	Altered body comfort (abdominal Pain) related to irritation in the peritoneum.	Patient would be relieved of pains within 24hours as evidenced by; a. Patient verbalizing intensity of pain has reduced using the pain rating scale. b. Nurse observing patient in a relaxed and comfortable posture.	1. Reassure patient pain will subside. 2. Assess the level of pain with the use of a numerical rating scale. 3. Put patient in a comfortable position. 4. Teach relaxation technique to help alleviate pain 5. Administer prescribed medication	1. Patient was reassured that measures will be taken to reduce pain. 2. Patient pain level was assessed using the numerical rating scale and she was rated under 4. 3. Patient was put in a comfortable position (that is from prone to lateral then to supine). 4. Relaxation technique was employed (watching television) 5. 100mg of suppository diclofenac was administered	10/11/21 At 10:00am	Goal fully met as; a. Patient verbalized that her abdominal pains has subsided b. Nurse observed patient relaxed comfortably in bed.	N.B

Table 6: Nursing Care Plan for Miss S.Y and Family

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
9/11/21 At 10:00am	Thermoregulation imbalance (38.8^0C) related to infective process of peritonitis.	Patient's body temperature will reduce to normal range (36.2^oC –37.2^oC) within 24 hours of hospitalization as evidenced by; a. Patient verbalizing that fever has subsided. b. Nurse recording normal values of temperature (36.2^oC – 37.2^oC).	1. Reassure patient that her high body temperature will reduce to normal range. 2. Tepid sponge patient to reduce temperature. 3. Ensure proper ventilation by opening the windows 4. Check and record vital signs (temperature) 4 hourly 5. Give liberal fluids 6. Administer prescribed antipyretic	1. Patient was reassured that measures will be taken to reduce high body temperature. 2. Patient was tepid sponged with tepid water for 2 hours. 3. Nearby windows were opened to allow fresh air into the room. 4. Vital signs were checked and recorded as 36.8^oC. 5. Cold voltic mineral water was given to patient (250mls). 6. 1g of IV paracetamol was administered	10/11/21 At 10:00am	Goal fully met as; a. Patient verbalized she has no fever. b. Nurse recorded a normal temperature of 36.8^oC	N.B

Table 6: Nursing Care Plan for Miss S.Y and Family

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
9/11/21 At 10:30am	Imbalance nutrition less than body requirement related to inadequate dietary intake as evidenced by poor appetite for food.	Patient would regain her normal nutritional pattern throughout the period of hospitalization evidenced by; a. Patient verbalizing she has regained her appetite b. Nurse observing patient consume ¾ of every meal served	1. Reassure patient that she would regain her normal eating pattern 2. Perform oral hygiene to boost appetite. 3. Involve patient/family in planning of diet and serve patient's food at right intervals (3-4 times) daily. 4. Serve food attractively and provide pleasant environment during meals 5. Congratulate patient to stimulate her appetite and to encourage her to eat well.	1. Patient was reassured that her normal eating pattern will be restored. 2. Patient brushed teeth twice daily and mouth rinsed before and after meals 3. Patient was always asked about the food she will like to eat and food was served at right interval (3-4 times) daily. 4. The environment was always kept neat and free from nauseated substance such as vomits, urine, stool and dirty linen. 5. Patient was congratulated after the meal.	18/11/21 At 10:00am	Goal fully met as; a. Patient verbalized she has regained her appetite. b. Nurse observed patient consume almost all of her meals served.	N.B

Table 6: Nursing Care Plan for Miss S.Y and Family

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
9/11/21 At 11:00am	Anxiety related to impending surgery	Patient would be relieved of anxiety within 24hours as evidenced by; a. Patient verbalizing she is no longer anxious about the surgery. b. Nurse observing patient cooperate with care and appears relaxed	1. Assess patient's level of anxiety. 2. Provide preoperative teaching. 3. Note expression of distress. 4. Introduce patient to the operating room staffs.	1. Patient's anxiety level was assessed, which indicated moderate anxiety. 2. Resources such as face mask, hair net and their uses were shown to patient before the surgery. 3. Expression of distress such as restlessness was noted. 4. Patient was introduced to the operating room staffs to help establish rapport and provide psychological comfort	10/11/21 At 11:00am	Goal fully met as; a. Patient verbalized she is no longer anxious about the surgery b. Nurse observed patient cooperated with care and appeared relaxed.	N.B

Table 6: Nursing Care Plan for Miss S.Y and Family

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
12/11/21 At 8:00am	Knowledge deficit related to lack of information about peritonitis and its treatment regimen	Patient will gain adequate knowledge about the disease and its treatment regimen within 12 hours of hospitalization as evidenced by; a. Patient verbalizing understanding of the disease process and its postoperative expectations b. Nurse observing patient adhere to the treatment regimen	1. Assess patient's level of understanding about disease (peritonitis) 2. Educate patient on disease condition and impending surgery. 3. Give preoperative instructions prior to the surgery. 4. Allow patient and relatives to ask questions on peritonitis 5. Answer all questions honestly and in plain language.	1. Patient was asked series of question to assess her level of understanding about the disease. 2. Patient was educated on condition (peritonitis) and what to expect during and after the surgery. 3. Instruction such as NPO time, skin preparation and premedication were made know to patient. 4. Patient and relatives were allowed to ask question. 5. Questions were answered tactfully and in plain language.	12/11/21 At 8:00pm	Goal fully met as; a. Patient verbalized understanding of disease process and postoperative expectations. b. Nurse observed that patient adhere to treatment regimen.	N.B

Table 6: Nursing Care Plan for Miss S.Y and Family

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
12/11/21 At 10:30am	Risk for infection as evidenced by surgical manipulation of tissues	Patient will be protected from infection throughout period of hospitalization as evidenced by; a. Patient being able to identify interventions to reduce potential risk of infection. b. Nurse maintaining safe aseptic technique at all time.	1. Adhere to aseptic policies and procedures of facility 2. Verify sterility of all items before wound dressing 3. Examine incision site for signs of infection 4. Apply sterile dressing always during dressing changes 5. Teach patient how to keep operation site clean. 6. Administer prescribed antibiotics	1. Aseptic policies and procedures were always adhered to. 2. Sterility of all items for dressing was verified. 3. Incisional site was examined for signs of infection such as redness, odour and pus. 4. Sterile dressing was applied after each dressing change. 5. Patient was informed to keep operative site clean. 6. Tablet metronidazole 400mg was administered	18/11/21 At 10:00am	Goal fully met as; a. Patient was able to identify interventions to reduce infection b. Nurse maintained safe aseptic technique at all times	N.B

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction.

The implementation phase of the nursing process involves carrying out the proposed plan of nursing care. The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, other members of the nursing team and other members of the health care team, so that the schedule of activities facilitates the patient's recovery (Smeltzer, Bare, Hinkle, & Cheever, 2014). This chapter is the fourth phase of the patient and family care study. It involves a summary of the actual nursing interventions rendered. This is where the objectives set and nursing orders given are really put in to practice with the purpose of aiding in patient recovery and getting over a health problem. It formally begins after the nurse develops a plan of care. It also includes the nursing care rendered on daily basis, preparation of patient and family towards discharge, continuity of care or home visits and rehabilitation. It also involves putting the nursing care plan which includes both medical and nursing interventions into action in order to obtain the desired outcome criteria of the patient.

4.1 Summary of Actual Nursing Care Rendered to Patient and Family

The actual nursing care rendered to patient and her family started on the day of admission 9th November, 2021 to the time care was terminated. The aim of the management was to meet the patient and family's psychological, physiological, emotional, spiritual needs, avoid complications and to ensure early recovery of patient.

First Day of Admission 9th November, 2021

Patient was admitted into the surgical ward of Holy Family Hospital, Berekum per ambulation accompanied by a student nurse and a relative (sister) on 9th November, 2021 at 9:30am with the diagnosis of peritonitis. They were welcomed to the nurses' station and seats were offered to them; patient was taken over from the student nurse as she handed over. Patient was made comfortable in an admission bed which was already made for her. On admission she complained of headache, nausea, abdominal pain and chills. On examination and observation, she was conscious and alert. She looked anxious. Patient had a high body temperature. Patient was made comfortable in bed and her vital signs were checked and recorded as follows;

Temperature	38.4 degree Celsius
Pulse	144 beats per minute
Respiration	21 cycles per minutes
Blood Pressure	130/80mmHg

Due to the increased in body temperature (38.4^{o}c), measures were taken to reduce patient's temperature. The measures include; patient was tepid sponged with tepid water, 1g of IV paracetamol was administered to patient, closed windows were opened and patient's temperature was rechecked which reduced to 37.5^{o}c.

Patient and relative were introduced to the staff nurses present and were assured of the competence of the health workers who were going to take care of her throughout the stay at the hospital. The following information was obtained: patient's name, age, religion, address and allergies. The particulars taken were then entered into the admission and discharge book and in the daily ward state. Patient's relatives were orientated to the ward annexes and ward routines explained to them. I introduced myself to patient and relatives as a final year student nurse of

Holy Family Nursing and Midwifery Training College, Berekum, who would like to use as my care study. Patient/family was informed that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of a license to practice as a Registered General Nurse. I explained to the patient/family the concept of the care study and assured them of privacy and confidentiality. It was added that a report will be written after the entire event and will visit their home while still on admission and when she is been discharged home. Patient/family agreed to my request and promised to offer me the necessary information and assistance. Patient/relatives were congratulated on such a decision. Hospital policies regarding visiting periods, payment of bills and the time vital signs will be checked were explained.

She was managed on the following prescribed medications:

1. Metronidazole injection 5mg/ml in 100ml
2. Diclofenac suppository 100mg bid x 10 days
3. Metronidazole 400mg tid x 1/52
4. Ciprofloxacin 500mg bid x 1/52
5. Dextrose saline 2L x 24hrs
6. Ringers Lactate 1L x 24hrs
7. IV Paracetamol 1G tid x 24hrs
8. Vitamin C 100mg tid x 14 days

The following diagnostic investigations were already requested and done for the patient;

1. Blood film for malaria parasite.
2. Blood for Full Blood Count
3. Blood Urea Nitrogen and Creatinine

4. Human Immunodeficiency (HIV) screening.

At 10:00am, patient complained of abdominal pains, therefore a nursing diagnosis of altered body comfort (abdominal Pain) related to irritation in the peritoneum was formulated. An objective of Patient would be relieved of patient within 24hours as evidenced by; Patient verbalizing intensity of pain has reduced using the pain rating scale and Nurse observing patient in a relaxed and comfortable posture was set. Nursing interventions included; Patient was reassured that measures will be taken to reduce abdominal discomfort, Patient pain level was assessed using the numerical rating scale and she was rated under 4, Patient was put in a comfortable position that is from prone to lateral then to supine, Relaxation technique were employed, watching television and 100mg of suppository diclofenac was administered.

At 10:00am, patient had a body temperature higher than normal (38.8^{o}C). A nursing diagnosis of Thermoregulation imbalance (38.8^{0}C) related to infective process of peritonitis was formulated. An objective of patient's body temperature will reduce to normal range (36.2^{o}C – 37.2^{o}C) within 24 hours of hospitalization as evidenced by; Patient verbalizing that fever has subsided and Nurse recording normal values of temperature (36.2^{o}C – 37.2^{o}C) was set. Nursing intervention implemented are as follows; Patient was reassured that measures will be taken to reduce high body temperature, Patient was tepid sponged with tepid water for 2 hours, Nearby windows were opened to allow fresh air into the room, Vital signs were checked and recorded as 36.8^{o}C, 250mls of cold voltic mineral water was given to patient and 1g of IV paracetamol was administered.

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

At 10:30am, Patient complains of loss of appetite and a nursing diagnosis of Imbalance nutrition (less than body requirement) related to inadequate dietary intake as evidenced by poor appetite

for food was formulated. An objective of Patient would regain her normal nutritional pattern throughout the period of hospitalization evidenced by; Patient verbalizing she has regained her appetite and Nurse observing patient consume ¾ of every meal served was set. Nursing interventions implemented included; Patient was reassured that her normal eating pattern will be restored, Patient brushed teeth twice daily and mouth rinsed before and after meals, Patient was always asked about the food she will like to eat and food was served at right interval (3-4 times) daily, The environment was always kept neat and free from nauseated substance such as vomits, urine, stool and dirty linen and Patient was congratulated after the meal.

At 11:00am, Patient was anxious about outcome of surgery. A nursing diagnosis of Anxiety related to impending surgery was set. An objective of Patient would be relived of anxiety within 24hours as evidenced by; Patient verbalizing she is no longer anxious about the surgery and Nurse observing patient cooperate with care and appears relaxed was formulated. Nursing interventions implemented included; Patient's anxiety level was assessed, which indicated moderate anxiety, Resources such as face mask, hair net and their uses were shown to patient before the surgery, Expression of distress such as restlessness were noted. Patient was introduced to the operating room staffs to help establish rapport and provide psychological comfort.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix. Patient was served with mashed kenkey for lunch.

At 6:00pm, patient's vital signs were checked and recorded as indicated in the appendix and her due medications were administered and recorded in the nurse's note. She was served with rice and stew for supper. Patient performed her personal hygiene (bath and oral care). She was made comfortable in bed.

At 10:00pm, Patient's vital signs were checked and recorded as indicated in the appendix. Patient went to bed at 10:10pm.

Second Day of Admission 10th November, 2021

On the second day of admission, I went to the ward around 7:00am to continue with the care to patient. Patient had already taken her bath, her teeth brushed and her locker cleaned. Her due medications were administered. Her vital signs were checked and recorded as indicated in the appendix. At 8:00am, patient was served with rice porridge and bread as breakfast.

At 10:00am patient's vital signs were checked and recorded as indicated in the appendix and her due medication were administered and recorded in the nurse's note.

At 10:00am, patient was assessed and her abdominal pains were relieved, therefore the nursing objective of; patient would be relieved of pains within 24hours set on 9th November, 2021 was fully met as; patient verbalized that her abdominal pains has total subside and Nurse observed patient relaxed comfortably in bed.

At 10:00am, the nursing objective to reduce patient's body temperature set on 9th November, 2021 was evaluated and goal was fully met as; Patient verbalized she has no fever and Nurse recorded a normal temperature of 36.8^{o}C.

At 11:00am, the nursing objective to relieve patient of anxiety set on 9th November, 2021 was evaluated and goal was fully met as patient verbalized she is no longer anxious about the surgery and Nurse observed patient cooperated with care and appeared relaxed.

At 2:00pm, vital signs were checked and recorded as indicated in the appendix and her due medications were administered and recorded in the medication chart. She was served with fried yam for lunch.

At 3:00pm, I left the hospital to patient's home for my first home visit.

At 6:00pm, vital signs were checked and recorded as shown in the appendix and her due medication were administered and recorded in the nurse's note. She was served with tea and slices of bread at 7:00pm. Patient was informed not to eat after 8:00pm because of the surgery to be performed the next day. At 10:00pm, vital signs were checked and recorded as indicated in the appendix. Patient slept immediately after vital signs were checked.

Third day of admission 11th November, 2021 (Day of Operation)

On the third day of admission, patient woke up around 5:30am, she took her bath and brushed her teeth. At 6:00am her vital signs were checked and recorded as indicated in the appendix. The need to avoid food was emphasized again. All oral medications were withheld before the procedure. The procedure as well as the purpose was explained to the patient to reduce anxiety and gain her cooperation.

Pre-operative preparation including psychological preparation, physiological preparation and physical preparation were ensured prior to surgery.

Psychological Preparation

She was informed that the surgery was the only reliable choice of treatment and was encouraged to ask questions of concern and to express her emotions freely to reduce the level of anxiety. All

questions asked were answered honestly and tactfully. She was introduced to other patients who have already gone through the same surgery and were recovering. The anesthetist and the operating theatre nurse were invited to talk to her briefly on the theatre environment and what to expect in the theatre including the outcome of the surgery. She was informed that anesthesia would be given to prevent her from feeling pains whiles the surgery was ongoing and analgesics such as morphine injection and diclofenac tablet will be administered to relief her of any post-operative pain. This helped in the reduction of her anxiety. Finally, the consent form which is a legal document that permits the surgeon to operate on the patient and protects the patient against unauthorized surgery was read and explained to her by the Surgeon. She signed the consent form to show her agreement to the procedure with a nurse as a witness at the nurse's station. Her facial expression looked more cheerful after preparing her psychologically.

Physiological Preparations

This is done preoperatively to establish a base line data to detect any abnormalities in the normal functioning of the body system and to correct any electrolyte imbalance. Laboratory investigations were requested and done and the results shown to the doctor and were later attached to the patient's admission papers. These revealed that the patient was fit for the surgery.

It also guided the doctor to prescribe the correct drugs and also helped in the preparation of the patient to go through a successful surgery. The patient was taught deep breathing and coughing exercises.

She was put on nil per os hours prior to surgery to empty the gastrointestinal tract and also to prevent vomiting and aspiration during the procedure. Her vital signs were checked and recorded 4 hourly preoperatively and immediately before patient were taken to the theatre. An IV line was

set for IV fluids intake both preoperatively, intraoperatively and postoperatively. She was allowed to empty her bladder and bowel by serving her with bedpan. A urethral catheter was also passed for her.

Physical Preparations

This is done to reduce the number of microorganisms on the skin surface thereby reducing infection. Patient was examined from head to toe and no other abnormality such as rashes, keloids, scars or incision of previous operations was found. Medicated soap and water was used to assist patient in bathing with particular attention to the abdomen and savlon used to rinse the area and finally, povidine iodine solution was applied to minimize microorganisms in the area. The site was draped with a sterile towel. She was again taught to support her wound with her palms when coughing or sneezing to prevent wound gaping. Patient was educated on the need for personal and oral hygiene after surgery and discharge. All jewelries were taken and appropriately labelled and documented. A trolley was prepared for patient to be taken to the theatre. She was draped in a sterile theatre gown and transferred onto the trolley. Her folder was attached to her drugs and she was taken to the theatre in the company of her relatives.

Immediate Post-Operative Care.

The objective of immediate post-surgical nursing care is to assist the patient to recover from anesthetic agent as quickly, safely and comfortable as possible. Patient was brought to the surgical ward at 3:30pm under general anesthesia. The following measures were taken to maintain patent air way. Patient and family were reassured that competent health team will do everything possible to maintain a clear air way.

POST OPERATIVE NURSING CARE

Position

- Patient was put in the supine position without a pillow with the head tilted to one side to prevent aspiration of secretions from mouth.
- Emergency equipment including oxygen apparatus, suction machine, endotracheal tube were placed at the bed side of patient in case of cyanosis or difficulty in breathing.
- Medication tray, vital signs tray and post- anesthetic tray were placed at patient's bedside for the management of patient.

Observation

- Vital signs (temperature, pulse, respiration and blood pressure) were checked 2 hours and 4 hourly as condition improved.
- The incisional site was observed for any bleeding which might lead to shock.
- Quick assessments were continuously made on consciousness, airway patency and incisional site for bleeding

Nutrition

- Patent was kept on nill per os
- Intravenous fluids were administered within the first 24 hours
- Patient was given sips of water in about 9 hours after the surgery

Medication

- Prescribed medications were administered

- The therapeutic effects as well as the side effects of the drugs were observed

Psychological Care

- Patient was constantly reassured
- Deep breathing technique was encouraged
- Divertional therapy was ensured by patient watching television
- Relatives were made comfortable and reassured

Exercise

- Patient was encouraged to perform deep breathing exercises to prevent hypostatic pneumonia
- Patient was educated on early ambulation
- Patient was encouraged to do passive exercises

Personal Hygiene

- Daily personal hygiene was ensured such as moth care.

Elimination

- Enough or adequate fluid and roughages were given to prevent constipation
- Patient emptied her bowel whenever she felt the urge to.

Wound care

- Incisional site was observed
- Wound was assessed for its state in terms of dryness, infection, gaping or discharge

- The dressings were changed daily
- The wound was dressed daily strictly under aseptic condition.

Patient's vital signs were checked and recorded as follows;

Temperature : 36.3^0C

Pulse : 78bpm

Respiration : 20cpm

Blood pressure : 110/70mmHg

The subsequent vital signs were strictly monitored quarter hourly for an hour, half hourly for an hour, hourly for four hours and four hourly for 24 hours. These are shown in the appendix. The incisional site was observed for bleeding but there was no post-operative hemorrhage. All drainage tubes were also checked and all were in situ and draining properly. Patient was assessed for pain and was managed for pain.

Patient skin colour and mucous membrane was observed to ascertain whether she was cyanosed. There was no sign of bleeding in patient. Drainage from catheter was observed and it was found to be clear and the amount recorded into the intake and output chart. The patient/family were reassured that she was in safe hands and everything will be done to ensure her safety and speedy recovery. The patient's post-operative drugs were served and she was left to sleep at 10:10pm.

First Day Post-operative (12th November, 2021)

According to the night nurse, patient had a sound sleep. Patient's vital signs were checked and recorded as indicated in the appendix. Due IV medications were also administered and documented in the medication chart.

At 8:00am, during my conversation with it was released that patient lack information about peritonitis and its treatment regimen. A nursing diagnosis of Knowledge deficit related to lack of information about peritonitis and its treatment regimen was formulated. An objective of Patient will gain adequate knowledge about the disease and its treatment regimen within 12 hours of hospitalization as evidenced by; Patient verbalizing understanding of the disease process and its postoperative expectations and Nurse observing patient adhere to the treatment regimen was set. Nursing interventions implement includes; Patient was asked series of question to assess her level of understanding about the disease, Patient was educated on condition (peritonitis) and what to expect during and after the surgery, Instruction such as NPO time, skin preparation and premedication were made know to patient, Patient and relatives were allowed to ask question, and questions were answered tactfully and in plain language.

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

At 10:30am, due to patient's incisional wound, a nursing diagnosis of Risk for infection as evidenced by surgical manipulation of tissues was formulated. An objective of Patient will be protected from infection throughout period of hospitalization as evidenced by; Patient been able to identify interventions to reduce potential risk of infection and Nurse maintaining safe aseptic environment at all time was set. Nursing interventions implemented includes; Aseptic policies

and procedures were always adhered to, Sterility of all items for dressing was verified, Incisional site was examined for signs of infection such as redness, odour and pus, Sterile dressing was applied after each dressing change, and Patient was informed to keep operative site clean.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix.

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

At 8:00pm, the objective set of 12th November, 2021 for patient to gain adequate knowledge about the disease and its regimen was evaluated and goal was fully met as patient verbalized understanding of disease process and preoperative expectation and Nurse observed that patient adhere to treatment regimen.

At 10:00pm, patient's vital signs were checked and recorded as shown in the appendix. Due IV medication was administered.

Second Day Post-operative (13th November, 2021)

According to the night nurse, patient had a sound sleep and her condition was gradually improving. I gave patient a bed bath, perineal care and assisted her in mouth care. Her bed was laid with clean linen and ensured it's free from creases and cramps. Patient was assisted and encouraged to frequently change position every two hours to enhance circulation and to prevent thrombus formation. Her vital signs were checked and recorded as indicated in the appendix at 6:00am. On ward rounds, patient was reviewed and she had no complains therefore there was no changes made in her treatment. Patient was encouraged to maintain nil per os.

At 2:00pm, patient's vital signs were checked and recorded as shown in the appendix. Due medications were also administered and documented in the medication chart.

At 6:00pm, patient's vital signs were checked and recorded as shown in the appendix. Due medications were also administered and documented in the medication chart.

At 10:00pm, patient's vital signs were checked and recorded as shown in the appendix. Due medications were also administered and documented in the medication chart.

Third day post-operative (14th November, 2021)

Patient slept soundly throughout the night according to the night nurses' report. At 6:00am, her vital signs were checked and recorded as indicated in the appendix. Her due medications were administered.

On ward rounds the doctor inspected patient's wound and ordered to start wound dressing. Patient was reassured that wound will heal with time. Privacy was provided; patient was assisted to assume the supine position to facilitate easy observation and dressing of the wound. Her wound was dressed aseptically with methylated spirit and sterile gauze, the wound was observed for signs of infection such as discharges, redness and swelling which none was present. The wound was covered with sterile gauze and plaster. Patient was made comfortable in bed, she was encouraged to support the wound when coughing, sneezing or laughing. She was also advised not to be touching the wound with her bare hands to prevent spread of infection. Patient's relatives visited her and were glad about her improvement.

At 10:00am, her vital signs were checked and recorded as indicated in the appendix and due medications were administered.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix.

At 6:00pm, patient's vital signs were checked and recorded as indicated in the appendix and her due medications were administered and documented in the medication chart.

At 10:00pm, vital signs were checked and recorded as shown in the appendix and her due medications were administered.

Fourth Day Post-operative (15th November, 2021)

Patient had a good night sleep according to the report given by the night staffs. She had her personal hygiene performed (bath and oral care).

At 6:00am, her vital signs were checked and recorded as shown in the appendix. Her due medications were administered and were made comfortable in bed.

At 10:00am, her vital signs were checked and recorded as indicated in the appendix. On ward rounds patient was reviewed and the doctor directed for the removal of the indwelling catheter. 10mls of water for injection was withdrawn from the catheter before removing it. Patient was also to start with sips of water and plain tea since the bowel sound had returned. After the ward rounds, the sips of water was started and patient was educated on how the sips should be taken. She was made comfortable in bed. Patient had no complained when retiring to bed.

At 2:00pm, patient's vital signs were checked and recorded as shown in the appendix and her due medications were administered.

At 6:00pm, patient's vital signs were checked and recorded as shown in the appendix and her due medications were administered

At 10:00pm patient's vital signs were checked and recorded as indicated in the appendix. Patient was made comfortable in bed.

Fifth Day Post-operative (16th November, 2021)

Patient woke up in good health and had her personal hygiene performed (bath and oral care). Her vital signs were checked and recorded as indicated in the appendix at 6:00am. She took in 200mls of lipton.

At 10:00am, her vital signs were checked and recorded as indicated in the appendix. Due medication were administered. Patient's wound was dressed using aseptic technique with methylated spirit and sterile gauze. Wound looked clean and dry and there was no signs of infection like redness and pus. Patient was made comfortable in bed and was reassured.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix and due medications were administered. Patient started eating light diet.

At 6:00pm, vital signs were checked and recorded as indicated in the appendix and due medications were administered. She was served with light soup for supper.

At 10:00pm, patient's vital signs were checked and recorded as indicated in the appendix. Patient slept at 10:10pm.

Sixth Day Post-Operative (17th November, 2021)

When I reached the ward in the morning, patient had already catered for her personal hygiene. Routine care was rendered, breakfast served, medication given and vital signs checked and recorded as indicated in the appendix.

At the time of ward rounds, patient had no complains, wound site was inspected and was found dry and healing. The doctor made no changes in the patient treatment. Patient was informed of possible discharge the next day after wound dressing. This kept a broad smile on faces of both patient and relatives. Patient however was bothered about her wound and was reassured that it will finally heal as she goes home and come for alternate dressing. Wound dressing was done and procedure documented. Emphasis was made on the need for patient to continue with light diet.

At 10:00am, patient's vital signs were checked and recorded as indicated in the appendix and due medications were administered.

At 2:00pm, patient's vital signs were checked and recorded as indicated in the appendix and due medications were administered.

At 6:00pm, vital signs were checked and recorded as indicated in the appendix and due medications were administered. She was served with soup for supper.

At 10:00pm, patient's vital signs were checked and recorded as indicated in the appendix.

Seventh Day Post-Operative/ Day of Discharge (18th November, 2021)

On this day, patient looked cheerful and there was no complains. Patient `s personal hygiene was maintained unassisted. Vital signs checked fell within normal ranges, prescribed medications were also served as ordered. Patient had her breakfast. According to patient, she had a good night's sleep.

Wound was aseptically dressed and periodic observations were made at the incisional site for signs and symptoms of infection of which none was present with a minimal scar formed.

During the ward rounds at 9:00am, patient did not lodge any new complain. Upon Assessment by medical officer confirmed patient was fit and was well to be discharged. Patient was informed to come for review on 25th November, 2021. Relatives were informed and hospital bills were assessed.

At 10:00am, the objective set on 9th November, 2021 that patient would regain her normal nutritional pattern was evaluated and goal was fully met as patient verbalized she has regained her appetite and Nurse observed patient consume almost all of her meals served.

At 10:00am, the objective set on 12th November, 2021 to protect patient's wound from infection was evaluated and goal was fully met as patient was able to identify interventions to reduce infection and Nurse maintained safe aseptic environment at all times.

Patient was discharged home with;

1. Tablet metronidazole 400mg tid x 1/52
2. Tab ciprofloxacin 500mg bid x 1/52

Patient was directed as to how to continue taking the drugs at home, side effects of the drug and the need to report any illness or adverse effect. Patient and relatives were also educated on the need to keep their environment clean. Patient was educated not to do strenuous exercise and the need to support the incisional wound when coughing or laughing in order to prevent gapping. She was educated to keep to wound clean in order to prevent infection and also visit any nearby hospital for the aseptic wound dressing. I planned with the patient that I will be visiting them for the second home visit on the 22th November, 2021 and that all arrangements for the visit were made. Vital signs prior discharge was checked and recorded as indicated in the appendix. I accompanied patient's mother to settle the bills. She went through it easily since patient was insured. I wrote her name in the discharge book and cancelled her name in the daily ward state. All other interventions undertaken were documented for easy referencing. I also helped them carry their belongings in a taxi that was waiting for them in front of the ward and bade them goodbye. After the patient had been discharged, the bed side locker and the bed were disinfected. All dirty bed linens and materials were removed. This was done to ensure cleanliness at the ward and to prevent cross infections.

4.2 Preparation of Patient/Family for Discharge

Preparation of Patient and her family for discharge started on the day of admission to the day of discharge. It was aimed at ensuring provision of sufficient care and also giving patient and family insight into her condition.

Patient and relatives were also educated on the need to keep their environment clean. Patient was educated not to do strenuous exercise and the need to support the incisional wound when coughing or laughing in order to prevent gapping. Patient and relatives were reassured that she

would recover and resume her normal activities. Patient and relatives was educated on the hospital's routine and the fact that patient may pay money on the day of discharge for only the non-insured drugs since she was registered with the National Health Insurance Scheme. They were also educated on the importance of practicing proper aseptic technique in caring for the wound. They were then reminded of the review date which was on 25th November, 2021.

4.3 Follow Up/Home Visit/Continuity of Care

Home visit is a family-nurse contact which allows the health worker to assess the home and family situation in order to provide the necessary nursing care and health related services. The purpose of home visit is to find out needs of patient/family and community in relation to health, socio-economic and cultural aspects, to provide teaching regarding the prevention and control of diseases, to assess the living condition of the patient/family, and to establish a close relationship between the nurses and the patient/family.

4.3.1 First Home Visit (10th November, 2021)

My first visit to patient house at Domfete was on 11th November, 2021 at 3:30pm while she was still on admission. Domfete is situated in the north of Nsapor and east of Jinijini. The main aim of the visit was to acquaint myself with the patient's home environment, to familiarize myself with the other family members, to confirm information given to me about the family and their home environment, to find out their health needs and assist towards effective solutions to any health problems that may be identified and to find a healthcare provider I would hand over patient to during the termination for care.

I set off based on the directions given to me by patient's mother around 3:00pm and gave me patient's sister's number to call when I alight at Domfete. I took a taxi from the hospital gate to

Domfete. I reached Domfete at 3:20pm. I called the number I was given and she came to pick me up to the house which was numbered DF/65. We exchanged greetings and I was offered a bottle of water to drink. She asked me the reason why I have paid her a visit that evening. I introduced myself as a final student of Holy Family Nursing and Midwifery Training College, Berekum who had taken her grandmother to render her comprehensive nursing care in the hospital till she was discharged. I told her my visit was to help me interact with the other members of the family, give them the necessary support to promote health and also to find a healthcare provider to leave patient to after I terminate my care.

Patient and family lived in their own house which was a 5 bedroom building, a kitchen, 2 toilet and 2 washrooms. It was built with cement and blocks, roofed with corrugated iron sheets and the windows are made of nets and Louver blades. Electricity was their main source of light. The rooms are spacious and have enough windows for good ventilation. The refuse bin is about 2km away from the house. The source of water was a standing pipe which was in the middle of the house. I had the chance to enter patient's bedroom. There toilet was littered which I used the opportunity to educate patient's sister tidy up the surroundings and the lavatories in other to maintain a good environmental hygiene since the untidy and dirty surrounding met cause diseases like cholera. She was also educated to cover foods to prevent flies, wash hands with soap and under running water after visiting the toilet and washing fruits before eating. She thanked me for given her such education. She was also reassured of her sister's health. I asked her for the healthcare facility in their town of which she told me that there is no healthcare facility in their town but there was a nurse in the town. She took me to Nurse K.P who live about 4 houses from theirs. I introduced myself to the staffs and told them I am a student and I was conducting study with a patient named Madam N.M. and then I was looking for nurse who

would continue to take care of patient's health needs after I terminate my care. He assured me that he was going to care for the patient for me when it gets to the termination of care. We exchanged contact and I thanked him for his willingness to help. I left the house with patient's sister, I sought for permission to leave at 4:30pm promising her of another visit after patient has been discharged from the hospital. She thanked me for having such a time to take care of her sister and assured me that she will ensure all what she has been educated on. I thanked her and bid her goodbye. I left Domfete at 4:40pm.

4.3.2 Second Home Visit, (22nd November, 2021).

On Monday, 22nd November, 2021 this was the fourth day after patient has been discharged. I paid patient and her family a visit at their home as planned. The purpose of this visit was to ascertain whether the education given to patient and her family during the period of hospitalization and first home visit had been adhered to and also to remind them of the review date. On arrival at patient's home at 1:30pm, we exchanged greetings and I was offered a seat. She called her mother and sister and I was asked my mission to the house. I told them my mission for coming to the house, thus, to know how patient was responding to treatment and also emphasize on the need to keep their surrounding clean and moreover remind them of the review date. I congratulated them for keeping the environment and lavatories clean.

Lastly, I reminded them of the review date which was Thursday 25th November, 2021 and its importance. At 2:30pm, I sought permission to leave and told them that I would officially visit them for the last time where I would terminate the care given. I bade them fare well and they expressed their gratitude for the help they had gotten so far from me and accompanied me to the road side before they departed.

4.3.3 Review: 25th November, 2021

On 25th November, 2021, patient and mother were met at the Out Patient Department of Holy Family Hospital, Berekum at 9:00am looking cheerful and lovely as noted from facial expression. Upon interaction with patient, it was observed that her condition had really improved. They were accompanied to go the patient's card to be assessed. The vital signs checked and recorded as follows; temperature 37.1^{o}C, pulse 94bpm, respiration 20cpm and Blood Pressure 130/80mmHg. She was seen by the surgical team in room 3 at the consulting room. Upon assessment by the team lead by Dr. F.K, patient was healthy; her wound was clean and neat. Patient had no complains. She was told not to hesitate to report to the hospital if she should encounter any health problem. They were assured of a third home visit. I then accompanied them to get taxi to their home.

4.3.4 Third Home Visit: 28th November, 2021

My last visit was made on 28th November, 2021 at 1:00pm. The main reason for conducting the third home visit was to: Assess the general condition of patient and family, reinforce the need to comply with treatment regimen, hand them over to the community nurse and finally terminate care.

On arrival we exchanged greetings, patient and relatives welcomed me warmly. Patient was happy and cheerful to see me again. She told me she was doing very fine. I thanked them for their co-operation during the care. I also told them that I was terminating care, but I had to leave them in the care of the healthcare provider. Patient was handed over to Nurse K.P he promised to take care of patient and they also promised to cooperate with him. I told them I would visit them unofficially whenever I had the chance. I thanked them for their cooperation throughout the care.

Permission was sought to leave and I was accompanied to the roadside where I boarded a car back to the house.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation is the final step of the nursing process which allows the nurse to determine the patient's response to the nursing interventions and the extent to which the objectives have been achieved. The plan of nursing care is the basis for evaluation (Smeltzer, Bare, Hinkle, & Cheever, 2014). This is the last phase of the nursing process. The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient and family.

5.1 Statement of Evaluation

The nursing care was based on the nursing process. During the period of her stay at the hospital a nursing care plan was designed to aid in delivery of quality care to the patient with emphasis on the nursing diagnosis. During the nursing care, actual and potential problems were identified, objectives were set, plans for patient's and family care implemented and later evaluated.

1. Patient's abdominal pain was relieved (10th November, 2021)

On 9th November, 2021 at 10:00am patient complained of abdominal pains, therefore a nursing diagnosis of altered body comfort (abdominal Pain) related to irritation in the peritoneum was formulated. An objective of Patient would be relieved of patient within 24hours as evidenced by; Patient verbalizing the intensity of pain has reduced using the pain rating scale and Nurse observing patient in a relaxed and comfortable posture was set. Nursing interventions included; Patient was reassured that measures will be taken to reduce abdominal discomfort, Patient pain

level was assessed using the numerical rating scale and she was rated under 4, Patient was put in a comfortable position (that is from prone to lateral then to supine), Relaxation technique were employed, watching television and 100mg of suppository diclofenac was administered.

On 10th November, 2021 at 10:00am, patient was assessed and her abdominal pains were relieved, therefore the nursing objective of; patient would be relieved of pains within 24hours set on 9th November, 2021 was fully met as; patient verbalized that her abdominal pains has subsided and Nurse observed patient relaxed comfortably in bed.

2. Patient's body temperature was reduced (10th November, 2021)

On 9th November, 2021 at 10:00am, patient had a body temperature higher than normal (38.8ºC). A nursing diagnosis of Thermoregulation imbalance (38.8^0C) related to related to infective process of peritonitis was formulated. An objective of Patient's body temperature will reduce to normal range (36.2ºC – 37.2ºC) within 24 hours of hospitalization as evidenced by; Patient verbalizing that fever has subsided and Nurse recording normal values of temperature (36.2ºC – 37.2ºC) was set. Nursing intervention implemented are as follows; Patient was reassured that measures will be taken to reduce high body temperature, Patient was tepid sponged with tepid water for 2 hours, Nearby windows were opened to allow fresh air into the room, Vital signs were checked and recorded as 36.8ºC, 250mls of cold voltic mineral water was given to patient and 1g of IV paracetamol was administered.

On 10th November, 2021 at 10:00am, the nursing objective to reduce patient's body temperature set on 9th November, 2021 was evaluated and goal was fully met as; Patient verbalized she has no fever and Nurse recorded a normal temperature of 36.8ºC.

3. Patient's nutritional pattern was regained (18th November, 2021)

On 9th November, 2021 at 10:30am, Patient complains of loss of appetite and a nursing diagnosis of Imbalance nutrition less than body requirement related to inadequate dietary intake as evidenced by poor appetite for food was formulated. An objective of Patient would regain her normal nutritional pattern throughout the period of hospitalization evidenced by; Patient verbalizing she has regained her appetite and Nurse observing patient consume ¾ of every meal served was set. Nursing interventions implemented included; Patient was reassured that her normal eating pattern will be restored, Patient brushed teeth twice daily and mouth rinsed before and after meals, Patient was always asked about the food she will like to eat and food was served at right interval (3-4 times) daily, The environment was always kept neat and free from nauseated substance such as vomits, urine, stool and dirty linen and Patient was congratulated after the meal.

On 18th November, 2021 at 10:00am, the objective set on 9th November, 2021 that patient would regain her normal nutritional pattern was evaluated and goal was fully met as patient verbalized she has regained her appetite and Nurse observed patient consume almost all of her meals served.

4. Patient was relieved of anxiety (10th November, 2021)

On 9th November, 2021 at 11:00am, Patient was anxious about outcome of surgery. A nursing diagnosis of Anxiety related to impending surgery was set. An objective of Patient would be relived of anxiety within 24hours as evidenced by; Patient verbalizing she is no longer anxious about the surgery and Nurse observing patient cooperate with care and appears relaxed was formulated. Nursing interventions implemented included; Patient's anxiety level was assessed, which indicated moderate anxiety, Resources such as face mask, hair net and their uses were

shown to patient before the surgery, Source of fear was validated and all misconceptions that has led to fear were clarified, Expression of distress such as restlessness were noted and Patient was introduced to the operating room staffs to help establish rapport and provide psychological comfort.

On 10th November, 2021 at 11:00am, the nursing objective to relieve patient of anxiety set on 9th November, 2021 was evaluated and goal was fully met as patient verbalized she is no longer anxious about the surgery and Nurse observed patient cooperated with care and appeared relaxed.

5. Patient gained adequate knowledge about her disease (12th November, 2021)

On 12th November, 2021 at 8:00am during my conversation with it was released that patient lack information about peritonitis and its treatment regimen. A nursing diagnosis of Knowledge deficit related to lack of information about peritonitis and its treatment regimen was formulated. An objective of Patient will gain adequate knowledge about the disease and its treatment regimen within 12 hours of hospitalization as evidenced by; Patient verbalizing understanding of the disease process and its postoperative expectations and Nurse observing patient adhere to the treatment regimen was set. Nursing interventions implement includes; Patient was asked series of question to assess her level of understanding about the disease, Patient was educated on condition (peritonitis) and what to expect during and after the surgery, Instruction such as NPO time, skin preparation and premedication were made know to patient, Patient and relatives were allowed to ask question, Questions were answered tactfully and in plain language and Patient was shown images on the internet pertaining to the issues that were discussed.

On 12th November, 2021 at 8:00pm the objective set of 12th November, 2021 for patient to gain adequate knowledge about the disease and its regimen was evaluated and goal was fully met as patient verbalized understanding of disease process and preoperative expectation and Nurse observed that patient adhere to treatment regimen.

6. Patient was prevented from infection (18th November, 2021)

On 12th November, 2021 at 10:30am due to patient's incisional wound, a nursing diagnosis of Risk for infection as evidenced by surgical manipulation of tissues was formulated. An objective of Patient will be protected from infection throughout period of hospitalization as evidenced by; Patient being able to identify interventions to reduce potential risk of infection and Nurse maintaining safe aseptic technique at all time was set. Nursing interventions implemented includes; Aseptic policies and procedures were always adhered to, Sterility of all items for dressing were verified, Incisional site was examined for signs of infection such as redness, odour and pus, Sterile dressing was applied after each dressing change and Patient was informed to keep operative site clean.

On 18th November, 2021 at 10:00am, the objective set on 12th November, 2021 to protect patient's wound from infection was evaluated and goal was fully met as patient was able to identify interventions to reduce infection and Nurse maintained safe aseptic technique at all times.

5.2 Amendment of care

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

5.3 Termination of care

This forms the last aspect of the interaction with client and family. Due to the psychological effects accompanying separation, it could sometimes lead to anxiety and depression. To avoid this, client and family were prepared psychologically from the day of admission to the day of discharge.

I made my last home visit on the 28th November, 2021. The main aim of the visit was to find out how client and her family members were doing and to terminate the care by handing over Miss S.Y to a healthcare provider and members of her family to continue the care. After exchange of greetings and a little interaction, client and her family confirmed they were doing well. I thanked them for their co-operation. I informed them that now that Miss S.Y's health has been restored; the care has officially ended. I advised them to report to the nearest health facility in case of any illness. They were not surprise to hear of the termination of care due to prior notice. She was however handed over fully to Nurse K.P, who promised to take very good care of her. I told them I would visit them unofficially whenever I had the chance. They were happy and said 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.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation (Weller, 2014). This is the last step of the patient/family care study which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing process.

6.1 Summary of care rendered.

Miss S.Y., a 29-years-old woman was admitted on 9th November, 2021 around 9:30am at the Holy Family Hospital, Berekum with the diagnose of Peritonitis. Her vital signs were checked and recorded as;

Temperature	38.4 degree Celsius
Pulse	144 beats per minute
Respiration	21 cycles per minutes
Blood Pressure	130/80mmHg

She spent a total of ten days at the hospital. During her period of hospitalization six (6) health problems were identified. These were; patient complained of abdominal pains, patient had high body temperature, patient complained of loss of appetite, patient was anxious about outcome of surgery, patient lacked information about peritonitis and its treatment regimen and patient had wound. Nursing diagnosis was formulated for each of the problems and in order to solve these

problems objectives were set, nursing orders were set, orders were implemented and all the goals were fully met. The following diagnostic investigations were requested to be done;

1. Blood film for malaria parasite.
2. Blood for Full Blood Count

She was managed on the following prescribed medications:

1. Metronidazole injection 5mg/ml in 100ml
2. Diclofenac suppository 100mg bid x 10days
3. Metronidazole 400mg tid x 1/52
4. Ciprofloxacin 500mg bid x 1/52
5. Dextrose saline 2L x 24hrs
6. Ringers Lactate 1L x 24hrs
7. IV Paracetamol 1G tid x 24hrs
8. Vitamin C 100mg tid x 14 days

On 18th November, 2021, patient was discharged during ward rounds. She was discharged tablet metronidazole and tablet ciprofloxacin. Her relatives were directed to go to the billing office to assess their bill. I accompanied client's daughter to go and pay the assessed bill. Client was encouraged to continue taking her drugs and was educated on the side effects of the drug and the need to report any illness. She was informed of her review date which was on 25th November, 2021. The need to take in medication was emphasized and review date was stressed. Three home visits were embarked on. My first home visit was on 10th November, 2021 the main aim of the visit was to acquaint myself with the client's home environment, to familiarize myself with the other family members, to confirm information given to me about the family

and their home environment, to find out their health needs and assist towards effective solutions to any health problems that may be identified and to find a healthcare provider in the town to handover client to after the termination of care. The second home visit was on 22nd November, 2021 and the purpose of the visit was to ascertain whether the education given to her and her family during the period of hospitalization and first home visit had been adhered to and also to remind them of the review date. The third home visit was on 28th November, 2021 and the reason for the visit was also to assess the general condition of patient and family, reinforce the need to comply with treatment regimen, hand them over to the community nurse and finally terminate care.

6.2 Conclusion.

The patient care study has helped me gain knowledge about nursing care rendered to patients, this study has also helped me to know how to collect relevant information from patients, identify health problems, analyze and formulate a nursing care plan using the nursing process approach. Recommendations of patient /family, medical team, opinions and appraisal of their co-operation towards the achievement of goals which promoted the well-being of patient/family physically, psychosocially and spiritually. This study has enabled me to put into practice the knowledge acquired during my three year training in the institution, it has helped me to be prepared to nurse patients effectively in the near future regardless of their condition with the help of nursing process adopted.

I therefore recommend that the patient/family case study should be maintained as a facade of the nurse trainee and fully establish in the country health care delivery system to aid in the improvement of health for the country.

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APPENDIX

DATE	TIME	TEMPERATURE (^{O}C)	PULSE (bpm)	RESPIRATION (cpm)	BLOOD PRESSURE (mmHg)
9/11/2021	10:00am	38.4	144	21	130/80
	2:00pm	37.5	89	20	120/80
	6:00pm	35.8	70	22	121/86
	10:00pm	36.2	82	24	119/73
10/11/2021	6:00am	35.1	66	19	128/74
	10:00am	35.4	62	18	127/56
	2:00pm	36.8	53	19	110/80
	6:00pm	36.4	88	25	129/70
	10:00pm	37.0	89	24	130/80
11/11/2021	6:00am	36.7	84	20	140/70
	10:00am	37.2	79	22	130/84
	2:00pm	36.4	81	21	132/72
	6:00pm	36.9	84	23	120/70
	10:00pm	37.8	80	24	119/88
12/11/2021	6:00am	37.0	82	21	120/80
	10:00am	37.2	98	20	130/92
	2:00pm	36.9	88	24	123/89
	6:00pm	36.7	87	21	124/82

	10:00pm	36.8	100	25	130/88
13/11/2021	6:00am	37.0	99	24	125/99
	10:00am	37.2	90	22	130/82
	2:00pm	36.6	89	25	128/74
	6:00pm	37.1	88	27	125/84
	10:00pm	36.9	84	19	131/88
14/11/2021	6:00am	36.7	80	20	129/70
	10:00am	37.0	90	21	130/80
	2:00pm	36.5	94	25	120/79
	6:00pm	36.8	99	24	125/78
	10:00pm	37.0	89	22	127/56
15/11/2021	6:00am	36.5	88	23	110/80
	10:00am	36.8	92	24	129/86
	2:00pm	36.4	99	27	127/84
	6:00pm	36.7	90	22	125/88
	10:00pm	36.8	89	20	130/76
16/11/2021	6:00am	36.4	87	22	131/81
	10:00am	37.0	89	21	129/80
	2:00pm	37.1	100	20	125/79
	6:00pm	37.0	98	21	130/82
	10:00pm	36.9	90	23	127/86
17/11/2021	6:00am	36.4	85	20	129/89
	10:00am	36.2	86	19	130/86

	2:00pm	36.4	85	22	127/81
	6:00pm	36.9	87	24	121/85
	10:00pm	37.1	90	21	126/79
18/11/2021	6:00am	36.4	85	20	130/88
	10:00am	37.0	90	21	124/89

SIGNATORIES

THE STUDENT NURSE

NAME: BELINDA NKRUMAH

SIGNATURE:.....

DATE: 04/10/2022

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

NAME: Ms. ANTOINETTE EFFUM

SIGNATURE:.....

DATE: 04/10/2022

THE NURSE-IN-CHARGE OF SURGICAL WARD (HOLY FAMILY HOSPITAL, BEREKUM)

NAME: Mrs. GRACE YEBOAH

SIGNATURE:.....

DATE: 06/10/2022

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

NAME: Ms. MONICA NKRUMAH

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DATE: 05/10/2022

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