HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT AND FAMILY CARE STUDY ON ACUTE APPENDICITIS WITH APPENDECTOMY DONE

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

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PREFACE

Health care delivery in recent times has progressed and has adopted innovative changes especially in the nursing care delivery. Due to this, the nurse is compelled to render a comprehensive care to every client in his or her charge.

Unlike the past, nursing now employs the use of research and the use of scientific data in the performance of the various roles in ensuring quality health delivery. This is evidenced by the broadening services to the door steps of clients, and the involvement of technologically based initiatives like Computers for effective documentation.

In effect to meet the ever changing demands of the client with time, there must be corresponding innovations in providing quality health care for the benefit of all.

The inclusiveness of certain subjects like Sociology, basic Nursing, and Anatomy to mention a few provides for dynamic skills in the care of the patient and family.

The care study (in which the nursing process is applied) is also one of the requirements of the Nurses and Midwives' Council of Ghana for the awarding of Registered General Nursing Certificates. It is also designed to upgrade the Ghanaian nurse to meet international standards.

Patient/family care study writing entails student nurse taking a client with a particular disease condition and nursing him or her taking into account the physical, psychological, social, economic and spiritual needs of the client from the day of admission till the day of discharge. Patient/family care study again equips the student with the necessary knowledge and skills to render a competent, professional, holistic and quality care to the patient/family. It also gives the student a chance to apply both theoretical and practical approaches to learning as he writes the care study and renders the nursing care to the client and his or her family.

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I wish to express my heartfelt gratitude to the Almighty God for his grace, mercies, protection, favor, good health, wisdom and understanding given to me to carry out this care study successfully.

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Again, I would like to express my profound appreciation to my mother Affum Sarah and sister Opoku Theresa for their encouragement, support in prayers and finance.

Moreover, I owe a great depth of appreciation to Madam K.R the subject of my study, her parents and family for allowing me to carry out this care study on them. Their maximum co-operation and the necessary information given me made this piece of writing a success.

I cannot forget the staff of Females' Surgical Ward at Sunyani Regional Hospital for their guidance and support.

Finally, I would like to express my appreciation to all the authors from whose books I used as references for my study.

May God richly bless you all.

INTRODUCTION

According to Virginia Avenel Henderson the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recover (or peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge.
The patient/family care study is a report of the nursing care rendered to a patient and family. It involves the interaction, between the patient, family and community on one hand and the health team on the other hand. It also involves the application of the nursing process to attain and maintain high level of wellness for a patient. This interaction occurs within a specific period of time.

The study was conducted on Madam K.R, a 42-year-old. She was admitted on the 21st November, 2022, with the history of sudden severe abdominal pains, anxiety and knowledge deficit. After thorough examination by the doctor, she was diagnosed as having Acute Appendicitis.

My interaction with Madam K.R started on 21st November, 2022 when she was transferred to Females' surgical ward from Accident and Emergency Unit of Sunyani Regional Hospital with the diagnose of Acute appendicitis.

Appendectomy was done for him on 22nd November, 2022 and she was discharged home on 25th November, 2022 with patient in better condition than when she came on admission. I visited her home while she was on admission and after discharge to ensure that patient was taking her medications as prescribed and also find out whether patient was adhering to the various advices given on admission. I had the desire to use Madam K.R because I wanted to know more about Appendicitis, its causes, signs and symptoms, treatment and complications in order to educate people on the disease and also to give a better nursing care to patients with the same or similar condition.

The report of this patient/family care study is organized in the six chapters, which are;

1. Assessment of patient and family
2. Analysis of data collected
3. Planning for patient and family care
4. Implementing patient/family care plan
5. Evaluation of the care rendered to patient and family
6. Summary and conclusion

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

According to Hinkle and Cheever (2018) assessment is the systematic collection of data to determine the patient's health status and any actual or potential health problems. The first phase of the nursing process is the assessment of the patient/family during the admission process. It entails collection of data from the patient/family through interviews, medical records, laboratory investigations and examinations. It covers the patient's particulars, family medical/surgical history, family socio-economic history, patient's developmental history, patient's obstetric history, patient's lifestyle and hobbies, patient's past medical/surgical history and the present medical/surgical history of the patient, literature review and validation of data. It continues from the day of admission and ends after termination of care. The patient/family's problems were identified and the appropriate nursing interventions rendered based on the information gathered.

1.1 Patient's Particulars

According to Elaine (2014) patient's particulars refers to facts or detail's especially the one that is officially written. It includes the person name, date of birth, age, gender, occupation, hometown, nationality and others. Madam K.R is the patient for the care study. She is 42 year-old, born on 25th November, 1980 to Madam S. H. and the late Mr. T. M. at Asuotiano, near Wamfie. She is a food vendor. She attended Asuotiano Junior High School and further continued her secondary education at Dormaa Senior High School. She got an admission into the then Sunyani Polytechnic (now Sunyani Technical University) where she graduated with a certificate in secretariat. She hails from Asuotiano but resides at Sunyani in the house numbered SY66/4. She is dark in complexion

with a height of 1.71metres and weighs 67kg. She is married with five (5) children. She gave birth to six (6) children but lost one (1) later in their childhood. She has four (4) sons and a daughter. She attends Methodist church (Christian) who had formal education up to tertiary. Miss A. W. her eldest child is her next of kin who resides at Kotokrom, a suburb of Sunyani. She speaks English and Bono fluently. She has no physical deformity.

1.2 Family's Medical/Surgical History

The interaction with Madam K.R. and family revealed that some of the men in their family are alcoholics, no known chronic, familial or genetic diseases such as epilepsy, hypertension, asthma, mental sub-normality or any other abnormality in their family. Her late child, her late father and grandparents were all hospitalized before their deaths but the various diagnosis were not known to them. They use over-the-counter drugs (OTCs) for minor sicknesses like headache, constipation, boils and fever but always seek medical attention at the Bono Regional Hospital, Sunyani when their conditions worsen.

Her elder sister underwent surgery to remove an unknown mass from her abdomen. According to her, her late father was hospitalised with a necrotic wound at his right lower limb and his limb was amputated. Her father's wound became infected until he finally died. None of their relatives except the aforementioned has undergone surgery of any kind for any reason. There is no known family allergy.

1.3 Family's Socio-Economic History

The family of Madam K. R. is an extended one in which the family members relate well with one another. According to her she receives emotional support from her elder sister. Most of the family members are subsistence farmers, so they earn less income from the surplus of food crops such as

cassava and plantain they sell. Madam K.R. and many of her relatives also cultivate cocoa. According to them, their cocoa farms are small and they have not been able to calculate their annual income due to the subsistence farming they are engaged in. However, they are more than able to meet their basic needs and some of their wants. Their parents/grandparents were also farmers. They use the National Health Insurance Scheme (NHIS) to seek health care. She said, all her family members are Christians and there is no kind of traditional belief or taboo governing them.

1.4 Patient's Developmental History

According to McIntosh (2011) Development is the process in which someone or something grows or changes and becomes more advanced.

According to Weller (2018) Growth is the natural process of increasing in size or developing and Maturation is the emergence of personal and behavioral characteristics through growth and process.

Madam K. R., a 42-year-old woman was born spontaneously per vaginum at home by a Traditional Birth Attendant. She was immunized against the vaccine preventable disease because I saw a BCG scar on her right deltoid muscle. She did not suffer any ailment or injury that might have affected her development. According to Madam K.R, she was breastfed for six months before supplementary foods were introduced. She has a normal developmental milestone. She started crawling when she was about six months old and started teething at eight months. She started uttering words like ‘’Mama’ ’Dada’’ and stood up around the fourteenth (14th) month. She had her menarche and developed her secondary female sexual characteristics when she was fifteen 15-year-old. She remembers however that she was given into marriage five 5 years after her puberty

rites was performed. She had her education up to tertiary level after pursing a one-year secretariat course. She worked as a secretary at Wamfie District Assembly for two 2 years before stopping and engage in occupation as a food vendor. She views marriage as a companionship even though her husband is quarrelsome and liked fighting.

According to Erik Erikson (1995), there are eight stages in the psychosocial development theory. These stages are;

- Trust versus mistrust (birth to 1year)
- Autonomy versus shame and doubt (2 to 3years)
- Initiative versus guilt (3 to 5years)
- Industry versus inferiority (6 to 11years)
- Identity versus role confusion (12 to 18years)
- Intimacy versus isolation (19 to 40years)
- Generativity versus stagnation (40 to 65years)
- Integrity versus despair (65 to death)

Comparing her age with Erik Erikson's psychosocial theory, Madam K.R falls under "Generativity versus stagnation", which is the seventh stage (40 to 65years). During adulthood we continue to build our lives, focusing on our carrier and family. Those who are successful within this year will feel they are contributing to the world by been active in their home or community. Those who failed to attain this will feel unproductive in the world. My patient has attained Generativity

because she has her own house. She is able to cater for her children's fees and lives peaceful with her partner.

1.5 Patient's Obstetric History

Madam K.R. has had six (6) pregnancies which she was able to carry all to term and had spontaneously per vaginum delivery for all without complications such as Ante Partum or Post-Partum Haemorrhage. She also went through puerperium safely with an average birth spacing of three (3) years but about eighteen (18) months birth spacing for the first two (2) deliveries. Five (5) of her children are still alive and well, the remaining one (1) died during their childhood life. She usually menstruates for five (5) days but the bleeding was scanty at first and later became moderate until four (4) years ago when she experienced bleeding in between periods and excessive menstruation. It has therefore become difficult for her to determine whether she is in her reproductive period, peri-menopausal period or in her menopause since she is 42 years old and still bleeding because of her condition. She has no history of contraceptive use but after delivery she stays away from her husband until about three (3) to six (6) months when she has regained her strength. After six months she uses the natural method of family planning.

1.6 Patient's Lifestyle/Hobbies

According to Madam K. R., she normally goes to bed at 9:00pm and wakes up around 4:30am, washes her face, brushes her teeth using pepsodent toothpaste and brush, sweeps her compound, dresses her children to school, empties her bowels before taking her warm bath in the morning. At about 7:00am, she goes sell her food and returns home at about 5:00pm when she prepares food for her nuclear family and converses with her children. She later watches television, takes her bath

and goes to bed. She normally empties her bladder four (4) times a day and empties her bowel twice daily. She brushes her teeth before bed.

On Sundays, she goes to church around 8:00am with her family and close around 11:00am. She is a caretaker for Methodist Gils Fellowship (MGF). She likes eating rice with any kind of stew or soup in the morning and afternoon and "fufu" with palm nut soup in the evenings. She usually sleeps/rests for an hour during the day and sleeps for about seven and half ($7\frac{1}{2}$) hours during the night. She usually has no problems with sleep but if she does, she takes some sedatives like valium (diazepam) to help her sleep. She has no known allergy.

She has no hobbies but engages herself in moderate exercises in the evenings. Apart from Sundays, all holidays and "resting" days from selling are used to decorate her room. She attends wedding ceremonies, funeral celebrations, church picnics but has never embarked on an excursion before. She is a mother who openly expresses her dissatisfaction about wrong behaviors put up by her children. She sometimes blinks her eyes to tell her children to stop misbehaving. She is a very good person to interact with, she is loving, open, fair, firm, disciplined, respectful and God fearing to mention a few. She dislikes frowning and likes healthy relationships. She is a mother to her children and a sister to her siblings and neighbors. She is a friendly and a nice woman to call a mother.

1.7 Patient's Past Medical/Surgical History

Madam K. R. had no childhood diseases like whooping cough, measles or any other disease as she grew through adolescent to adulthood. She has no known allergy. She has never been admitted to the hospital before except during her labor periods. She always relies on over-the-counter drugs

(OTCs) like paracetamol, amoxicillin and flucloxacillin for minor ailments and diazepam when she has trouble sleeping. She has never been involved in any accident.

She has not undergone any surgical procedure before. She relies on the NHIS to seek medical attention. Madam K. R. does not go for medical check-ups.

1.8 Patient's Present Medical/Surgical History

Patient stated that she was feeling well until 21st November, 2022 when she experienced mild abdominal pain particularly at the right iliac fossa region around 7:00am but did not pay much attention to it. According to Madam. K.R., the pain became severe and unbearable around 2:00pm in the afternoon and she was rushed to the Accident and Emergency Unit of Sunyani Regional Hospital where she was detained. On arrival at the hospital his vital signs were checked and recorded as follows

Temperature 36.1^{o}c

Pulse 77bpm

Respiration 21cpm

Blood Pressure 149/91mmHg

Injection Buscopan 40mg was served as a stat dose. She was seen by Doctor Egote and was diagnosed of acute appendicitis at the Accident and Emergency Unit and was admitted to the Females' Surgical ward.

1.9 Admission of patient

Patient was admitted on the 21st of November, 2022 at 6:30pm into the Females' Surgical ward of Regional Hospital, Sunyani. Patient had a history of colicky abdominal pain, abdominal muscle rigidity, fever, the right iliac fossa was soft, tender and not distended. She was diagnosed of acute appendicitis to which doctors advised her that surgery was the best treatment so she consented. Patient was fully conscious at the time of admission, she was brought into the ward by a staff nurse and accompanied by her sister and eldest child. She was well received at the front desk of the females' surgical ward where all her particulars were taken and this includes name, age, sex, address, religion, occupation and next of kin. The information was recorded into the admission papers as well as the admission and discharge books and the daily ward state. She was admitted unto an admission bed and her vital signs which include temperature, pulse, respiration and blood pressure were checked and recorded as;

Temperature - 37.6^0c

Pulse - 89bpm

Respiration - 20cpm

Blood Pressure - 110/60mmHg

Weight - 67kg

I introduce Madam K.R to other patients on the ward especially those who have gone through surgery. She and her relatives were reassured that they have themselves in the hands of a competent and professional health team and also availability of modern equipment to help go through the surgical procedure successfully. Her sister and daughter were oriented to the ward and its annexes.

The following investigations were carried out;

- Full Blood Count
- Abdominal scan
- Rapid Diagnostic Test
- Serum electrolytes

The following medications were prescribed for Madam K.R.:

- Injection Buscopan 40mg stat
- IV Ciprofloxacin 400mg bd x 24hrs
- IV Metronidazole 500mg tds x 24hrs
- Tablet Paracetamol 1g tds x 5
- Dextrose Normal saline 1000mls x 24hours
- Ringers lactate 1000mls x 24hours
- Normal Saline 1000mls x 24hours

Patient was educated and advised not to take anything by mouth as this could cause aspiration, she was also educated on the need to undergo surgery as it was the best option. Patient relatives were also educated that patient will not take in food nor fluid after the surgery until bowel sounds is heard. Relatives were told that patient will be transferred back to the ward after the surgery.

On the 22nd day of November, 2022, at 10:10am, Madam K. R., a 42-year old woman with a diagnosis of acute appendicitis at the Accident and Emergency Unit was sent to the Operating Theatre. On the 22nd day of November, 2022, at 11:50am, Madam K. R. was brought back into the ward through the Operating Theatre to the Female Surgical Ward, per stretcher, after Appendectomy was done under spinal anaesthesia. Two student nurses (including myself) accompanied by her sister and eldest daughter brought her to the ward in a conscious state. At the Theatre, incisional site on inspection was clean and dry.

At the ward, the patient was admitted into a prepared warm operation bed in the supine or recumbent position. The bed accessories that were made available for the purpose of resuscitation included the following: Infusion or drip stand, suction machine, vital signs tray and blood pressure apparatus, mouth care tray and dressing pack. On inspection, there was no bleeding at the incision site.

In-situ was Intravenous Fluid Ringers Lactate 500mls. The infusion was set on the drip stand and was ensured that it was flowing. Also in in-situ was urethral catheter with 400mls of urine drained. The urine bag was emptied and the output recorded in the intake and output chart. The catheter bag was tied to the bottom of the bed. Her vital sign s were checked to serve as the baseline for evaluation and the following were the results:

Temperature 35.5 ^{o}C

Pulse 64bpm

Respiration 20cpm

Blood pressure 120/70mmHg

These were recorded on the vital signs sheet. The vital signs were checked and recorded again, 15mins for the first one-hour and every 30mins for 2 hours and every hourly for 4 hours until they were stable.

The incisional site was again observed for any sign of bleeding and swelling but it was dry and clean. The client was covered with extra blankets because of her subnormal temperature.

The client was encouraged not to raise or turn the head up and down or side to side respectively to prevent headache after she had recovered from anaesthesia. Her family together with her were reassured that they were in competent hands of health workers and they would help her to regain her health to allay fears and anxiety. Family members were given seat to relax and also helped to feel at home. Patient complained of incisional pains.

Vital signs monitoring was ordered for her and she was put on the following medications post-operatively;

- IV Ringers Lactate 1 litre (L)× 24 hours
- IV 5% Dextrose water $1^{1}/_{2}$ L × 24 hours
- IV Ciprofloxacin 400mg bd × 72 hours
- IM Pethidine 100mg stat then
- Rectal Diclofenac 100mg bd × 5 days.

She was served with IM Pethidine100mg to relieve her incisional pain.

I introduced myself again to Madam K.R. as a final year nursing student of Holy Family Nursing and Midwifery Training College, Berekum who wants to care for her with the aid of other staffs

and would like to take her for my care study. Nursing care was planned using the nursing process for my patient and family. The purpose of the care study is that before one becomes a professional nurse the person needs to carry out a study on a patient in partial fulfillment for the award of diploma certificate. I reassured them of confidentiality based on the information provided and total comprehensive and holistic nursing care. Her sister and daughter was informed that, their stay in the hospital is temporal and will be discharged home if Madam K.R's condition subsides. I told her about a visit which would be made to her house whilst Madam K.R. was still on admission and after discharge. I thanked her for her cooperation and also assured her that the information that will be given will be kept confidential. I chose to write on this condition (Acute Appendicitis) because I wanted to gain more insight about it.

1.10 Patient's Concept of Illness

My Patient believed that it is normal to fall sick irrespective of whoever you are. Upon interviewing the patient, she did not attribute her sickness to any spiritual factor but she strongly said that by the grace of Almighty God and with the quality care from the hospital staff, she will get better soon.

1.11 Literature Review on Appendicitis

Definition

According to Hinkle and Cheever (2018) appendicitis is an inflammation of the vermiform appendix, the appendix is a small, fingerlike pouch about 8cm (3inches) long attached to the caecum of the colon. Its usual location is the right iliac region, just below the ileocecal valve. The appendix has no function but as part of the caecum, it fills with food and empties on a regular basis.

Incidence

According to World Health Organization (2010) about 7% of the population will have appendicitis at some time in their lives; males are affected more than females and teenagers more than adults. Although it can occur at any age, it occurs most frequently between the ages of 10 and 30 years.

Etiology

According to Weller (2018) appendicitis is generally caused by obstruction. Since the appendix is a small, finger-like appendage of the cecum, it is prone to obstruction as it regularly fills and empties with intestinal contents. The obstruction may be caused by

1. A fecalith (a hard mass of feces).

2. A foreign body in the lumen of the appendix.

3. Fibrous disease of the bowel wall.

4. Infestation of parasites.

5. Twisting of the appendix by adhesions.

Of all cases, approximately 60% are associated with hyperplasia of the sub mucosal lymphoid follicles and 35% to fecal stasis or fecalith.

Pathophysiology

According to Gerrald and Bryan (2010) appendicitis is inflammation of the appendix vermiform. The appendix becomes inflamed and oedematous as a result of either becoming kinked or occluded by a faecalith (that is hardened mass of stool), tumour or foreign body or infections from microbes. There is increase blood supply to the site causing the oedema. The blood contains leukocytes,

macrophages for phagocytic activities. The inflammatory process increases intraluminal pressure, initiating a progressively severe, generalized or upper abdominal pain that becomes localized in the right lower quadrant of the abdomen within a few hours. The appendix becomes grossly inflamed and may perforate, spilling intestinal content into the peritoneum resulting in generalized peritonitis or localized peritonitis. The localized peritonitis leads to appendicular mass which eventually forms pus leading to appendicular abscess.

Types

According to Gerrald and Bryan (2010) there are two (2) main types of appendicitis namely,

a. Acute appendicitis

b. Chronic appendicitis

Acute Appendicitis

The onset of the signs and symptoms are sudden and reaches its peak within a short period of time. The patient experience abdominal pain with rapid deterioration and can lead to death if untreated. Acute appendicitis may lead to chronic appendicitis.

Chronic Appendicitis

In chronic appendicitis, there is recurrent of the appendicitis that is, the patient exhibit the signs and symptoms such as nausea and vomiting and has been diagnosed as suffering from appendicitis. Patient is put on treatment after which it subsides but reoccurs.

Clinical Features of Acute Appendicitis

According to Weller (2018) signs and symptoms of acute appendicitis include;

1. The onset is sudden

2. Continuous mild generalized or lower abdominal pain, the pain intensifies over the next four hours and localizes in the right upper quadrant of the abdomen.

3. Low grade fever due to infection in the body.

4. Guarding and rebound tenderness at the Mc Burney point which is 1.5 – 2inches from the anterior superior iliac spine.

5. Nausea and vomiting

6. Constipation

7. Generalized malaise

8. Abdominal distention develops as a result of perforated appendix.

9. Loss of appetite due to vomiting.

10. Rovsing's sign (pressure on the left iliac fossa produces right sided pain).

11. Psoa's sign (pain during passive extension of the right thigh)

12. Frequency of micturition in those with the appendix adjacent to the bladder.

Diagnostic Investigations

Laboratory tests are used along with physical examination to determine the diagnosis and rule out other possible causes for the patient's symptoms. The following may be ordered;

1. Full Blood Count

a) WBC count is measured to indicate the presence of infection. In acute appendicitis WBC count is elevated (10,000/m3 to 20,000/mm3).

b) Neutrophil count may exceed 75% 12 2. Urinalysis is performed to determine whether the urine contains erythrocytes or leukocytes. Leukocytes count may exceed 10,000cell/mm3.

3. Abdominal X – ray may reveal calculus or faeces in the right upper quadrant or a localized ileus may be demonstrated.

4. Abdominal ultrasound is most effective test, it may reveal an inflamed appendix.

5. Pelvic examination to rule out a gynecological disease.

6. Intravenous pyelogram (IVP) may be used to differentiate appendicitis from possible urinary tract infection.

7. Computed tomography scan may reveal a right lower quadrant localized distention of the bowel.

Differential Diagnosis of Acute Appendicitis

According to Thomas (2015) diagnostic investigations includes;

1. Gastroenteritis- usually there is vomiting and/or diarrhea before the abdominal pain. There may be other ill contacts with similar symptoms.

2. Inflammatory bowel disease- usually symptoms are more chronic and history of poor weight and height gain

3. Testicular torsion and other intra-scrotal pathology

4. Ovarian cysts and twists

5. Inflammatory disease

6. Intestinal obstruction

Medical Treatment of Acute Appendicitis

According to Williams and Hopper, (2014) medical treatment includes

A. Drugs

1. Antibiotic therapy Ceftriaxone, Cefotaxime, Ciprofloxacillin, Gentamicin etc

2. Analgesics to relieve pain E.g. Diclofenac, Pethidine, Morphine, and Paracetamol

3. Intravenous infusions are administered to replenish or maintain vascular volume and prevent electrolyte imbalance IV ringers lactate, Normal saline, Dextrose Normal Saline.

B. Nasogastric tube is inserted to empty the stomach.

Surgical Treatment of Acute Appendicitis

According to Weller (2018) the treatment choice for acute appendicitis is an appendectomy, that is surgical removal of the appendix and it may be performed as soon as possible to decrease the risk of perforation and as such it is an emergency operation.

Nursing Management

The nursing goals include relieving pain, preventing fluid volume deficit, reducing anxiety, eliminating infection from the potential or actual disruption of the GI tract, maintaining skin integrity, and attaining optimal nutrition. The nurse prepares the patient for surgery, which includes

Preoperative Management

The general preoperative care of the patient pending an appendectomy are considered under the following headings

A. Psychological preparation

B. Physiological / physical preparation

A. Psychological Preparation

The patient is reassured that, the surgery will relieve her pain and will not interfere with her normal gastro-intestinal functioning. Briefly explain to the patient that before the procedure she will be anaesthetized to relieve her of any pains during the surgical procedure. Also reassure patient that after the wound has healed, she can go about her normal activities without any disfigurement. Allow the patient to ask questions and express her fears, then provide solutions to these questions asked. The patient can be introduced to other patients who have gone through appendectomy and are recovering to help allay her fears and build confidence. Tell patient to expect drainage tubes after the procedure and explain their purposes. Patient is also told to expect some pains after recovering from anaesthesia and that appropriate analgesic will be given to relieve the pains. Hinkle and Cheever (2018).

B. Physical Preparation

Elimination should be encouraged morning of the operation, shaving of the site, washed with soap and water, and keep dry, obtain patient on nil per os about 6 to 8 hours prior to surgery, remove dentures, serve pre- op medications 30-40 minutes before patient is taken to theatre, and checking and monitoring of vital signs. Inform client on food and fluid restrictions (when she can have

meals) based on anesthesia protocol and type of anesthesia to be given. Carry out basic laboratory investigations such as: Full Blood Count (FBC), Bleeding and clotting time, Blood chemistry for urea and nitrogen, blood sugar, HIV, VDRL, grouping and X-matching Monitor intake and output chart if the patient is on IV infusion. Assess for any skin abnormalities such as rash, keloid, scar or incision of a previous operation and report. Hinkle and Cheever (2018).

Other preoperational management includes;

A. Elimination

A nasogastric tube is inserted into the nasal cavity through to the stomach to decompress the stomach and drain its content to reduce post – operative nausea and vomiting. Catheterization is done to prevent accidental incision of the bladder and empty the urinary bladder. Avoid applying heat to the abdomen or giving enemas as these measures could trigger rupture of the appendix. However, a bowel washout may be requested by the doctor to wash the bowels if the surgery involves the bowels (Hinkle & Cheever, 2018).

B. Skin Preparation

Some surgeons prefer that the skin should be prepared at the ward, others prefer if being washed at the theater, so the skin is prepared according to the surgeons' preference. The skin /is prepared by washing the part to be incised with soap and water, then shave from the xiphoid sternum to the mid-thigh, wash with clean water and soap, then use antiseptic solution to clean the incisional site and cover with a sterile towel. The purpose of skin preparation is to reduce the incidence of wound infection and the shaving is either performed in the evening or on the morning of the day of operation (Hinkle & Cheever, 2018).

C. Rest and Sleep

It is important that the patient has a calm peaceful rest the night before the surgery. The nurse should ensure this by providing a comfortable bed with soft pillow, ensures good ventilation, maintain a quiet environment by restricting visitors to save the patient from disturbance. The nurse may also serve the patient with a warm beverage. Sedative and tranquilizers may be served for the purpose of rest and sleep if the above mentioned measures fail (Hinkle & Cheever, 2018).

Immediate Post-Operative Management

Prepare post-anaesthetic bed to receive client after surgery. Assemble all necessary equipment needed for resuscitation of the patient at the bedside. Organize for adequate number of people to transfer client from operating room. Ensure you are receiving an alive client Connect all tubes and ensure that they are functioning properly. Receive client properly by reading through the postoperative notes for special information (Hinkle and Cheever, 2018).

Post-Operative Management

1. Position

Patient is placed on a prepared post-operative bed preferably in the fowler's position after she awakens from anaesthesia, this is done to decrease the risk of infecting the upper abdomen with contaminated peritoned fluid. All tubes are connected and ensured that they are functioning properly, and then the nurse stays with patient till he recovers. (Williams & Basavanthappa, 2013).

2. Observation

Carefully monitor vital signs including temperature, pulse, respiration and blood pressure every 15minutes for the first 2 hours, then every 30minutes for the next one hour and then hourly until

patient's condition stabilizes. Intake and output are monitored and recorded for at least two days after surgery. The site of infusion is checked for swelling, needle dislodgement. Check for over bleeding at the site of operation, if bleeding is present reinforce with sterile gauze and notify surgeon immediately. Also, observe for signs and symptoms of internal bleeding such as restlessness, falling blood pressure, cyanosis and record the amount and nature of drainage and maintain its patency. If a nasogastric tube and catheter are in situ check for its patency, colour, consistency and frequency. Pain assessment is also done, this is achieved by assessing for restlessness and facial expression. The location, intensity and type of pain is assessed. If pain is caused by position, change the patient's position gently to enhance her comfort and not contraindicated to her condition. (Williams & Basavanthappa, 2019). The patient's level of consciousness is assessed to see if she is fully conscious or deeply unconscious. This can be done by prick

ing or calling him by his name or using a torch light to assess whether the pupil reacts to light or not. Patient mental orientation is observed as time goes on. (Williams & Basavanthappa, 2013).

3. Nutrition

After surgery patient is put on Nil per OS until bowel sounds are heard. If bowel sounds are heard, sips of water is initiated, then fluid diet, light diet and finally normal diet is given as patient condition progresses. A lot of fruits containing vitamin C is given to enhance wound healing and high caloric diet given to restore lost strength. (Williams & Basavanthappa, 2013).

4. Ambulation

Encourage early ambulation within 12hours after surgery if possible. The patient is assisted to move body parts, sit in bed, get out from bed and tries to walk around his bed. This is done to

avoid thrombosis, embolism and accumulation of lactic acid in the muscles. Also encourage deep breathing and coughing exercise to help expand the lungs, teach patient how to splint the abdomen when coughing, sneezing and breathing to reduce pain and prevent pulmonary complications. Assess patient for signs of peritonitis which include pain, fever, excessive wound drainage, hypotension, pallor and treat immediately. (Williams & Basavanthappa, 2013).

5. Patient Education

Teach patient on the need to maintain personal hygiene. Advise her to avoid touching the incision site with hand to prevent any infection. Educate patient to avoid putting stress on the abdomen by doing heavy work and to go for follow ups at the appointed time and date to monitor healing and early detection of any developing complications. Patient is educated to take in fruits containing vitamin C to help in the healing process. (Williams & Basavanthappa, 2013).

6. Wound Care

Patient's wound is observed for signs of bleeding and infection, any offensive odour, discharge of pus or signs of wound gaping. Wound dressing is changed and dressed aseptically as directed by the surgeon. This is usually on the third day and is dressed with normal saline. The wound is dressed from inside out to prevent wound contamination. Alternate stitches are removed aseptically as directed by the surgeon, it is usually done on the 7^{th} day post operatively, and then the remaining stitches are removed on the 9^{th} day or 10^{th} day as directed by surgeon the patient is educated to keep the wound dry and not to be touching it with the hand to prevent infection. Patient is also encouraged to take in high protein diet with vitamin C to promote wound healing and repair of worn out tissues. (Williams & Basavanthappa, 2013).

Complications

1. **Perforation**: It is a hole that develops through the wall of a body organ.

2. **Peritonitis**: It is the inflammation of the membrane lining the abdominal wall and covering of the abdominal organs. If the appendix inflames and bursts, the linen of the abdomen (peritoneum) will become infected with bacteria which can also damage other internal organs.

3**. Abscess:** It is a confined pocket of pus that collects in tissues, organs or spaces inside the body. Patents with ruptured appendicitis spill stool from the appendix into the belly causing an infection resulting in a collection of pus or an abscess.

4. Pyelonephritis: It is an inflammation of the kidney due to specific type of urinary tract infection which begins in the urethra or bladder and travels to the kidneys. The development of acute renal failure after appendectomy is usually related to either a ureteral injury caused during appendectomy.

5. Gangrene formation: Gangrene occurs when tissues in the body die after a loss of blood caused by illness, injury, or infection The cause of appendicitis relates to blockage of the inside of the appendix leading to increased pressure, impaired blood flow and inflammation. If the blockage is not treated, gangrene and rupture (breaking or tearing) of the appendix can result.

Prognosis

Most appendicitis patients recover easily with surgical treatment, but complications can occur if treatment is delayed or if peritonitis occurs.

Recovery time depends on age, condition, complications, and other circumstances, including the amount of alcohol consumption, but usually is between 10 and 28 days. For young children (around 10 years old) the recovery takes three weeks.

1.12 Validation of Data

According to Mcintosh (2013) it refers to the process of establishing the suitability of mechanism or system to performing a particular task. The signs and symptoms exhibited by the client were verified with literature review. In order to confirm the diagnosis, investigations that were carried out on the patient and treatment given were also verified with the standard of management. All information gathered from the client were cross checked from client's relatives, her folder, and literature review and from the home visits I made and it proved that patient suffered from Acute appendicitis. The data collected is therefore valid and hence free from any biases.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

This chapter forms the second phase of the patient/family care study. Analysis of data deals with the critical examination and interpretation of the data collected during the assessment phase of the patient/family care study. It deals with comparison of the results of investigations carried out with standards in the literature review. It also gives the pharmacology of drugs prescribed by the medical officer. It further involves the interpretation and identification of the patient and family health needs; physical, spiritual, social and psychological. The chapter entails the causes and clinical manifestation of my patient's condition (Acute appendicitis), the diagnostic investigations, medical management, complications, patient and family's strength, related health problems identified and their corresponding nursing diagnosis.

2.1 Comparison of data with standard

A. Diagnostic Investigation/Test

These are investigations carried out to diagnose or confirm the patient's condition. The following investigations were conducted on Madam. K.R. on admission.

1. Rapid diagnostic test (RDT) to rule out malaria.

2. Abdominal scan to reveal an inflamed appendix.

3. Full blood count (FBC)

4. Serum electrolytes

TABLE 2.1 Diagnostic investigation/test in the literature review compared with those carried out on Madam K.R.

Laboratory investigations stated in the Literature review	**Laboratory investigations carried out on the patient**
1. Full blood count	Full blood count was done for the patient
2. Intravenous Pyelogram	Intravenous Pyelogram was not done for the patient
3. Serum electrolyte	Serum electrolyte was done for the patient
4. Rapid diagnostic test	Rapid diagnostic test was done for the patient
5. Urinalysis	Urinalysis was not done for the patient
6. Pelvic examination	Pelvic examination was not done for the patient
7. Abdominal X- ray	Abdominal X- ray was not done for the patient
8. Abdominal scan	Abdominal scan was done for the patient

The table below shows detailed results of the laboratory investigations carried on Madam. K.R.

TABLE 2.2: RESULTS OF DIAGNOSTIC INVESTIGATIONS CARRIED ON MADAM. K.R

Date	**Specimen**	**Investigation**	**Laboratory Results**	**Normal Values**	**Interpretation**	**Remarks**
21/11/22	Blood	Haemoglobin	15.4g/dl	Female:12.0-16.0g/dl Male:13.0-18.0g/dl	Patient was not anemic	No treatment was given
		White blood cell count	13x109/ ul	4.5 – 11 x 109 /uL	Infection was present	Intravenous flagyl 500mg and intravenous ciprofloxacin 400mg were given
		Red blood cell count	5.47x1012/l	Male: 4.6–6.2x1012/L Female: 4.25.4x1012 /L	Patient had normal red blood cell count	No treatment was given
		Differential count, Neutrophils Lymphocytes	 71.7% 30.0%	 45%–73% 20%–40%	WBC Differential count was within the normal range except	Antibiotic was prescribed for treatment.

		Monocytes Basophils	12.8% 0.1%	2%–8% 0%–1%	monocytes which was above the normal range	
21/11/22	Blood	Malaria parasite	No malaria parasite seen	Should not be present	Patient was not suffering from malaria	No antimalarial medication was given
22/11/22	Blood	1. Blood urea nitrogen 2. Creatinine	5.4mmol/L 70µmol/l	3.6–7.2 mmol/L 62–124 µmol/L	Normal Creatinine was normal.	No treatment given No treatment was given
22/11/22	Lower abdomen of the body	Abdominal Scan	Enlarged than its normal	Uninflamed appendix	inflamed appendix	Appendectomy done for the patient

C. Cause of Patient's Illness

From the interview with Madam K.R and the laboratory investigations carried out on the patient, it was realized that the possible cause of the patient illness was by an obstruction of the lumen by a foreign body.

TABLE 2.3: COMPARISON OF CLINICAL FEATURES IN THE LITERATURE TO THOSE EXHIBITED BY MADAM K.R

Clinical features outlined in the literature review	**Review Clinical features exhibited by patient**
1. Low grade fever	Patient experienced low grade fever
2. Nausea and vomiting	Patient did not experience nausea and vomiting
3. Local and rebound tenderness at the McBurney's point	Patient experienced tenderness at the McBurney's point
4. Generalized malaise	Patient had generalized malaise
5. Constipation is present	Patient did not become constipated
6. Abdominal distention	Patient had no sign of abdominal distention
7. Psoa's sign	Patient exhibited psoa's sign

2.2 Treatment

The patient was treated using both surgical and medical interventions. Surgically, the patient underwent appendectomy. In terms of medical treatment, the following specific drugs were prescribed for the patient. This is in particular reference to the treatment indicated in the literature review.

Pre-operative drugs prescribed were:

1. Intravenous metronidazole 500mg tds x 24hours

2. Intravenous ciprofloxacin 400mg bd x 24hours

3. Tablet Paracetamol 1g tds x 5

4. Injection Buscopan 40mg stat

5. Dextrose Normal saline 1000mls x 24hours

6. Ringers lactate 1000mls x 24hours

7. Normal Saline 1000mls x 24hours

After the operation, she was managed on these drugs;

- Intramuscular pethidine 100mg stat, 50mg qid x 24hours
- Intravenous dextrose normal saline 1000mls
- Intravenous metronidazole 500mg tds x 48hours
- Intravenous ciprofloxacin 400mg bd x 48hours
- Suppository diclofenac 100mg bd x 5
- Tablet metronidazole 400mg tid x 7days
- Tablet Ciprofloxacin 500mg bd x 7days
- Ringers lactate 1000mls x 24hours
- Normal Saline 1000mls x 24hours

TABLE 2.4: COMPARISON OF TREATMENT OUTLINE IN THE LITERATURE REVIEW TO THOSE GIVEN TO MADAM K.R.

DRUGS IN LITERATURE REVIEW	DRUGS GIVEN TO THE CLIENT
A. DRUGS 1. Antibiotics. E.g., Amoxicillin, clarithromycin	Patient was given intravenous metronidazole 500mg tds x 48hrs and intravenous ciprofloxacin 400mg bd x 48hrs
2. Analgesics. E.g., diclofenac, Paracetamol	Patient was given intramuscular pethidine 100mg stat and suppository diclofenac 100mg bd x 5
3. IV Infusions. E.g., IVF dextrose saline	Patient was given ringers lactate, dextrose saline and normal saline
B. Nasogastric tube is inserted to empty the stomach	No Nasogastric tube was inserted
D. SURGERY The surgery of choice for acute appendicitis is an appendectomy	Appendectomy was done for the patient.

The table below shows the pharmacology of drugs that were administered to Madam K.R. during her period of hospitalization. Information as to the name of specific drugs, dosage, route of administration, classification, desired effects side effects and remarks are provided in the table.

Table 2.5: Pharmacology of Drugs Administered To Madam K.R.

Date	**Drug**	**Dosage/Route Of Administration In The Literature Review**	**Dosage/Route Of Administration Given To Client**	**Classification**	**Action/ Desired Effect**	**Actual Action Observed**	**Side Effectand Its Remedy**
21/11/22	Intravenous Ciprofloxacin	Dosage: 400mg bd x 72hours Route: Intravenous	Dosage: 400mg bd x 72hours Route: Intravenous	Quinolones	Inhibit bacteria DNA synthesis and replication mainly by blocking DNA bactericidal	Infection was minimized and patient's condition improved	Nausea, Vomiting itching of the skin, and diarrhea. None was observed
21/11/22	Intravenous Metronidazole	Dosage: 15mg/kg, 8hourly Route: intravenous	Dosage: 500mg tds x 72hours Route: intravenous	Antibacterial and anti-protozoa	Hinders the growth of selected organism like anaerobic bacteria. Anti-protozoa inhibit nucleic	Infection was controlled and condition of patient improved.	Headache, vomiting, loss of appetite and mouth sores. None was observed

					acid formation causing cellular death		
21/11/ 22	Buscopan	Dosage; 20mg/ml solution Route; Intramuscular	Dosage; 40mg stat. Route; Intramuscular	Anticholinergics/ antispasmodics	To relieve smooth muscle spasms (cramps) in the stomach and intestines.	Smooth muscles were relaxed to reduce spasms	Constipation, dry mouth, nausea. Patient had no side effects.

Table 2.5: Pharmacology of Drugs Given To Madam K.R. Cont'd

Date	Drug	Dosage/Route Of Administration In The Literature Review	Dosage/Route Of Administration Given To Client	Classification	Action/ Desired Effect	Actual Action Observed	Side Effect And Its Remedy
21/11/22	Pethidine	Dosage: 25-150mg 3-4 hours when necessary Route: Intramuscular	Dosage; 100mg stat, then 50mg qid x 24hours Route: Intramuscular	Narcotic analgesic	Binds with opiate receptor in the central nervous system altering both perception of an emotional response to pain	Pain subsided and patient slept comfortably	Drowsiness, lightheadedness, nausea, vomiting, hallucination. No side effect was observed
21/11/22	Ringer's Lactate	Amount to be given depends on patient's condition. Route: Intravenous	Dosage: 2000mls in 48 hours Route: Intravenous	Intravenous fluid and electrolyte	To correct fluid loss and maintain hydration	Patient's fluid balance level was maintained	Fluid and cardiac overload. Cardiac overload was not seen.
21/11/22	Normal Saline	Amount to be given depends on patient's condition. Route: Intravenous	Dosage: 2000mls in 48 hours Route: Intravenous	Intravenous fluid and electrolyte	To correct fluid and electrolyte balance	Patient's fluid balance level was maintained	Fluid overload. No circulatory overload was seen

Table 2.5: Pharmacology Of Drugs Given To Madam K.R Cont'd

Date	Drug	Dosage/Route Of Administration In The Literature Review	Dosage/Route Of Administration Given To Client	Classification	Action/ Desired Effect	Actual Action Observe D	Side Effect and Its Remedy
21/11/22	Dextrose normal Saline	Amount to be given depends on patient's condition and electrolyte required Route; Intravenous	Dosage: 2000ml for 48hours. Route; Intravenous	Intravenous fluid and Electrolyte	To correct fluid and energy loss	Patient's fluid balance was maintained	Apnea, muscle pain and tension in chest and abdomen, fluid overload. Fluid overload was not seen.
22/11/22	Suppository Diclofenac	Dosage: 75-100mg daily Route: Rectal	Dosage: 100mg bd x 5 Route; Rectal	Anti-inflammatory, analgesic and antipyretic (NSAID)	To relieve incisional pain	Patient's pain was relieved.	Headache, drowsiness, blurred vision, local rectal irritation, insomnia. No side effect seen.
21/11/22	Tablet paracetamol	Dosage: 500–1000mg Route; Oral	Dosage: 1g tds x 5 Route; Oral	Antipyretics	Used to treat mild to moderate pain and fever	Client's fever and pain reduced	Dyspnea, cyanosis, hypoglycemia and rashes. Non were observed

Table 2.5: Pharmacology Of Drugs Given To Madam K.R Cont'd

Date	Drug	Dosage/Route Of Administration In The Literature Review	Dosage/Route Of Administration Given To Client	Classification	Action/ Desired Effect	Actual Action Observed	Side Effect and Its Remedy
22/11/22	Tablet Metronidazole	Dosage: 200 – 400mg Route; Oral	Dosage: 400mg tid x 7days Route; Oral	Antiprotozoal and antibacterial	Hinders the growth of selected organism like anaerobic bacteria. Anti-protozoa inhibit nucleic acid formation causing cellular death	Infection was minimized and patient's condition improved	Headache, vomiting, loss of appetite and mouth sores. None was observed
22/11/22	Tablet Ciprofloxacin	Dosage; 500mg bd x 7days Route; oral	Dosage 500mg bd x x 7days Route; oral	Quinolones	Inhibit bacteria DNA synthesis and replication mainly by blocking DNA bactericidal	Infection was minimized and patient's condition improved	Nausea, Vomiting itching of the skin, and diarrhea. None was observed

2.3 Complications

With reference to the literature review, patient did not develop any complications due to good nursing care and timely intervention by the medical team.

2.4 Patient/Family Health Problems

Health problem according to Hornby (2010) is health need to which the patient responds in a variety of ways. With respect to information collected from patient and some observations made. The under mentioned problems were identified.

Pre-operative problems

1. Patient had pain at the right lower quadrant of the abdomen (21/11/22)
2. Patient complained of inability to sleep. (21/11/22)
3. Patient and family were anxious about the impending surgery (22/11/22)

Post-operative problems

4. Patient had pain at the incisional site. (22/11/22)
5. Patient and family had insufficient knowledge about the condition (23/11/22)
6. Risk of infection at surgical site (23/11/22)

2.5 Patient's and Family Strength

According to Hornby (2010), strength is explained as the factors that contribute to the patient wellbeing. The strength of a patient and a family involves what can be done on their part to facilitate the work of health care providers in providing holistic care to promote recovery. Through interaction with Madam. K.R. and family, their strengths were observed as;

Pre-operative strength

1. Patient was able to express the intensity of pain

2. Patient could sleep when lights were switched off

3. Patient and family were able to express their fears

Post-operative strength

4. Patient could express the intensity and location of pain

5. Patient and family were ready to learn about the condition.

6. Patient kept her wound site clean and dry.

2.5 Nursing Diagnosis

A nursing diagnosis is a clinical judgment about individual, family or community's response to actual or potential health problems. It provides the basis for selection of nursing interventions to achieve objectives for which the nurse is accountable. Nursing diagnoses for Madam K.R. were as follows;

Pre-operative nursing diagnosis

1. Acute pain related to inflammation of the appendix

2. Disturbed sleep pattern(insomnia) related to change of environment

3. Anxiety (Patient and relatives) related to unknown outcome of the impending surgery (appendectomy)

Post-operative nursing diagnosis

4. Impaired body comfort related to surgical incision

5. Deficient Knowledge related to lack of information about appendicitis

6. Risk of infection related to incisional wound.

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning in the nursing process is the process whereby the nurse formulates strategies required to eliminate or decrease client's health problem. Client's relatives are also included in planning process of the patient.

3.1 Objectives/Outcome Criteria

The following objectives were set for the patient and family care during the period of hospitalization to help solve their health problems identified;

Pre-operative objectives

1. Patient will be relieved of abdominal pain within 6hours

2. Patient will achieve improved sleep pattern within 12hours

3. Patient and family will demonstrate relieved anxiety within 12hours

Post-operative objectives

4. Patient will be relieved of incisional pain within 6 hours

5. Patient will gain adequate knowledge about his condition within the period of hospitalization

6. Patient will be free from infection during the period of hospitalization as evidence by patient and nurse observing no discharge from the incisional site.

Table 3.1: Pre-Op Nursing Care Plan For Madam K.R.

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
21/11/22 At 7:00pm	Acute Pain related to inflammation of the appendix	Patient will be relived of right lower abdominal pain within 6 hours as evidenced by a) patient verbalizing that her pain has reduced. b) nurse observing that client is relaxed in bed	1. Reassure patient 2. Assess the severity of pain by using a scale of 0- 10 3.Engage patient in diversional therapy 4. Assist client to assume a comfortable position 5.Administer prescribed medication	1. Patient was reassured 2. Patient's pain was assessed on the pain rating scale and recorded 7 before analgesic was given and recorded 1 after analgesic was given. 3. Patient was encouraged to watch show on Citi Television 4. Patient was assisted to assume a left lateral position which she said was comfortable for her 5.Prescribed antispasmodics such as buscopan injection was administered.	22/11/22 At 1:00 am	Goal fully met as evidenced by; a) Patient verbalized that she is relived of pain b) Nurse observed that client is relaxed in bed	O. H

Table 3.1: Pre -Op Nursing Care Plan For Madam K.R. Continued

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
21/11/22 At 8:00pm	Disturbed sleep pattern (insomnia) related to change of environment	Patient will achieve improved sleep pattern within 12 hours as evidenced by: a. patient verbalizing that she had a sound night sleep b. Nurse observing patient sleep long hours at night	1.Assess client's usual sleeping pattern 2. Provide a comfortable bed. 3. Ensure a calm environment. 4.Restrict visitors during sleep hours. 5. Give patient warm bed bath	1. Client sleeping pattern was assessed to help in planning nursing care. 2. Patient bed was made neatly from creases and cramps. 3. Client environment was made calm by turning off volume of television set. 4. Visitors were restricted during sleep hours to ensure a sound and uninterrupted sleep. 5. Patient was given warm bed bath to help relax her	22/11/22 At 8:00am	Goal fully met as evidenced by: a. patient verbalized that she had a sound night sleep. b. Nurse observed that patient slept for long hours at night.	O.H

Table 3.1: Pre -Op Nursing Care Plan For Madam K.R. Continued

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
22/11/22 At 7:45am	Anxiety (patient/family) related to impending surgery	Patient and family will demonstrate relieved anxiety within 12 hours as evidenced by: a. Patient and family verbalizing that they are no more anxious b. Nurse observing that patient and family are calm and have relaxed facial expression	1. Allow patient to express her fears and concerns 2. Answer all questions calmly and honestly 3.Clarify every misinformation with honesty in simple understandable language 4. Assess patient's/family's knowledge on the condition. 5. Explain all nursing procedure to client. 6. Introduce patient to other patients	1. Patient was allowed to express her fears and concerns 2. All questions were answered tactfully. 3. Every misinformation was clarified with honesty in simple understanding language 4. Patient's /family' knowledge was assessed. 5. All nursing procedures done on patient were explained. 6. Patient was introduced to other patients who have successfully recovered from appendectomy	22/11/22 7:45pm	Goal fully met as evidenced by: a. Patient and family verbalized that they are no more anxious b. Nurse observed that patient and family are calm and have a relaxed facial expression	O.H

Table 3.2: Post-Op Nursing Care Plan For Madam K.R.

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
22/11/22 At 8:00pm	Impaired body comfort related to surgical incision.	Client will be relieved of incisional pain within 6 hours as evidenced by: 1. Client verbalizing relieve of pain 2. Nurse observing Client had a cheerful facial expression and was relaxed in bed	1.Reassure Patient 2. Encourage client to have enough bed rest. 3. Encourage client to avoid touching incisional site 4. Educate client on factors that enhance incisional wound healing 5.Administer prescribed analgesic	1. Client was reassured that the pain will subside as nursing measures were being put in place to relieve her of the pain. This helped to allay her fears. 2. Client was encouraged to have enough bed rest. Noise level on the ward was minimized by controlling banging of door and turning down the volume of radio and television sets. Visitors were told to spend less time with her to reduce disturbances. 3. Client was encouraged to avoid touching incisional site 4. Client was educated on proper nutrition and exercise 5. Prescribed analgesic such as pethidine was administered	23/11/22 at 2:00am	Goal fully met as evidenced by: a) Client verbalized relieve of pain. b) Client had a cheerful facial expression and was relaxed in bed	O.H

Table 3.2: Post-Op Nursing Care Plan For Madam K.R Continued

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
22/11/22 At 8:30am	Deficient knowledge related to lack of information about her condition	Patient will gain adequate knowledge about her condition within the period of hospitalization as evidenced by; a) Patient being able to mention some causes and signs and symptoms of appendicitis. b) Nurse observing patient answer questions on the condition correctly	1. Establish rapport with patient. 2. Assess patient knowledge on the condition. 3. Educate patient about appendicitis 4. Encourage patient to ask questions. 5. Provide simple answers to patient's questions	1. Patient was greeted and given a warm hand shake to help built rapport 2. Patient's knowledge was assessed by asking her some signs and symptoms of appendicitis. 3.patient was educated on the causes, signs and symptoms and complications of appendicitis 4. Patient was allowed to ask questions bothering her mind about her condition 5. Patient's questions were answered in simple language to enhance her understanding	24/11/22 8:30am	Goal fully met as evidenced by: a) Patient was able to mention some causes and signs and symptoms of appendicitis. b) Nurse observed patient answer questions on the condition correctly	O.H

Table 3.2: Post-Op Nursing Care Plan For Madam K.R Continued

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
23/11/22 9:35am	Risk of infection related to surgical wound	The patient's wound will not show any sign of infection within the period of hospitalization as evidence by: a. Nurse observing the incisional site is clean and free from pus. b. Patient observing no discharge from the incisional site	1. Set trolley for wound dressing. 2. Dress wound aseptically. 3. Observe site for signs of infection. 4. Educate her to avoid touching incisional site and also report any discharges if any. 5. Check and record vital signs every 4 hourly. 6. Decontaminate all instruments used for wound dressing. 7. Administer prescribed antibiotics	1. A sterile trolley was set for wound dressing. 2. Wound was dress aseptically. 3. The wound was inspected for signs of infection on incisional site. 4. She was educated not to touch the incisional site and to report discharges. 5. Vital signs was checked and recorded every 4 hourly. 6. Instruments used for the dressing were decontaminated 7. Antibiotics such as IV metronidazole were administered.	25/11/22 9:35 am	Goal fully met as evidenced by: a. Nurse observed the incisional site is clean and free from pus. b. Patient observed no discharge from surgical wound	O.H

CHAPTER FOUR

IMPLEMENTATION OF PATIENT/FAMILY CARE PLAN

4.0 Introduction

Implementation is the fourth phase of the nursing process. This involves the measures that are put in place to assist the client in activities she is unable to perform, reinforcement of coping mechanism, continuous data collection and monitoring of patient's condition, reporting, recording and consultations and therapeutic measures and not necessarily medical actions and also health promotion and health education. This phase requires the collective effort of the patient, the family, the nurse and other members of the health team.

4.1 Summary of Actual Nursing Care Rendered to Patient/Family

Nursing care to Madam K.R. started from the day of her admission that was 21st November 2022 and continued till the termination of care. The summary of the care given was written on daily basis as follows;

First Day of Admission (21/11/22)

Madam K.R was admitted to the Females' surgical ward at 6:30pm by Dr. Egote through the Accident & Emergency Unit. She was brought to the ward in a conscious state by a staff nurse, student nurse, her sister and daughter for an admission. Patient and her relatives were welcomed and offered a seat. I collected her folder from the accompanying nurse and her name was mentioned and she responded. I quickly glanced through the folder and took the medical history. On arrival patient complains of severe abdominal pains which was located at the left iliac fossa

and headache; hence an objective was set to relieve her of pain. The following interventions were put in place.

Her vital signs were checked and recorded. She was made comfortable on an admission bed, and reassured of good medical and nursing care. Madam K. R's relatives was oriented to the ward and its annexes and was introduced to other patients and nurses on the ward. Patient and relative were informed about the hospital protocol such as visiting hours, medication serving, vital signs and ward rounds. All other vital information needed during her period of hospitalization was provided to them.

The patient's particulars including; sex, name, age, residential address, religion etc. were recorded in the admission and discharge book and daily ward state. She was to be managed with the following medications;

- Injection Buscopan 40mg stat
- IV Ciprofloxacin 400mg bd x 24hrs
- IV Metronidazole 500mg tds x 24hrs
- Tablet Paracetamol 1g tds x 5
- Dextrose Normal saline 1000mls x 24hours
- Ringers lactate 1000mls x 24hours
- Normal Saline 1000mls x 24hours

A sample of blood was ordered and has already been taken to the laboratory by the Emergency staffs and awaiting results for the following investigations;

- Rapid Diagnostic Test for malaria parasites
- Full blood count
- Abdominal scan
- Serum electrolytes

Vital signs checked and recorded are as follows;

- Temperature - 37.6^0c
- Pulse - 89bpm
- Respiration - 20cpm
- Blood pressure - 110/60mmHg

Later on, when the patient was stable in bed, I engage her and the sister in a therapeutic conversation, and introduced myself as a student of Holy Family Nursing and Midwifery training College, Berekum writing a care study and when given the consent I would like to write about Madam K.R's condition as a partial fulfillment for the award of license to practice as a professional registered general nurse by the Nursing and Midwifery Council of Ghana. I explained what it will entail and assured them to make any information about them confidential. Patient and family were made to understand that other health care members will care for Madam K.R. and this will mostly be in my absence. I asked for maximum support and cooperation, and they gave the consent for me to carry on with my study. During the interaction with the family, questions were asked to assess the level of understanding about the condition to clear any misconception. I also explained to them on the surgical treatment to be given and the need to undergo that surgery. At 7:00pm and

objective was set to relieve the pain within 6 hours. Interventions that were carried out to meet the objectives were; assisting patient to assume a left lateral position which she said was comfortable for her, also prescribed antispasmodics such as buscopan injection was administered. Patient's pain was assessed on the pain rating scale and recorded 7 before analgesic was given and recorded 1 after analgesic was given and diversional therapy was provided. Also, at 8:00pm (21/11/22), a diagnosis of Disturbed sleep pattern (Insomnia) related to change in environment was made. The following interventions were made which includes; client sleeping pattern was assessed to help in planning nursing care, patient bed was made neatly free from creases and cramps, client environment was made calm by turning off television set, restricting visitors during sleep hours to ensure a sound and uninterrupted sleep, all nursing activities were grouped and carried out at a go and patient was given warm bed bath to help relax her.

Second Day of Admission (22/11/22)

At 1:00am, the objective which was set on 21/11/22 at 7:00pm to relieve patient of abdominal pain was evaluated and goal fully met as evidenced by patient verbalizing that pain has been reduced.

Madam K.R woke up at 5:00am, and was assisted to take her bath and brushed her teeth. Her 6:00am medications were administered.

Also at 7:15am, the objective which was set on 21/11/22 at 8:00pm to ensure patient achieve improved sleep pattern was evaluated and goal fully met as evidenced by patient verbalized that she had a sound night sleep and Nurse observed that patient slept for long hours at night.

At 7:30am her morning vitals were checked and recorded as follows;

- Temperature - 37.1 ^{0}c

- Pulse - 92bpm
- Respiration - 22cpm
- Blood pressure - 130/80mmHg

At 7:45am on the same day (22/11/22), patient and relatives present were very anxious so an objective was set to relieve patient and family of anxiety within 12 hours. The following nursing orders were made and their interventions carried out; allowing patient to express her fears and concerns, answering all questions calmly and honestly, clarifying misinformation with honesty in simple understandable language, orienting patient and family into the ward and its annexes, reassuring patient and family, explaining all nursing procedures to the patient and introducing patient to other patients who have successful recovered from acute appendicitis. Madam K.R was reviewed by Dr. Egote at 8:00am. The doctor advised her that the best treatment for her condition was surgery and she consented.

The following were the orders given by doctor

1. Keep nil per os
2. IV antibiotics extended for 48 hours
3. To do abdominal scan
4. 1000mls of DNS x 24hours
5. 1000mls of Ringers x 24hours
6. 1000mls of NS x 24hours

Immediate Pre-operative preparation (psychological)

The nature of the surgery and its benefit was explained to the patient and family. Questions asked were answered in simple language. I introduced client to other patients who had successfully undergone appendectomy.

A. Signing A Consent Form

The need to sign a consent form was explained to patient and family, it was further explained that the consent form served as a legal document authorizing the surgeon and his team to perform the surgery. Client and her sister present agreed after which they signed the consent form. The need to pass urethral catheter was explained to her and she agreed to it so I passed it.

Physical Pre-Operative Preparation

A. Observation

Client vital signs that is temperature, pulse, respiration were continuously observed every 2 hours to help detect any sign of abnormalities. Intravenous infusions were administered and monitored to prevent fluid overload as well as leakages. An intake and output chart was maintained. Patient pain intensity was assessed with a scale of 7. Client's skin was also observed for any skin abnormalities such as rash, keloid and scars.

B. Nutrition

Client was put on nil per os, however, intravenous infusions were set up. Patient was reassured of resuming feeding after the surgery and when indicated by the surgeon. The importance of maintaining nil per os was explained to the patient as to prevent vomiting when given anaesthesia.

C. Exercise

Post-operative exercises such as deep breathing, coughing and ambulatory were demonstrated to the patient. It was further explained to the patient that the importance of the exercise is to prevent post-operative complications and to improve her wellbeing physically.

D. Skin Preparation

Client was bathed with antimicrobial soap and shaved from below the umbilical area through the pubic region and the site was cleansed with Savlon. The area was covered with a sterile towel and kept in position with adhesive plaster.

Immediate Pre-Operative Management

This entails preparations that should be rendered to the patient before sent to the theatre. Client was assisted to empty her bowel, care for the mouth and take a shower with an antiseptic soap. Ornaments, dentures and jewelries were removed. Client and relatives were reminded on the need to adhere to NPO. Prescribed IV fluids were administered and monitored. The site to be operated was cleaned thoroughly with antiseptic solution and marked. Drainage tubes such as urethral catheter was passed and were checked for patency and displacement. Vital signs were checked and recorded. Client was changed into theatre gown and identification band was fastened to clients' wrist. Checklist to ensure all necessary information is obtained and recorded was used Client was sent to the theatre on a stretcher and well covered with sheet at 4:30pm with her folder containing temperature, treatment sheet, nurse's notes, laboratory sheets, consent form. She was handed over to the theatre nurse with her drugs at the theatre. The surgical ward in-charge was informed of the necessary preparation before patient arrived. Relatives were reassured and asked to wait patiently.

Immediate Post-Operative Care

At 11:50am, patient was received from the theatre in a semi-conscious state with DNS in situ. She was admitted to an already made operation bed and surgical site inspected for bleeding. There was no blood observed at the incision site. She was protected from injury by raising the side rails of the bed. Immediate post-operative vitals were checked and recorded as follows;

- Temperature - 36.9^{o}c
- Pulse - 106bpm
- Respiration - 25cpm
- Blood pressure - 135/90mmHg
- SpO2 - 99%

Vital signs were checked and recorded every 15minutes for 1hourly, 30minutes for 1hourly and the next hours till client gain consciousness. A fluid intake and output was monitored and the surgeon notes read. All post-operative orders and medications were served and recorded. At 7:45pm, objective which was set on 22/11/22 at 7:45am to relieved patient/family of anxiety was evaluated and goal fully met as evidenced by patient and family verbalizing they are no more anxious and nurse observing that they have relaxed facial expression. At 8:00pm on the day of operation (22/11/22), a diagnosis of impaired body comfort related to surgical incision was made. The following interventions were therefore carried out to help relieve patient of incisional pain within 6 hours. These include; Patient was reassured that the pain will subside as nursing measures were being put in place to relieve her of the pain to help allay her fear. Patient was encouraged to have enough bed rest. Noise level on the ward was minimized by controlling banging of door and

turning down the volume of radio and television sets. Visitors were told to spend less time with her to reduce disturbances. Analgesics such as pethidine was administered to relieve client of pain. Patient was also encouraged to avoid touching incisional site. Client was educated on proper nutrition and exercise. At 10:00 pm in the evening, vital signs were checked and monitored, due medications were administered and recorded. Client returned to sleep at exactly 10:15 pm without making any complains.

Post-operative Day 1/ Third Day of Admission (23/11/22)

I arrived at the ward at 6:00am and went to the patient to know how she was doing. The incisional site was inspected for bleeding and drainage. I inspected the urine bag for color, amount and patency which was recorded in the intake and output chart. The urine bag was then emptied. The intravenous line was in place and infusion was dripping well. Vital signs were checked and recorded as;

- Temperature - 37.3^{o}c
- Pulse - 98bpm
- Respiration - 25 cpm
- Blood pressure - 130/100 mm/Hg
- SpO2 - 98%

Prescribed medications were also served. At 8:30am during interaction with patient and family, I realized that they lack adequate knowledge on the disease and an objective was set to enable them gain adequate information on the disease condition and the following interventions were carried out; client was greeted and given a warm hand shake to help built rapport, assessing patient/family

knowledge level on the appendicitis, educating patient and family on the causes, signs and symptoms and complications of appendicitis, allowing patient/family to ask questions that were bothering their mind about the condition and providing answers to patient/family questions in simple language to enhance her understanding.

At 9:00am, patient was reviewed by Dr. Egote but made no serious complain. The following orders were made;

1. Remove urethral catheter
2. Start sips

At 9:35am, a diagnosis of risk for infection related to Incisional site wound was made. An objective was set to prevent patient's wound from infections throughout the period of hospitalization. The following interventions were wound dressing, decontamination of instruments, educating the patient keep the site clean and dry, monitoring of vital signs and education of patient to take nutritious diet.

At 10:00am vitals checked and recorded. At 10:30am, I asked permission from the ward in-charge to embark on my first home visit to my client's home which was approved.

Client took tea for lunch. At 2:00pm, client's vital signs were checked and recorded. Due medication was served. During supper, patient ate porridge, she took her bath after eating and relaxed in her comfortably made bed. At 6:00pm, client's vital signs were checked, recorded and due medication was served. At 10:00pm, vital signs were checked and recorded. Due medication was served. Client slept around 10:30pm.

Post-operative Day 2/ Fourth Day of Admission (24/11/22)

Client woke up around 5:30 am and was able to sit up in bed without support, brushes her own teeth, took a warm bath and a cup of porridge with groundnut. She never complained of pain. Her wound was assessed for signs and symptoms of infection but all were absent. At 6:00am, her morning vitals were checked and recorded as follows;

- Temperature - 36.9^{o}c
- Pulse - 83bpm
- Respiration - 21cpm
- Blood pressure - 120/80mmHg

At 10:00am, patient was reviewed by Dr. Egote. The following orders were made;

1. Start light diets
2. Continue ambulation
3. Switch to oral antibiotic if patient completes Iv medication

At 2:00pm, afternoon vital signs were checked and recorded and also due medication served and documented. Client took soup for lunch. At 6:00pm her vital signs were checked and recorded and due medication served and documented. She took Hausa Koko for supper and was encouraged to eat more. At 10:00pm, vital signs were checked and recorded and due medications served and documented. Patient was made comfortable in bed which was free from creases and cramps and she slept around 10:15pm.

Post-operative Day 3/ Fifth Day of Admission (Day of Discharge) (25/11/22)

Madam K.R woke up at exactly 5:00 am, took her bath and brushed her teeth. It was observed that her condition was markedly improved. She was served with Tom brown as breakfast, medications were administered and vital signs checked and recorded as;

- Temperature - 36.9^{o}c
- Pulse - 83bpm
- Respiration - 21cpm
- Blood pressure - 120/80mmHg

At 7:00am on ward rounds, she was discharged home on oral medications such as Paracetamol 1g tds x 5, Metronidazole 400mg tid x 7days and Ciprofloxacin 500mg bd x 7days and was asked to come for review in one week (02/12/22) for possible removal of stitches. Her wound was then dressed for her aseptically to prevent infection. At 8:30am, objective which was set on 24/11/22 at 8:30am to enable patient gain adequate knowledge about her disease condition was evaluated and goal fully met as evidenced by patient being able to mention some causes and signs and symptoms of appendicitis and nurse observed patient answered questions on the condition correctly.

Also, at 9:35am, objective which was set on 24/11/22 at 9:35 am to prevent patient's wound from being infected was evaluated and goal fully met as evidenced by nurse observing the incisional site is clean and free from pus and patient observing no discharge from surgical wound. Patient was educated on her drugs and made aware of the review date (02/12/22). The necessary nursing

processes for discharging a patient were done. I helped patient pack all her belongings and assisted them to settler their hospital bills at the cash point.

The client and her sister said goodbye to other clients on the ward and the nursing staff and went home. Client bed linens were stripped off and her bed was disinfected with 0.5% bleach solution. The water proof mattress was disinfected and dried. Bed linens were taken to the sluice room and bed was made ready for next admission

4.2 Preparation of Patient/ Family for Discharge and Rehabilitation

Client and family were prepared towards discharge on the day of admission. First of all, client and family were informed that, the hospital was a temporal place to stay when one is sick. Therefore, they were reassured that after recovery, client will go back to the house or community to continue her normal life.

She was then advised to co-operate with the health team to ensure her speedy recovery. Client and family were prepared towards discharge through effective education. They were reassured that the hospital has competent medical, nursing and other health care providers who will be available to give her good care. The cause, signs and symptoms, treatment and complications of her disease were explained to their understanding, since during admission, it was observed that patient and family were very anxious and disturbed about the disease condition and the long stay at the hospital.

They were educated on good personal hygiene which facilitated speedy recovery and promote good health and were informed to make good use of health facilities as well. Client and family were also educated on the need to adhere to good nutrition especially to include enough protein to help in early wound healing. Source of good food such as milk, beans, food rich in vitamin C like

oranges were encouraged to be taken. They were also informed to take enough vegetables and roughage to prevent constipation. They were educated on the drug prescribed for her and the need to comply with the treatment regimen. Information was given to them on the need for regular visit to the hospital and also to come for review on the specific date given to them.

Client and family were informed on when to come for wound dressing at the theatre after discharge and also not to engage in vigorous activities including lifting of heavy objects. Finally, client's wound was dressed, her name was then entered into the daily ward state and Admission and Discharge (A&D) book. After paying their bills at 1:00pm, I escorted them to the entrance of the hospital and reminded them of the impending visit to their home.

4.3 Follow Up/ Home Visit/ Continuity of Care

Follow-up and home visit play a vital role in the care of the client after discharge. It is done to find out how client and family are feeling at home and the use of available resources within the client's environment to solve any problem through their own efforts. It also helps to determine if there are any predisposing factors to client's condition so that the needed health education will be given to prevent any recurring disease.

First Home Visit (23/11/22)

This visit was arranged and made possible by the company of client's husband whiles client was still on admission. The reason for the visit was to assess the home environment of patient and to detect any predisposing factors and contributing cause to client's disease in the environment. And also, to assess how client will cope with the home environment after discharged.

I made the visit with her husband in the afternoon with commercial Car after he came to see his wife on admission. It was about 20minutes journey and we met her eldest daughter and other

family members. We exchanged greetings and the reason of the visit was explained to them. Client and family lives in a house built with blocks and roofed with roofing sheet. On observation, their source of water supply was from pipe borne, situated in front of the house. The building has a blue paint, consisting of four bed rooms, a hall, toilet and bath. The surrounding was clean with covered drains.

They were informed to maintain the clean environment to avoid any other diseases. After observing the environment, I realized that the patient can stay in the house after discharged. I then reassured them of client's progressing condition and sought permission to leave after I informed them about my next visit.

Second Home Visit (28/11/22)

During my second home visit, client was met in the house. It was a scheduled visit. The aim of the visit was to see how patient was responding to treatment, help solve any problem and to remind patient to come for review. The visit took place around 9:30am, all family members were very grateful and the patient looked cheerful. The wound was inspected for any drainage. Patient was asked about her eating and sleeping pattern, which she responded happily that it's better than the time she was hospitalized, during and a day after being discharged.

She was reminded to have enough rest and to avoid strenuous activities. The whole family was advised on the need to continue to maintain good personal and environment hygiene. I told them that the next visit will be my last visit and also informed them not to forget about the day of review was to be on the 2nd of December 2022.

Day of Review (02/12/ 2022)

On the day of review, client called me when she arrived and I met her at the Out Patient Department at Sunyani Regional Hospital. After exchanging pleasantries, I helped patient to collect her folder and handed over to the nurse who was in charge of vital signs. Her vital signs were checked as;

- Temperature - 36.9^{o}c
- Pulse - 83bpm
- Respiration - 21cpm
- Blood pressure - 120/80mmHg

She went to the consulting room. There was no complaint made by client. The doctor then advised the client to continue with her drugs and to report to the hospital if she experienced any abnormalities in her state of health. Doctor ordered tablet Amoxiclav 1g bd x5 and she was sent to dressing room for alternate stitches removal after which wound was dressed.

Third Home Visit (14th December, 2022)

I visited Madam K.R. and her family for the last time at home. The purpose of the visit was to terminate care and introduce a community health nurse to ensure continuity of care. On arrival at 4:00pm, the family welcomed me and offered a seat. After I was welcomed, I interacted with client and family. There were no complains and the family expressed their joy over the client's condition. I introduced the community health nurse from Sunyani Regional Hospital, Miss. Yvonne Adjei who accompanied me to the house. I then made it clear to them that since it was my last visit the community health nurse will continue with the care. I thanked them for their good interpersonal relationship and cooperation during admission and after discharged, after which I left.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/FAMILY

5.0 Introduction

According to Hinkle and Cheever (2018) evaluation is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process. Evaluation in nursing care seeks to measure the effectiveness of assessment, diagnoses and implementation. Patient's health status is compared to goals of health care to determine goals achieved. It involves the members of the health team, patient and her family. Unachieved goals of nursing care plan are amended and care is terminated afterwards with conclusions made on the care rendered.

5.1 Statement of Evaluation

During hospitalization, many goals were set with specific outcome criteria for the patient. They were aim at providing patient with holistic nursing care to ensure speedy recovery.

1.Patient was relieved of abdominal pain

At 7:00pm on 21/11/22, patient complained of abdominal pain and an objective was set to relieve patient of pain within 6 hours. Some of the interventions that were carried out to achieve this goal includes; Patient was reassured, Patient was assessed on the pain rating scale and recorded 7 before analgesic was given and recorded 1 after analgesic was given and diversional therapy was provided. On 22/11/22 at 1:00am the objective was evaluated and goal was fully met as evidenced by patient verbalized that pain has relieved and Nurse observed that client is relaxed in bed.

2. Patient achieved improved sleep pattern

On 21/11/22 at 8:00pm, patient complained of inability to sleep and an objective was set to achieve improved sleep pattern within 12hours and the following interventions were carried out; client sleeping pattern was assessed to help in planning nursing care, patient bed was made neatly free from creases and cramps, client environment was made calm by turning off television set, restricting visitors during sleep hours to ensure a sound and uninterrupted sleep, all nursing activities were grouped and carried out at a go and patient was given warm bed bath to help relax her. On 22/11/22 at 8:00am, objective was evaluated and goal was fully met as evidenced by patient verbalized that she had a sound night sleep and nurse observed client sleep for 8 hours.

3. Patient/Family were relieved of anxiety

On 22/11/22 at 7:45pm, patient and family were anxious and a nursing objective was set to relieve them of anxiety within 12hours. Some of the nursing interventions carried out include; Patient was allowed to express her fears and concerns, all questions were answered tactfully, every misinformation was clarified with honesty and in simple understanding language. Patient's family knowledge was assessed. Patient and family were reassured and all nursing procedures done on patient were explained. Patient was also introduced to other patients who have successfully recovered from appendectomy. Objective was evaluated on 22/11/22 at 7:45pm and goal was fully met as evidenced by the nurse observed that patient has relaxed facial expression.

4. Patient was relieved of incisional site pain

At 8:00pm on the day of operation (22/11/22), a diagnosis of impaired body comfort related to surgical incision was made. The following intervention was therefore carried out to help relieve patient of incisional pain within 6 hours. These include; Patient was reassured that the pain will

subside as nursing measures were being put in place to relieve her of the pain, to help allay her fear. Patient was encouraged to have enough bed rest. Noise level on the ward was minimized by controlling banging of door and turning down the volume of radio and television sets. Visitors were told to spend less time with her to reduce disturbances. Patient was also encouraged to avoid touching incisional site. Client was educated on proper nutrition and exercise. Objective was evaluated at 2:00am on 23/11/22 and goal was fully met as evidenced client verbalized relieve of pain and also client had a cheerful facial expression and was relaxed in bed.

5. Client/Family gained adequate knowledge about her disease condition

At 8:30am on 23/11/22, patient and family less knowledge on her condition and a nursing objective was set to help patient/family gain adequate information about her condition within the period of hospitalization. Some of the interventions that were carried out include; client was greeted and given a warm hand shake to help built rapport, assessing patient/family knowledge level on the appendicitis, educating patient and family on the causes, signs and symptoms and complications of appendicitis, allowing patient/family to ask questions that were bothering their mind about the condition and providing answers to patient/family questions in simple language to enhance her understanding. At 8:30am on 25/11/22, objective was evaluated and goal was fully met as evidenced by patient been able to mention some causes and signs and symptoms of appendicitis.

6. Patient was free from incisional wound infection

At 9:35am, a diagnosis of risk of infection related to surgical wound made. An objective was set to prevent patient from incisional wound infection throughout the period of hospitalization. The following interventions were carried out; a sterile trolley was set for wound dressing. Wound was dress aseptically. The wound was inspected for signs of infection on incisional site. She was

educated not to touch the incisional site and to report discharges. Vital signs were checked and recorded every 4 hourly. Instruments used for the dressing were decontaminated and Antibiotics such as IV metronidazole were administered. At 9:35am on 25/11/22, objective was evaluated and goal was fully met as evidenced by Nurse observed no signs and symptoms of infection and Patient verbalized absence of pain at the catheter site.

5.2 Amendment of Care

With the competent nursing care and support from other health members and cooperation of patient and family, all objectives set for patient were fully met. Therefore, there was no need for any amendment of goals set since there were no unmet goals. This went a long way to contribute to speedy recovery of the patient.

5.3 Termination of Care

This is the period in which the therapeutic relationship between the nurse and client comes to an end.

My interaction with patient and family started on 21st November, 2022 when Madam K.R was admitted at the Female's surgical ward at Sunyani Regional Hospital by Dr. Egote with the diagnose of acute appendicitis through to the date of discharge which was 25th November, 2022. It continued to follow-up after discharged.

The termination of care was done in a suitable manner from the beginning of interaction to prevent separation anxiety. She was informed that, my interaction with her will come to an end after she has been handed over care to the community health nurse to ensure continuity of care. One home visit was made when patient was on admission and two other follow up were also made after discharged. First home visit was made on 23rd November, 2022 during which patient's

environment was assessed to find out factors that contribute to patient's health problem. Second home visit was made on 28th November, 2022. During this visit, patient wound was observed for any sign of infection and to see how patient was responding to treatment. Patient was also reminded on the review date (2nd December, 2022). I introduced patient and family to a community health nurse on my third home visit (14th December, 2019) and also terminate care. During the visit I stressed on the need to avoid strenuous activities and to maintain environmental hygiene.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

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

6.1 Summary of Care Rendered

According to Webster (2010) summary is a brief statement of the most important information in a piece of writing or speech. Madam K.R a 42-year-old woman was admitted to the Females' surgical ward of Sunyani Regional Hospital through the emergency unit on 21st November 2022 at 6:30pm with the diagnosis of acute appendicitis. After going through the admission processes, she was made comfortable on an admission bed and was reassured of competent health care that could be rendered to her. Drugs prescribed for the patient throughout hospitalization includes;

- Injection Buscopan 40mg stat
- IV Ciprofloxacin 400mg bd x 72hrs
- IV Metronidazole 500mg tds x 72hrs
- Dextrose Normal saline 2000mls x 48hours
- Ringers lactate 2000mls x 48hours
- Normal Saline 2000mls x 48hours
- Suppository diclofenac 100mg bd x 5

- Tablet Paracetamol 1g tds x 5
- Tablet metronidazole 400mg tid x 7days
- Tablet Ciprofloxacin 500mg bd x 7days

Laboratory investigations such as Full Blood Count and Rapid Diagnostic Test were ordered and carried out. Abdominal scan was also ordered and carried out. Patient was taken to theatre on 22/11/2022 for the surgical removal of the inflamed vermiform appendix (Appendectomy). While on admission, nursing problems identified were; pain at the right lower quadrant of the abdomen, Patient complained of inability to sleep, Patient and family were anxious about the impending surgery, Patient had pain at the incisional site, Patient and family had insufficient knowledge about the condition and Risk of infection at Surgical site.

Objectives were set and nursing orders implemented to resolved them. Nursing interventions such as reassurance, observing client's wound for discharge, educating patient on her disease condition, assessing appropriate pain severity using pain scale and administering of prescribed drugs were carried out successfully. All goals were fully met and no amendment was made. Client's condition improved considerably and was discharged on 25th November, 2022 and was to report on 2nd December, 2022 for review. Three home visits were carried out. First home visit was done when my patient was still on admission with the aim of knowing the patient's residence and environment in which he resides and also to identify the predisposing factors to the condition. Second home visit was done after discharge to inspect the wound for drainage and to remind her on the review date. Patient came for review on 2nd December, 2022 where she was given Tab Amoxiclav 1g bdx5. Alternate stiches removal was done. The third home visit was to find out how patient was feeling and to hand over patient to the community health nurse to ensure continuity of care. After

interacting with them during the third home visit, I thanked patient and family for their cooperation throughout the study and I sort permission to leave. I was escorted by patient and her husband and we said goodbye to each other.

6.2 Conclusion

According to Hornby (2010) conclusion is the end of something. In a nutshell, the patient/family care study is of great benefit to me as it has made me understand what complete and comprehensive nursing care is and how to render it to an individual. It has given me the chance to put my knowledge acquired both theoretically and practically over the three-year training as a nursing student to use.

Choosing and nursing a client with a disease condition and the writing of this care study, has been challenging, good experience and very educative as well. This study has enhanced my knowledge on the concept of cause, signs and symptoms, diagnosis, treatment and possible prevention of acute appendicitis. It has also helped me established good interpersonal relationship with client and family, and this also helped client to achieved maximum health. The additional knowledge and experience I have acquired while nursing Madam K.R and her family would help me offer expert and comprehensive nursing care to other patients and the community as a whole where ever my service would be needed.

Also, it is my recommendation that all student nurses should be given the opportunity to embark on the patient/family care study, and implement the nursing process in order to render individualized comprehensive care to patient/families. In brief, I really enjoyed every bit of writing this script despite the challenges encountered.

APPENDIX

TABLE 6.1: Immediate Post-Op Vitals for Madam K.R on 22/11/2022

Time	Temperature	Pulse	Respiration	Blood Pressure
6:35pm	36.9^0c	106bpm	25cpm	135/90mmHg
6:50pm	36.8^0c	105bpm	24cpm	130/90mmHg
7:05pm	36.9^0c	104bpm	23cpm	130/90mmHg
7:20 pm	37.1^0c	104bpm	22cpm	130/90mmHg
7:50 pm	37.0^0c	96bpm	20cpm	130/80mmHg
8:20pm	36.7^0c	94bpm	21cpm	125/80mmHg
9:20pm	36.8^0c	99bpm	23cpm	120/80mmHg
10:20pm	36.5^0c	91bpm	20cpm	120/70mmHg
11:20 pm	36.2^0c	88bpm	22cpm	120/70mmHg
12:20 am	36.8^0c	86bpm	21cpm	110/70mmHg
4:20am	37.0^0c	84bpm	20cpm	110/90mmHg
8:20am	36.9^0c	84bpm	20cpm	110/80mmHg
2:00pm	37.0^0c	82bpm	21cpm	120/80mmHg
6:00pm	36.7^0c	84bpm	22cpm	120/80mmHg

TABLE 6.2: VITAL SIGNS FOR MADAM K.R DURING THE PERIOD OF HOSPITALIZATION.

DATE	TIME	TEMPERATURE	PULSE	RESPIRATION	BLOOD PRESSURE
21/11/22	5:00pm	37.6^0c	89bpm	20cpm	110/60mmHg
22/11/22	6:00am	37.1^0c	92bpm	22cpm	130/80mmHg
	2:00pm	36.9^0c	88bpm	22cpm	120/8ommHg
	6:35pm	36.9^0c	106bpm	25cpm	135/90mmHg
	7:00pm	36.9^0c	104bpm	23cpm	130/90mmHg
23/11/22	6:00am	37.3^0c	98bpm	25cpm	130/100mmHg
	2:00pm	37.2^0c	88bpm	21cpm	120/80mmHg
	10:00pm	37.0^0c	86bpm	22cpm	130/80mmHg
24/11/22	6:00am	36.9^0c	83bpm	21cpm	120/80mmHg
	10:00pm	36.8^0c	89bpm	23cpm	130/80mmHg
25/11/22	6:00am	36.9^0c	83bpm	21cpm	120/80mmHg

Table 6.3: Intake and Output for Madam K.R on 22/11/22 and 23/11/22

DATE/TIME	**INTAKE**		**OUTPUT**	
22 / 11/22	**KIND OF FLUID**	**AMOUNT OF FLUID**	**KIND OF FLUID**	**AMOUNT OF FLUID**
6:00am	Ringers lactate	500mls		
8:15am	Dextrose saline	500mls	urine passed at 10:00am	900mls
12:30pm	Ringers lactate	500mls		
5:45pm	Normal saline	500mls	urine passed at 6:00pm	800mls
7:00 pm	Dextrose saline	500mls		
8:30pm	Ringers lactate	500mls		
10:00pm	Dextrose saline	500mls	Urine passed at 10:15 pm	1400mls
23/ 11/22	**KIND OF FLUID**	**AMOUNT OF FLUID**	**KIND OF FLUID**	**AMOUNT OF FLUID**
2:00am	Ringers Lactate	500mls	Urine passed	400mls
5:30am	Normal saline	500mls		
6:00am	Total Intake 4500mls		Total output 3500mls	

Balance= Intake-output

Balance= 4500mls-3500mls

Balance= 1000mls

BIBLIOGRAPHY

Erickson, E. (1995*). Erick Erickson's Psychosocial Theory of Human Development, Eight Stages.* Retrieved from www.simplypsychology.org/Erik

Hornby, A.S. (2012). *Oxford Advance learner's Dictionary* (8th ed.). USA: Linppincott Wils and Winkins Company.

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner and Saddarth'sTextbook of Medical SurgicalNursing.(14th ed.).* Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins

Suddarth, D.S (1991). *The Lippincott Manual of Nursing Practice(5th ed.)* Philadelphia: J.B Lippincott Company.

Tortora, G.T & Bryan,D. (2010). *Principles of anatomy and physiology(12th ed.).*U.S.A: R.R Donnelley

Weller, B. (2018). *Bailler's Nurses Dictionary* (25th ed.). China: Flserter Limited.

Williams, S. L. & Hopper, D.P. (2013). *Medical and Surgical Nursing.* Philadelphia: J.B Lippincott Company.

Patient's Folder Number: AAG 8516

SIGNATORIES

The Student Nurse

Name: Henry Opoku

Signature: .....

Date: 03/07/2023

The Nurse In-Charge of the Females' Surgical Ward (Regional Hospital, Sunyani)

Name: Mrs. Barbara Y. Asante

Signature: ..... (for)

Date: 07/07/2023

The Supervisor (Holy Family Nursing and Midwifery Training College, Berekum)

Name: Ms. Grace Asantewaa

Signature: ..... (For)

Date: 3rd July 2023

The Principal (Holy Family Nursing and Midwifery Training College, Berekum)

Name: Monica Nkrumah

Signature: .....

Date: 17th July 2023

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM