HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM.

A CLIENT/FAMILY CENTERED NURSING CARE STUDY ON

SEVERE ANAEMIA

AGYEIWAA PRISCILLA

4120220014

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

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PREFACE

The nursing profession has developed throughout history seeing a lot of transformation in practice, type of caregivers, role and policy. Nursing has become a profession of caring and service to those in need, promoting the health of individuals, their families and the entire community. The patient/family care study is a detailed account of nursing care rendered to the patient and family to meet their needs. The study is designed to give a comprehensive nursing care to both patient and family from the time of admission till when patient is finally discharged, as well as follow-ups/home visits for continuity of care. The study provides a systematic way of collecting data, analyzing information, and reporting the results of nursing care. This patient/family care study is based on holistic care, considering all factors impacting the health of the patient.

The patient/family care study forms an integral part of the curriculum for educating nursing students hence a necessity for completing the nursing course and also a partial fulfillment of the requirement for the award of professional license by the Nursing and Midwifery Council of Ghana. Using the nursing process in caring for a patient, emphasis is placed on health promotion and maintenance, restoration of health and enhancing a peaceful death depending on the patient's condition. The nursing process is a series of organized steps designed for nurses to provide excellent care. This involves five phases, including assessing patient/family, making a diagnosis for patient/family, planning, implementing and evaluating nursing care. The nursing process offers a framework for thinking. The nursing process usually uses the NANDA taxonomy. The study is carried out to enable the student nurse put into practice the knowledge and skills acquired from the training period in school to ascertain how best the theoretical knowledge would be used to nurse patients who will come under his or her care in the near future. Initials were used instead of full name to maintain confidentiality and anonymity. The study serves as a reference paper for other student nurses and qualified health personnel who may be interested in its content.

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Finally, I am grateful to my entire family, my classmates and authors and publishers whose books have been used and those who have contributed in diverse ways to make the writing of my care study, a successful one, I say God bless you all.

INTRODUCTION

This comprehensive study was carried out on Miss O.A. a 25 years old girl, who was admitted to the female medical ward of Holy family hospital with the diagnosis of severe anaemia on the 22nd August, 2023. Client and relative were welcomed into the female's ward and taken through the admission process. I convened with her on the very day of admission. On admission, she presented with dizziness, general body weakness, difficulty in breathing, general malaise and loss of appetite. Patient and relatives were reassured of competent nursing care. She spent eight days at the hospital. Throughout her stay in the hospital, treatment and care was rendered to her and patient responded to interventions and was discharged on 29th August, 2023.

The following were the diagnostic investigations that were carried on Miss O.A.

1. Full Blood Count
2. Blood test for malaria
3. Grouping and Cross match

The following medications were given to Miss O.A.

1. IVF Dextrose in normal saline 1L overnight
2. Hydroxide Polymaltose Complex 20mg bid x 30days
3.IVF Normal Saline 500mls stat
4. Oral tothema 1 vial bd x 14days
5. IV Paracetamol 500mls 1G stat

With proper care and attention, she got well and was discharged on 29th August, 2023 without any complication. I made three follow up visits, two during admission and one after discharge and maintained the relationship between client and family until I eventually handed over to her mother in the client home for continuity of care.

The study is presented in six chapters which is in line with the nursing process.

Chapter one dealt with the assessment of patient and family. It includes Patient particulars, family medical and socio-economic history, lifestyle and hobbies, past and present medical history, admission of patient, patient concept of illness, literature review as well as data validation

Chapter two dealt with the analysis of data collected about patient and comparing this data with standards. It also involves identification of patients and family strength, their health problems and formulating diagnosis for them.

The chapter three concerns the planning of care for the patient and family where nursing care plan is drawn from the problems and used in the management of the patient.

In the chapter four, nursing interventions of the care plan were implemented. It entails giving the summary of the actual nursing care plan, preparation of patient and family for discharge and rehabilitation, follow up and home visit and continuity of care.

Chapter five concerns about evaluation and amendment of nursing care, thus assessing to check for fully or partially met or unmet outcome criteria and termination of care.

The final chapter gives the summary and conclusion of the care rendered to patient, followed by bibliography, reference and appendix.

CHAPTER ONE

THE ASSESSMENT OF PATIENT AND FAMILY

1.0 INTRODUCTION

This is the initial phase of the nursing process. Assessment is the gathering of information about the patient's health status, analysis and synthesis of the data and the making of a clinical nursing judgment (Weller, 2019).

It can be done through observations, physical examination, interviewing and investigation such as laboratory results. It includes the patient particulars, patient/family medical history, socio-economic history, patient developmental history, patient's obstetric history, patient's lifestyle/hobbies, patient's past and present medical/surgical history, admission of patient, patient/family concept of illness, literature review on anaemia and validation of data. All information was gathered from patient and her relatives and information on the Logistic Management Information (LMIS).

1.1 PATIENT'S PARTICULARS

Patient refers to an individual under medical care and treatment (Merriam-Webster, 2022). Particulars is defined as an individual fact or details regarding information (Merriam-Webster, 2022). Patient particulars give detailed information about the patient including his/her name, age, hometown, date of birth, nationality, religion, etc.

Miss O.A. is a 25-years old girl born on the 21st Febuary,1998 at Berekum. She is dark in complexion; she weighs 85kg and a height of 1.4m tall and she is a Ghanaian by nationality. Miss O.A. is a National Health Insurance (NHIS) beneficiary. She comes from Berekum (Kutre) in the Bono Region, with the house number H/13 at Abrodwam. Mr. K.Y and Madam A.G are her parents. They are living in a compound house painted in yellow., O.A. is the Last born of her parents and has three (3) siblings and they are A.L., A.S., A.G.

O.A is a Christian and attends Assembles of God. O.A.is an Akan and she speaks Twi and English and a Student Tailor at Kutre number 2. Patient has no physical impairment on assessment. Miss O.A. is not married but has one child with Mr. K.P. The next of kin is her

boyfriend Mr. K.P., who stay with her at Kutre number 2 with house number H/3 at Abrodwam Patient's folder number is B2420.

1.2 PATIENT'S/FAMILY MEDICAL HISTORY

Health history is a holistic assessment of all factors affecting a patient's health status, it is designed to assess the effects of health care deviations on the patient and family, to evaluate teaching needs, and to serve as the basis of an individualized plan for addressing wellness (Miller-Keane, 2020).

According to Miss O.A. she said there are no known chronic or familial diseases such as hypertension, asthma, diabetes, epilepsy and leprosy in the family. She and the family sometimes get minor ailments like headache, menstrual cramps and fever of which they patronize drugs from the pharmacy for treatment. As a student nurse I educated them to desist from buying unprescribed drugs from over the counter and encouraged them to always visit the nearby hospital when they are not feeling well. Patient said this is her first time of suffering from anaemia. The parent of Miss O.A. are both alive and in a health state as well as her Sibilings. Their source of medical care financing was National Health Insurance Scheme (NHIS) which they use any time they report to the hospital. The family members are allergic to snail.

1.3 PATIENT/FAMILY SOCIO-ECONOMIC HISTORY

Hellmich (2019), states that socio-economic history relates to a combination of an individual's income occupation, Miss O.A is from the middle socio-economic class family so they are able to meet most of their daily expenses though they sometimes face some difficulties in purchasing some of their needs. The family members have a cordial relationship and thus give the necessary help to each other when the needs arise. The father is a famer where he makes his income through the food stuff he sells and the mother is a trader who also makes income out of the food she sells. Miss O.A. depends fully on her brother who is a teacher for financial support. According to Miss O.A. her brother ends a monthly salary which estimate about thousand-five. According to Miss O.A, most of the family members are Christian's and they uphold Christian values and cultural practice dearly. Also, they attend funerals, weddings, and other social activities organized in the community including communal labor. Others believe in taboos, myths and respect people from other religion, Also the family is well respected in the area in

which they find themselves. Miss O.A. usually attends Sunday church service. Miss O.A. stated that the source of medical financing in the family is the national health insurance scheme (NHIS).

1.4 PATIENT'S DEVELOPMENTAL HISTORY

Development is the process of growth and differentiation which involves cognitive, psychosexual and psychosocial processes (Weller, 2014). Growth is the progressive development of a living thing, especially the process where the body reaches its complete physical development (Weller, 2019). Maturation refers to the process of ageing (Weller, 2019).

The patient developmental history was provided by the mother. Miss O.A.'s mother mentioned that she had a normal nine-month pregnancy with no pregnancy related problems and had a spontaneous vaginal delivery at Home, without any deformity. She was immunized against childhood vaccine-preventable disease, as established by Bacillus Calmette Guerin (BCG) scar on her right upper arm. According to miss O.A.s mother, she could cry and move her limbs at the 8^{th} week. Miss O.A. was very aware of her environment, she could raise her head and arms from surface and her eyes could follow movement of object at the 12^{th} week. On 22^{nd} week she developed her first milk teeth. she was breastfed for four (4) months before she started eating supplementary foods. She started crawling at the 9th months, walking at age two and started talking at age three (3) and she stop bed wet at age 5. She did not suffer from any congenital abnormalities when growing. At age 3 she started schooling at word of friends in Berekum and later stope when she was in JHS2 and continue at saint Theresa where she completed. she continued her SHS at Methodist senior high and completed at 2019. She experienced her secondary sexual characteristics such as development of breast, growing of pubic hair around age thirteen (13) and had her menarch around age14. She is a now a student tailor. Miss O.A. has a man in her life and therefore she has engaged herself in sexual activities and she has one child. When asked about her goals and intentions for the future, Miss O.A.

stated that she wanted to become a lawyer in the near future. She also said that she has a regular menstrual cycle and that she usually gets her menses every twenty- eight days. She usually menstruates for four (4) days with mild pains in the lower abdomen.

Erick Erikson (1902-1994) focused on the role of cultural and socio-economic influences in behaviour. Erikson was concerned with the development of ego, the concious, organised and

logical aspect of the personality. He explained eight stages of ego development from birth to death. Each stage is marked by a specific conflict, crisis, pertaining to individual's biological and, which will maturity and what society aspects of a person at that age. Miss O.A. falls within the sixth stage, Intimacy verses Isolation (19years to 40 years). According to Erickson, intimacy is loving relationship of any sort. It requires sharing yourself with other. They explore personal relationship because they want to fit in the society. Erickson believed it is vital that people develop close, committed relationship with other people. Those who are successful at this stage will have the ability to love and have a committed and secured relationship. Some people seek deep intimacy and satisfying relationship, but if unsuccessful isolation occurs. Miss O.A. has achieved the intimacy stage because she has developed close, committed relationship with other people. According to Miss O.A. she is leaving with her boyfriend.

1.5 PATIENT'S OBSTETRIC HISTORY

Obstetrics is a branch of medical science that deals with pregnancy, childbirth, and the postpartum period (Merriam-Webster,2023). According to miss O.A, she had her menarch around the age of fourteen. She revealed that she has had sexual intercourse and she has a child. She also said that she has a regular menstrual cycle and that she usually gets her menses every twenty- eight days. She usually menstruates for four (4) days with mild pains in the lower abdomen.

1.6 PATIENT'S LIFESTYLE AND HOBBIES PATIENT'S OBSTETRIC HISTORY

Life style is defined as the typical life of an individual or group (Merriam-Webster, 2022). Miss O.A usually goes to bed around 10pm. She wakes up in the morning around 5am and maintains her oral hygiene with the use of tooth brush and tooth paste. She then empties her bowel, takes her bath with tepid water and she then dress up her child for school during the week days. According to miss O.A she sometimes takes in hot tea with bread as breakfast before she leaves for work. She said, she normally takes her breakfast around 10am at work and continue sewing afterwards. She takes her launch around 1pm. Her favourite meal is banku with okro’ stew. She normally helps her child do her home work in the evening at 8pm. After work she picks her child from school. She takes her supper around 6pm and takes her bath. She then watched television

with her boyfriend. She dislikes someone who gossip and does not respect the elderly. Miss O.A is interested in playing netball. She normally washes her dirty clothes on Saturdays. On Sundays, she prepares for church in the morning. She closes from church around 1pm and takes her lunch. She then spent more time with her child. Afterwards, she prepares for upcoming week by ironing her dress together with her man and child.

1.7 PATIENT'S PAST MEDICAL HISTORY

Past medical history is a record of past medical problems and treatments that a person has had (Merriam-Webster, 2022). According to miss O.A, she did not experience any childhood illness like measles, tuberculosis, poliomyelitis, tetanus and has no allergy to drugs. She said she usually suffers from minor ailments like headache and common cold which she treats with over- the-counter medications. Miss O.A said she has not had any accident or injuries. She does not go for medical check-up. She is a registered member of the National Health Insurance Scheme and have easy access to health care whenever she attends hospital. She has been hospitalized once when she gave birth on 25th March,2018.

1.8 PATIENTS PRESENT MEDICAL HISTORY

The history of the present illness or problem includes such information as the date and manner (sudden or gradual) in which the problem occurred, the setting in which the problem occurred, and the course of the illness including self-treatment, specific symptoms are also described in detail (Hinkle & Cheever, 2018).

According to Miss O.A. she was well until 22nd of August, 2023, when she experienced general feeling of unwell which started with dizziness, general body weakness, difficulty in breathing, general maliase and loss of appetite. Patient said she was in agony and crying bitterly where Mr. K.P. decided to take her to the hospital that is Holy Family Hospital. The signs and symptoms started in the morning around 8:30am and had a sudden onset. Miss O.A. stated it was the first time she experienced those signs and symptoms.

She reported to Holy Family Hospital, Berekum at 11:00am where she was attended to by Dr. A.M. She was looking pale and complained of dizziness, general body weakness, difficulty in breathing, general maliase and loss of appetite. Patient blood sample was taking to the laboratory and result confirmed low hemoglobin level and with the above signs and symptoms, the doctor

made a diagnosis of severe aneamia. The doctor detained her to the Accident and Emergency ward where she was later transferred to the Female ward.

1.9 ADMISSION OF PATIENT

Admission is the act or process of accepting someone into a hospital, clinic or other treatment facility as an inpatient (Merriam –Webster, 2023).

Miss O.A was trans into the female's medical ward from the accident and emergency unit on 22nd August, 2023 at 3:00pm accompanied by a staff nurse and the boyfriend. Patient was ambulant. They were warmly welcomed by the staff on duty and a confirmation was done on the system to know that indeed the patient was trans in to the female's ward. A well-prepared admission bed, free from creases and cramps was given to make the patient comfortable because she was feeling dizzy. The patient and her boyfriend were introduced to staff on duty. Tight clothes were removed from patient. They were reassured that the patient was in competent hands and everything possible will be done to ensure her recovery. The patient particulars such as name, date of admission, time, age, and next of kin among others were taken and recorded in the ward admission and discharge book. A quick assessment of the patient general appearance was made and vital signs were checked and recorded accurately as follows;

Temperature……. 37.5℃

Pulse…….127bpm

Respiration…… 23cpm

Blood Pressure……149/93mmHg

SPO2……96%

Weight ……85kg

Patient treatment plan are as follows;

1.IVF Dextrose in Normal Saline 1L Overnight

2.Hydroxide Polymaltose complex 20mg BID x 30days

3.IVF Normal saline 500mls stat

4.Oral tothema 1 vial BD x 14days

5.IV paracetamol 500mls 1G stat

Laboratory Investigation Ordered Includes;

1. Full blood count

2. Blood film test for malaria

3. Grouping and cross matching

The need for blood transfusion was explained to her. Four unit of blood was ordered for patient and one unit was retrieved from the blood bank. Patient was educated on the blood transfusion and pretransfusion vital signs was done and recorded as

Temperature……. 38.8^0C

BP……. 130/90mmHg

Pulse…… 127bpm

SPO2…… 92%

Respiration……. 30cpm

Teachings was done prior to transfusion about the possible reaction that may occur during the transfusion process such as rashes, chills, itching, and fever and documented accordingly. Afterwards blood was set up at 7:00pm and completed successfully at 9:10pm. Upon interaction with patient and observation and assessment made during the transfusion process there was no post transfusion reaction. Intravenous paracetamol 500mls in 1G was administered accordingly to alleviate pains and to control the high body temperature of 38.8^0C.

Miss O.A. was asked if she has any valuable items with her that the ward can keep safe for her but she insisted she would like to keep everything with her. Miss O.A. boyfriend was informed about the ward policy on visiting hours, ward rules, items that were needed during hospitalization. He was oriented to the ward by showing them the toilet and bathroom, and the nurse's station. They were also introduced to other patient at the ward. Miss O.A. and the boyfriend was informed of the ward routine such as time of the doctor's rounds, serving medications, checking vital signs and was encourage to call the nurses whenever the needs arose. Patient was already a registered member of the National Health Insurance Scheme so she was advised to continue renewing whenever it expires. Patient and the boyfriend were briefed on visiting hours which were 5:30am-6:30am in the morning, 12:30pm-1:30pm in the afternoon and 4:30pm-5:30pm in the evening each day. Discharge planning was also initiated between the patient and relative by telling them that the hospitalization is temporary period and that patient will be discharged home after the treatment.

An introduction of self was done to the patient again as a student nurse of Holy Family Nursing and Midwifery Training College, Berekum who would like to use her and her family for care

study. An explanation was given to the patient and her family, to seek consent and the concept of the patient/family care study and assured them of privacy and confidentiality. The patient and family were informed that they will be visited in their homes during admission and after discharge. Consent was inquired from Miss O.A. and her family accepted the request and promised to offer the necessary information and assistance that will needed throughout the entire study. Patient and family were congratulated on their decision made. The family was made aware that Miss O.A. admission to the ward was a temporal one and so will be discharged to continue the care at home once she is well. This condition was chosen because it is a common condition in society, so having a patient with this condition will create the opportunity to enrich more knowledge base concerning the cause of the disease, its signs and symptoms, and the treatment.

1.10 PATIENT'S/FAMILY CONCEPT OF HER ILLNESS

Miss O.A. believe that it is natural that people fall sick at one point in time. Miss O.A. was anxious about her condition since this is her first time she has been admitted to the hospital with such diagnoses. She did not attribute her condition to any supernatural forces. She was hopeful that with the help of God and quality medical and nursing care she will recover very soon. She was therefore looking forward to be discharged home as soon as possible with the help of competent nursing staff and quality care.

1.11 LITERATURE REVIEW

This section deals with documented information about Miss O.A diagnoses that is severe anaemia. Literature review of a condition gives a detailed insight into the condition. It talks about the established and laid down facts about the disease condition, which aids in the medical and nursing diagnoses and the appropriate management for that particular diseases. It comprises of the following:

- Definition
- Incidence
- Aetiology / Causes
- Types
- Pathophysiology
- Clinical features

- Diagnostic investigations
- Medical management
- Nursing management
- Prevention
- Complication

Definition of Anaemia

Anaemia is present when there is a decrease in haemoglobin in the blood below the reference level for the age and sex of the individual. Alterations in haemoglobin concentration may occur as a result of changes in the plasma volume. A reduction in the plasma volume will lead to a spuriously high haemoglobin; this is seen in dehydration and in the clinical condition of apparent polycythaemia. A raised plasma volume produces a spurious anaemia, even when combined with a small increase in red cell volume, as occurs in pregnancy. Anaemia can be classified in a variety of ways. For example, it can be divided into that due to decreased production or increased destruction, or alternatively into inherited or acquired causes. One common way of categorizing the various types of anaemia is by the Mean Corpuscular Volume. (Kumar & Clark, 2021).

Incidence of Anaemia

According to World Health Organization (W.H.O) the incidence of anaemia is extremely high particularly in developing countries where nutrition is poor. It is a serious global public health problem that particularly affect young children and pregnant women. WHO estimates that 42% of children less than 5 years and 40% of pregnant women worldwide are anaemic. It is also high in the tropical regions where hookworm and malaria are endemic. Women of the reproductive age especially pregnant women and children are the most vulnerable. Elderly people are not left out in this and it is the most common haematological condition that affect the elderly (Smeltzer, Bare, Hinkle & Cheever, 2019).

Types of Anaemia

According to (Kumar & Clark,2021), the types of anaemia can be classified based on either the aetiology or morphology of the red blood cell. Aetiological classification is related to the clinical condition causing anaemia such as decrease erythrocytes destruction. Morphological classification is based on descriptive and laboratory information about erythrocytes, size, and colour. They are as follows;

1.Nutritional Anaemia

. Aplastic Anaemia

. Iron Deficiency Anaemia (Ida)

. Pernicious Anaemia

2.Hemolytic Anaemia

. Sickle cell Anaemia.

. Glucose-60-Phosphate Dehydrogenase Deficiency

. Thalassaemia

. Auto-Immune Anaemia

3.Hyperchromic Macrocytic Anaemia

4.Hypochronic Microcytic Anaemia

5.Normochromic Normocytic Anaemia

1.Nutritional Deficiency Anaemia

- Aplastic Anaemia

Aplastic anaemia is defined as pancytopenia with hypocellularity (aplasia) of the bone marrow; there are no leukaemia, cancerous or other abnormal cells in the peripheral blood or bone marrow. It is usually an acquired condition but may rarely be inherited. Aplastic anaemia is due to a reduction in the number of pluripotent stem cell, together with a fault in those remaining or an immune reaction against them so that they are unable to repopulate the bone marrow. Failure of only one cell line may also occurred, resulting in isolated deficiencies such as the absence of red cell precursors in pure red cell aplasia. Evolution to myelodysplasia, paroxysmal nocturnal haemoglobinuria (PNH) or acute myeloid leukaemia occurs in some cases, probably owing to the emergence of an abnormal clone of haemopoietic cells. (Kumar & Clark, 2021).

- Iron Deficiency Anaemia (IDA)

Iron deficiency anaemia develops when there is inadequate iron for haemoglobin synthesis. The causes. Blood loss, increase demands, e.g. growth and pregnancy, decreased absorption (e.g. post – gastrectomy), poor intake. Most iron deficiency is due to blood loss, usually from the uterus or gastrointestinal tract. Premenopausal women are in a state of precarious iron balance owing to menstruation. A common cause of iron deficiency worldwide is blood loss from the gastrointestinal tract resulting from parasites such as hookworm infestation. The poor quality of

the diet, predominantly containing vegetables, also contributes to the high prevalence of iron deficiency in low income countries. Even in developed countries, iron deficiency is not uncommon in infancy, when iron intake is insufficient for the demands of growth. It is more prevalent in infants born prematurely or where the introduction of mixed feeding is delayed. (Kumar & Clark,2021).

C. Pernicious Anaemia

Pernicious anaemia (PA) is an autoimmune disorder in which there is atrophic gastritis with loss of parietal cells in the gastric mucosa and consequent failure of intrinsic factor production and vitamin B12 malabsorption. (Kumar & Clark,2021).

2. Hemolytic Anaemia

Hemolytic anemia is caused by increased destruction of red cells. The red cell normally survives about 120 days, but in hemolytic anemia the red cell survival times are considerably shortened. Breakdown of normal red cells occurs in the macrophages of the bone marrow, liver and spleen. (Kumar & Clark,2021).

- Sickle Cell Anaemia

SCD can cause a severe hemolytic anemia that result from inheritance of the sickle hemoglobin (HbS) gene, which causes the hemoglobin molecule to be defective. HbS acquires a crystal-like formation when exposed to low oxygen tension. The oxygen level in venous blood can be low enough to cause this change; consequently, the erythrocyte containing HbS loses its round, pliable, biconcave disc shape and becomes dehydrated, rigid, and sickle shaped. These long, rigid erythrocytes can adhere to the endothelium of small vessels; when they adhere to each other, blood flow to a region or an organ may be reduced. If ischemia or infarction results, the patient may have pain, swelling, and fever. The sickling process takes time; if the erythrocyte is again exposed to adequate amount of oxygen before the membrane becomes too rigid (e.g., when it travels through the pulmonary circulation), it can revert to a normal shape. For this reason, the ‘sickling crises’ are intermittent. Cold can aggravate the sickling process, because vasoconstriction slows the blood flow. Oxygen delivery can also be impaired by an increased blood viscosity, with or without occlusion due to adhesion of sickled cells; in this situation, the effects are seen in larger vessels, such as arterioles. (Hinkle & Cheever, 2018).

- Glucose-6- Phosphate Dehydrogenase Deficiency

The glucose-6-phosphate dehydrogenase (G6PD) enzyme occupies a vital position in the hexose monophosphate shunt oxidizing glucose-6- phosphate to 6-phosphoglycerate with the reduction of NADP to NADPH. The reaction is necessary in red cells where it is only source of NADPH, which is used via glutathione to protect the red cell from oxidative damage. G6PD deficiency is a common condition that present with a hemolytic anemia and affects millions of people throughout the world, particularly in Africa, around the Mediterranean, and in the Middle East (around 20%) and South-east Asia (up to 40% in some regions). (Kumar & Clark, 2021).

- Thalassaemia

The thalassaemias affect people throughout the world, and at least 60000 severely affected individuals are born every year. Normally, there is balanced (1:1) production of α and β chains. The defective synthesis of globin chains in thalassaemia leads to 'imbalanced' globin chain production, causing precipitation of the excess globin chains within the red cells leads to hemolysis. This concept globin chain imbalance is critical in understanding the relationship between a patient's genotype and phenotype (the greater the imbalance, the words the phenotype), as well as understanding how novel therapies are being used to ameliorate the disease. (Kumar & Clark, 2021).

- Auto-Immune Anaemia

Autoimmune hemolytic anemias (AIHAs) are acquired disorders resulting from increased red cell destruction due to red cell autoantibodies. These anemias are characterized by the presence of a positive direct antiglobulin (coombs) test, which detects the autoantibody on the surface of the patient's red cells AIHA is divided into 'warm' (65%), 'cold (30%) and mixed (5%) types depending on whether the antibody attaches better to the red cells at body temperature (37^{o}C) or at lower temperatures. The major features and the causes of these two forms of AIHA are shown in warm AIHA, IgG antibodies predominate and the direct antiglobulin test is positive with IgG alone, IgG and complement, or complement only. In cold AIHA, the antibodies are usually IgM. They easily elute off red cells, leaving complement, which is detected as C3d. (Kumar & Clark, 2021).

CLASSIFICATION OF ANAEMIA ACCORDING TO THE MORPHOLOGY OF THE CELLS AND HAEMOGLOBIN CONCENTRATION.

3. Hyperchromic Macrocytic Anaemia

In this type of anemia, the red blood cells are fewer but larger than normal (macrocytic) with increase haemoglobin content (hyperchromic). It is caused by lack of vitamin B12 or folic acid (Kumar & Clark, 2021).

4. Hypochromic Microcytic Anaemia

Microcytic anemia most commonly results from iron deficiency, the most common cause of anemia globally, affecting 30% of the world's population. This is because of the body's limited ability to absorb iron and the frequent loss of iron owing to bleeding. Although iron is abundant, most is in the insoluble ferric (Fe3) form, which has poor bioavailability. Ferrous (Fe2) irons is more readily absorbed. (Kumar & Clark, 2021).

5. Normochromic Normocytic Anaemia

Normocytic, normochromic anemia is seen in anaemia of chronic disease, in some endocrine disorders (e.g. hypopituitarism, hypothyroidism and hypoadrenalism) and in some haemotological disorders (e.g. aplastic anemia and some haemolytic anemias). In addition, this type of anemia is seen acutely following blood loss. (Kumar & Clark, 2021).

AETIOLOGY OF ANAEMIA

According to (Kumar & Clark, 2021), the causes of anaemia vary among different school of thought. These include;

- Disease condition e.g. malaria, cancers, hookworm infestation
- Nutrition deficiencies such as vitamin B12, folic acid, ascorbic acid and protein deficiencies
- Haemorrhage (excessive blood loss)
- Haemorrhoids causes iron deficiency anemia due to rectal bleeding which result in large amount of blood being lost from the body
- Haemolysis (excessive destruction of erythrocytes)
- Chemicals or drug (cytotoxic drugs) with the potentials to suppress bone marrow activities
- Morphological abnormalities (structure, shape and size)

PATHOPHYSIOLOGY OF ANAEMIA

The appearance of anaemia either reflect bone marrow failure i.e. excessive red blood cell loss or reduced erythropoiesis or both. Bone marrow failure may occur as a result of a nutritional

deficiency, toxic exposure, tumour invasion or as in many instances from unknown causes. Red blood cell may be lost through haemorrhage or haemolysis. The red cells which are produced in the bone marrow transport oxygen to the tissues.

Physiological, anaemia reduces the oxygen carried to the tissue resulting in deficient oxygen supply (hypoxia) to the tissues leading to reduced metabolism. The tissue hypoxia brings about an increase in carbon dioxide retention and hence decrease in respiratory rate which causes hyperventilation. The reduced blood volume also triggers an increase in the heart rate hence, tachycardia and palpitation. The deficiency in blood result in headache, dizziness, pale conjunctiva, tiredness and weakness among others as signs and symptoms. (Kumar & Clark, 2021).

GENERAL CLINICAL FEATURES OF ANAEMIA

According to (Kumar & Clark, 2021), the clinical features of anemia are as follows;

. Breathlessness

. fatigue

. Headaches

. Palpitation

. Faintness

. Pallor

. Tachycardia

. Systemic flow murmur

. Cardiac failure

. Jaundice

. Bone deformities

. Leg ulcers

. Brittles nails

. Angular stomatitis

. Brittle hair

. Spoon-shape nails

. Oedema

DIAGNOSTIC INVESTIGATIONS

There are more haematological test and other investigation that can be done to determine the type and causes of anaemia. (Kumar & Clark, 2021), some of these are as follows;

- Physical examination
- Blood film for malaria parasite
- Sickling solubility test
- Red bone marrow examination
- Haemoglobin level estimation
- Haematocrit
- Erythrocyte sedimentation rate
- A test for vitamin B12 absorption (schilling test)
- Blood smear reveals variation in size, shape and number of cells
- Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination

MEDICAL TREATMENT OF ANAEMIA

According to (Kumar & Clark, 2021), Medical treatment of anemia can be directed as follows;

- Treating the underlying cause of anemia and restoration of hemoglobin level to normal i.e. 14-18g/dl in males and 12-16g/dl in females.
- Replenishing iron store after correction of anemia in iron deficiency.

In order to achieve the above objective, the following treatment regimen can be given;

- Blood transfusion in severe cases
- Iron preparation like ferrous sulphate orally. Adult. 200mg tid x 30 days
- Give antimalarial drug if anemia is due to malaria.
- Administer antihaemorrhoidal drugs like Himalaya Pilex 1 TDS x 14days and phlebodia 600mg BID x 14days when anemia is as a result of haemorrhoids
- In the case of sickle cell anemia, hydroxyuria which is effective in increasing haemoglobin level and decrease the formation of sickle cell can be given
- Folic acid can be given and the dosage depends on the condition but it can be given prophylactically. The dosage is as follow, adult 5mg daily x 30days, children 2.5mg daily x 30days

- If anemia is due to worm infestation, tabs albendazole can be given, adult 400mg bd x 3days, children 200mg daily x 3days.
- Tabs vitamin C 200mg tid x 7days.
- Analgesics like tabs tramadol, paracetamol to relieve pain
- Haematenic. Eg. Hydroxide polymaltose complex and Oral Tothema
- Antibiotics may be given to control and treat infections. Some of the antibiotics that can be given include; ciprofloxacin, amoxicillin, and metronidazole.

SURGICAL TREATMENT OPTION

According to (Kumar & Clark, 2021), the surgical management of anemia are as follows;

. Bone marrow transplantation can be done if anemia is due to bone marrow depression

. Splenectomy is done if anemia is caused by hypersplenism

. Stripping and ligation can be done if blood vessels are damaged due to trauma

NURSING MANAGEMENT OF ANAEMIA

According to (Hinkle & Cheever, 2018), nursing management of a client with anaemia is focused on the replacement of the lost blood and if possible the correction of the condition. It is also in the objectives to the nurse to ensure prevention of possible complications whiles on admission. The nursing management of patient with anaemia can be grouped under the following headings.

Diet

The nurse should explain to the patient and family that there is a direct relationship between a balanced diet and resolving the disease. The following are the nursing management on diet;

. The nurse must ensure that the client is served with a well-balanced diet as much as possible. The diet should be rich in iron, protein, vitamin etc. Some of the food advisable for the patient includes egg, milk, vegetables, meat, fruit like banana, orange and so on.

. Give iron and folic acid supplement daily.

. Diet must be served in bits to enhance appetite

. Pass NG tube if necessary.

Rest and Sleep

Rest and sleep should be observed since this can promote fast recovery. The following point are noted to ensured rest and sleep;

. Dress the bed to be free from creases and cramps

. Restrict visitors

. Minimize noise and improve ventilation by opening windows and funs

. Plan activities in such a way that they don't interfere with the patient's time of rest and sleep

. Give warm bath and serve beverages at bed time

. Assess patient's sleeping pattern

. Administer prescribed analgesics and sedatives

PERSONAL HYGIENE

. The relevance of personal hygiene must be explained to the client

. The patient has to be educated on the need to bath at least twice daily and if the client is bed ridden, bed bathing should be given.

. Assist the client to trim his/her nails and also care for hair of the patient

. Ensure oral hygiene twice daily

. Advice the patient on washing the hands after visiting toilet

CHEMOTHERAPY

. Administer prescribed antianemic drugs and chart them

. Observe for any side effects and report appropriately

. Educate patient on the side effect of the drugs

. Educate patient on the contraindication of the drug.

OBSERVATION

. General physical appearance of the client should be observed and examination including the colour of the skin and mucus membrane, nature of the hair and nails.

. Check and record vital signs four hourly or as directed.

. Observe and estimate the level of anxiety in client and family.

. Observe for bed sore and treat if any

. Look for signs of shock including tremors, hypotension, and clummy skin.

. If patient is on transfusion, monitor for reaction example; sweating, restlessness, rashes, flushing.

. Check out for any reaction or side effects of drugs and report if any.

. Observe and record intake and output of the client.

PSYCHOLOGICAL CARE

. Reassure patient and family of competent care.

. Introduced the patient to other patients especially those recovering from similar sickness.

. Encourage client to ask questions about her condition and express her feelings and take time to address those questions.

. Explain every procedure to be carried on the patient and family.

. Establish an effective interpersonal relationship between yourself and the client and family.

HEALTH EDUCATION AND PREVENTION

. The nurse should educate the client and family on the causes, signs and symptoms, treatment and prevention of anaemia.

. The patient should be advised against self-medication.

. Educate the patient to take a well-balanced diet.

. Inform the client to report any abnormality to the hospital after discharge.

COMPLICATION OF ANAEMIA

According to (Kumar & Clark, 2021), the complication of anaemia include;

- Hepatomegaly (Enlargement of the liver)
- Splenomegaly (Enlargement of the spleen)
- Congestive heart failure. (Failure of the heart muscle to pump or expel enough blood)
- Renal failure. (Inability of the kidney to remove metabolic waste and balance fluids)
- Growth retardation in children. (Failure of children to grow)
- Shock (The state of insufficient blood flow to the tissues)
- Cerebral infarction
- Transient ischemic attacks (brief interruption of blood flow to the brain less than a five minutes)
- Myocardial infarction (Blockage of blood flow to the heart muscles which causes death to the tissues of the heart)

1.12 VALIDATION OF DATA

Validation is also the process where a valid assessment of data is made to render quality nursing care to patient and families to prevent errors in the care plan and to aid speed recovery (New Concise Medical Dictionary, 2016). It is the act of measuring or indicating the quality of a data collected as far as it can be judged. This is to ensure that, data compiled on patient and relatives

are free from biases. The information given by Miss O. A. and relatives were compared with those in the patient's folder. Visits to the patient house also confirmed most of the information given by Miss O.A. The data collected from patient, health workers (medical team and nurses), patient's folder, laboratory investigation and physical assessment were compared with literature review to ensure that information collected was free from errors, bias and misinterpretations. The collected data on Miss. O.A. were valid and reliable for the study since no difference was seen in the entire sources.

CHAPTER TWO

ANALYSIS OF DATA COLLECTED

2.O INTRODUCTION

According to Turnbull & Philips (2017), analysis is a careful examination of something in order to understand it better or fine out what it consists of. This is the second phase of the nursing process. It involves the act of sorting out pieces of information collected from the patient, family, and friends to bring out the actual and potential problems; so that solutions can be found for the problems.

The chapter comprises;

. Comparison of data with standards

. Patient and family strength

. Patient health problems

. Nursing diagnosis

2.1 COMPARISON OF DATA WITH STANDARDS

This deals with comparing the data obtained with that of the standards. These include;

- Diagnostic investigation
- Causes
- Clinical features
- Treatment
- Complication

DIAGNOSTIC INVESTIGATION/ TEST

Diagnostic investigation is a study conducted on a patient to confirm the condition he/she is suffering from and to find the causes of a disease to guide treatment plan. (Kumar & Clark ,2021).

To help in the diagnosis and treatment of Miss. O.A., the following investigations were carried out on Miss O.A. during her period of hospitalization;

- Blood for grouping and cross matching
- Full blood count
- Blood film test for malaria parasite

The test that were carried out are compared on the table 1 below

Table 1; Comparing the laboratory investigation carried out on Miss O.A. with those stated in the literature review

Laboratory Investigation Stated in the literature review	Laboratory investigation carried out on the patient
Physical examination	Physical examination was done
Blood film for malaria parasite	Blood film for malaria parasite was done
Sickling test	Sickling test was not done
Red bone marrow examination	Red bone marrow was not done
Haemoglobin level estimation	Haemoglobin level estimation was done
Haematocrit	Haematocrit was not done
Erythrocyte sedimentation	Erythrocyte sedimentation was not done
A test for vitamin B12 absorption	A test for vitamin B12 absorption was not done
Blood smear reveals variation in size, shape, and number of cells	Blood smear was not done
Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination	Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination was not done

From table 1 most of the test done on Miss O.A was in literature review. However, blood grouping and cross matching was done to estimate corpuscular volume and prevent incompatibility though it was not mentioned in the literature review.

Table 2; Diagnostic Investigation/Test carried Out on Miss O.A.

DATE	SPECIMEN	INVESTIGATION	RESULT	NORMAL VALUE	INTERPRETATION	REMARKS
22/08/23	Blood	Haemoglobin level estimation	6.1g/dl	Male 12-18g/dl Female 11-16g/dl	Patient was very anemic since her haemoglobin level was below normal	Whole blood transfusion and Haematenics like hydroxide polymaltose complex were administered.
22/08/23	Blood	Red blood cell count	2.46 10^6/UL	4.50-5.50K/UL	Patient red blood cell was below normal range indicating the present of anaemia.	Whole blood transfusion and Haematenics like hydroixed polymaltose complex 20mg given twice daily.
22/08/23	Blood	White blood cell count	6.83 10^3/UL	2.6 8.50K/UL	Patient white blodd cell count was within normal range.	No treatment was givem.
22/08/23	Blood	Grouping and cross matching	Blood group B positive	A (+ or -) AB (+ or -) B (+ or -) O (+ or -)	Client belonged to blood group B with Rhesus Positive, (B+)	Client was transfused with B positive blood with batch number
22/08/23	Blood	Blood film for	Negative	No malaria	No malaria parasite	No treatment given

		malaria parasite		parasite	present	
26/08/23	Blood	Hemoglobin level	8.3g/dl	Male 12-18g/dl Female 11-16g/dl	Hemoglobin level was below normal indicating the presence of anemia	Whole blood transfusion was done with batch number H048

- CAUSE OF PATIENT'S ILLNESS

With reference to the general causes of anaemia in the literature review and compared with the laboratory results of Miss O.A. the exact cause of her anaemia could not be identified.

CLINICAL FEATURS

Table 3; Comparison of patient's Clinical Features in the literature

TEXTBOOK CLINICAL FEATURES	PATIENT'S CLINICAL FEATURES
1.Breathlessness	1.Breathlessness was not present
2.Fatigue	2.Fatigue was present
3.Headaches	3.Headache not present
4.Palpitation	4.Palpitation not present
5.Faintness	5.Faintness was not present
6.Pallor	6.Pallor was observed in patient
7.Tachycardia	7.Tachycardia was present
8.Systemic flow murmur	8.Systemic flow murmur not present
9.Cardiac failure	9.Cardiac failure not present
10.Jaundice	10.Jaundice not present
11.Bone deformities	11.Bone deformities not present
12.Leg ulcers	12.Leg ulcers not present
13.Brittles nails	13.Brittles nails not present
14.Angular stomatitis	14.Angular stomatitis not present
15.Brittle hair	15.Brittle hair not present
16.Spoon-shape nails	16.Spoon-shape nails was not present
17.Oedema	17.Oedema of the ankle present

From the table 3 Miss O.A. exhibited most of clinical manifestation as indicated in the literature review hence diagnosis confirmed that patient had severe anaemia.

- TREATMENT GIVEN TO THE PATIENT

In view of the medical treatment under the literature review, the specific treatment ordered for the patient includes;

- IV Dextrose in Normal Saline 1L Overnight
- Hydroxide Polymaltose Complex 20mg BID x 14days
- IVF Normal Saline 500mls stat
- Oral totheman 1 vial BD x 14days
- IV paracetamol 500mls stat
- Blood transfusion (4 pint)

The table 4 shows the comparison of drugs given to patient and those in the literature.

Table 4; Comparison of Drugs given to patient and those in Literature Review

Drugs Outlined In The Literature Review	Drugs given to my patient
1.Blood transfusion	1.Blood transfusion was done
2.Iron	2.Iron was not given
3.Antimalaria	3.Antimalaria was not given
4.Antihaemorrhoidal	4.Antihaemorrhoidal was not given
5.Hydroxyuria	5.Hydroxyuria was not given
6.Folic acid	6.Folic acid was not given
7.Albendazole	7.Albendazole was not given
8.Tabs vitamin C	8.Tabs vitamin C was not given
9.Analgesics	9.Analgesics (IV paracetamol) was given
10.Haematenics	10.HydroxidePolymaltose Complex were given
11.Antibiotics	11.Antibiotics was not given.

Table four shows the drugs that were used for the patient. Some of the drugs which were present in the literature review such as Hydroxide polymaltos complex and Oral tothema, IV Paracetamol, IV Normal Saline were given which confirms that the patient had the right treatment which led to her recovery.

Table 5; Pharmacology of Drugs Administered to Miss O.A.

DATE	DRUGS	DOSAGE/ROUTE OF ADMINISRATION IN LITERATURE REVIEW	DOSAGE/ROUTE OF ADMINISTRATION GIVEN TO CLIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECT AND REMARKS
22/08/23	IV Dextrose In Normal Saline	Dose; Amount to be given depends on the patient's condition Route- Intravenously	Dosage;1L Route; Intravenous	Isotonic intravenous infusion	Hydration And electrolyte replacement	Dehydration was prevented	Circulatory overload, extravasation, infection at the injection site. These were not observed.
22/08/23	Hydroxide Polymaltose complex	Dose; Adult 1 Tab once daily Route- Oral	Dosage;20mg bid X 14days Route- Oral	Hematinic	Increase red blood cell formation as it combines	Haemoglobin level of client improved from 6.1g/dl	Nausea, diarrhea, constipation these were not

					with porphyrin globin chains to form heamoglobin	to 8.3g/dL	observed.
22/08/23	IV Paracetamol	Dose;500mls-1g Route; intravenous	Dose; 500mls-1g stat Route-intravenous	Analgesic	It exhibit analgesic action by peripheral nerve blockage, probably by inhibiting prostaglandin synthesis in the central nervous system	Pain was alleviated.	Skin rash, dizziness, nausea, vomiting. These were not observed.
23/08/2	Oral	Dose; Adult 1 vial	Dosage; 1 Vial BD x	Hematinic	Improves	Haemoglobi	Gastric

3	tothema	twice daily Route-Oral	14days Route-Oral		hematologic and biochemical index, completely supplies iron and cooper deficiency.	n level of client improved.	burning, nausea, vomiting, diarrhea. These were not observed
23/08/23	IV Normal Saline	Dose; Amount to be given depends on the patient's condition Route-Intravenously	Dosage; 500mls Route-Intravenous	Isotonic intravenous infusion	Hydration and electrolyte replacement.	Dehydration was prevented.	Circulatory overload, extravasation, infection at the injection site. These were not observed.

COMPLICATIONS

According to the literature review, the complications of severe anaemia are infections, heart failure, renal failure, and pneumonia but due to early detection and proper management rendered to Miss O.A. during the period of hospitalization, she did not develop any of the complications in the literature review.

2.2 PATIENT/ FAMILY STRENGTHS.

Adams and Kroshinsky (2019), explained strengths as a resource and ability that an individual has which can help her cope with the stress of her condition. Patient and family strength include health physiological functioning, emotional health, cognitive abilities, coping skills, and interpersonal strength. These strengths of the patient and family will assist the nurse to be able to plan effective nursing care for the patient.

The following strength were observed on Miss O.A. and her family.

- Patient could lie down on bed anytime she feels dizzy.
- Patient was able to perform some activities with the help of an assistance.
- Patient could eat at least 1/3 of food being served to her.
- Patient stated that adhering to treatment can improve health outcome.
- Patient was ready to learn about her condition.
- Patient could verbalize the presence of pallor in her conjunctiva.

2.3 PATIENT/ FAMILY HEALTH PROBLEMS.

1. Patient complain of dizziness (22/08/23)
2. Patient complain of general malaise (22/08/23)
3. Patient has poor nutrition status (22/08/23)
4. Patient complained of uncertainty about possible outcome of condition (23/08/23)
5. Patient had little knowledge about disease condition (24/08/23)
6. Patient has low level of haemoglobin (25/08/23)

2.4 NURSING DIAGNOSE

A nursing diagnosis according to NANDA International (2019) is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group of community. It is a clear and definite statement of the patient's health status that can be influenced by nursing interventions.

1. Activity intolerance related to decrease tissue oxygen per fusion.
2. Fatigue related to decreased haemoglobin and diminished oxygen- carrying capacity of blood.
3. Imbalanced nutrition; less than body requirement, related to inadequate intake of essential nutrient
4. Anxiety related to unknown outcome of disease condition.
5. Knowledge deficit related to lack of information on cause, sign and symptoms and management of anaemia
6. Altered tissue perfusion related to inadequate haemoglobin and haematocrit

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 INTRODUCTION

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2019). This phase deals with designing of nursing strategies and interventions required to prevent, reduce or eliminate those problems of the client/family identified during the analysis phase. The objectives are set and the necessary interventions made to solve patient's health problems.

3.1 PATIENT/FAMILY CARE OBJECTIVE

Based on Miss O.A. health problems identified, the following objectives were set for her and her family during her hospitalization.

1. Patient would be able to perform activity unaided within 48 hours as evidenced by;
   a. Patient verbalizing absence of dizziness.
   b. Nurse observing patient performing self-care activities without assistance.
2. Patient would report less fatigue throughout her stay at the hospital as evidenced by;
   a. Patient performing activities without complaining of fatigue.
   b. Nurse observing patient verbalize she has the ability to work and participate in activities.
3. Patient would attain and maintain adequate nutrition throughout the period of hospitalization as evidenced by;
   a. Patient eating enough food served.
   b. Nurse observing that patient show adequate interest towards food intake.
4. Patient would be relieved of anxiety within 24 hours as evidenced by;
   a. Patient acknowledging and discussing fears and concerns.
   b. Nurse observing that patient maintains regular daily routine throughout hospitalization.

5. Patient would verbalize accurate information about condition and treatment by the end of hospitalization as evidenced by;

a. Patient verbalizing that she understands the new situation and treatment.
b. Nurse observing that patient has made adjustment in her eating habit.

6. Patient would attain and maintain adequate tissue perfusion within 48 hours as evidenced by;

a. Patient having vital signs within normal ranges.
b. Nurse observing her pulse oximetry value within normal limits.

Table 3.1 Patient/Family Nursing Care Plan for Miss. O.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
22/08/2023 At 5:30pm	Activity intolerance related to decrease tissue oxygen perfusion	Patient would be able to perform activities unaided within 48 hours as evidence by; 1. Patient verbalizing absence of dizziness. 2. Nurse observing patient performing self-care activities without assistance.	1. Nurse patient on a low bed and raise the side rails. 2. Group specific task together so that patient can rest. 3. Put personal items within reach. 4. Encourage adequate bed rest.	1. Patient was nursed on a low simple bed and side rails raised to prevent fall. 2. Specific task like vital signs, medications and ward rounds were grouped together to increase patient ability to rest. 3. Items for oral care, bath and water for drinking were kept on bed side	24/08/2023 5:30pm	Goal fully met as; 1. Patient verbalized absence of dizziness. 2. Nurse observed patient performing some self-care activities without assistance but not all activities.	A.P.

			5. Monitor vital signs and oxygen saturation regularly. 6. Assist patient in activities of daily living.	lockers. 4. Relatives and visitors were restricted to encourage bed rest. 5. Vital signs and oxygen saturation were monitored 4hourly. 6. Patient was assisted to perform activities of daily living like oral care and bath.			

Table 3.2 Patient/Family Nursing Care Plan for Miss. O.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
22/08/2023 At 5:45pm	Fatigue related to decreased haemoglobin and diminished oxygen-carrying capacity of blood.	Patient would report less fatigue throughout her stay at the hospital as evidenced by; 1. Patient performing activities without complaining of fatigue. 2. Nurse observing patient verbalize she has the abilities to	1. Prioritize activities. 2. Provide balance between activities and rest. 3. Perform active and passive exercise. 4. Monitor vital signs. 5. Educate patient not to move around without assistance.	1. Activities were prioritized. 2. Balanced between activities and rest were provided. 3. Active and passive exercise were performed. 4. Vital signs were monitored. 5. Patient was educated not to move around	29/08/2023 At 9:00am	Goal fully met as; 1. Patient performed activities without complaining of fatigue. 2. Nurse observed that patient verbalize she has the abilities to work and participate in activities.	A.P

		work and participate in activities.	6. Serve prescribed medication.	without assistance. 6. Prescribed medication was served.			

Table 3.3 Patient/Family Nursing Care Plan for Miss. O.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
22/08/2023 At 5:45pm	Imbalanced nutrition; less than body requirements, related to inadequate intake of essential nutrients.	Patient would attain and maintain adequate nutrition throughout the period of hospitalization as evidenced by; 1. Patient	1. Educate patient on importance of nutritious diet. 2. Plan meal with patient that promotes optimal nutrition.	1. Patient was educated on intake of protein foods, iron and its benefits. 2. Patient was involved in planning meal with regards to	29/08/2023 At 8:30am	Goal fully met as; 1. Patient eats enough food served. 2. Nurse observed that patient showed adequate interest	A.P

		eating enough food served. 2. Nurse observing that patient show adequate interest towards food intake.	3. Serve meal regularly and attractively. 4. Advice the patient on the interference of alcohol and essential nutrient utilization. 5. Provide dietary supplement (iron, vitamin). 6. Provide patient with healthy diet.	food containing protein, iron and vitamins. 3. Meals were served three times a day with garnished vegetables. 4. Patient was advice to limit the intake of alcohol since it interfered with absorption of vitamin B12. 5. Dietary supplement (iron, vitamin) were provided. 6. Healthy diet was provided to		towards food intake.	

				patient			

Table 3.4 Patient/Family Nursing Care Plan for Miss. O.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN
23/08/2023 At 9:35am	Anxiety related to unknown outcome of disease condition	patient would be relieved of anxiety within 24 hours as evidenced by; 1. Patient acknowledging and discussing fears and concerns. 2. Nurse	1. Identify anxiety triggering factors. 2. Maintain a calm reassuring environment. 3. Utilizes existing cooperating	1. Complication of anaemia (enlarge liver) was identified as triggering factor of anaemia. 2. Patient was nursed in a noise free environment and privacy, confidentiality	24/08/23 At 9:35am	Goal fully met as; 1. Patient acknowledge and discussed fears and concerns. 2. Nurse observed that patient	A.P

		observing patient maintains regular daily routine throughout hospitalization.	strategies. 4. Encourage support system presence and participation. 5. Orient patient to the ward to relieve anxiety. 6. Introduced patient to another patient who have recover from this condition.	assured. 3. Respect for patient opinions and allowing her to speak up during interaction were utilized. 4. Patient relatives were engaged in her care. 5. Patient was oriented to the ward to relieve anxiety. 6. Patient was introduced to other patient who had recover from the same condition.		maintains a regular daily routine throughout hospitalization.	

Table 3.5 Patient/Family Nursing Care Plan for Miss. O.A

DATE/ TIME	**NURSING DIAGNOSIS**	**OBJECTIVE/ OUTCOME CRITERIA**	**NURSING ORDER**	**NURSING INTERVENTION**	**TIME/ DATE**	**EVALUATION**	**SIGN.**
24/08/2023 At 9:35am	Knowledge deficit related to lack of information on cause, signs and symptoms and management of anaemia.	Patient would verbalize accurate information about condition and treatment by the end of hospitalization as evidenced by; 1. Patient verbalizing that she understood the cause, signs and symptoms and	1.Assess patient and family current level of knowledge about the new diagnosis. 2.Observe for possible barriers that might make learning more difficult. 3.Create a friendly learning environment. 4.Explain standard terms used in describing the disease process.	1.Patient and family were assessed of the current level of knowledge about the new diagnosis. 2.Pain and anxiety were observed as barrier to the learning process. 3.Introduction of staff and addressing of patient by the correct title was done to create a friendly environment. 4.Keywords were explained in clear simple terms. 5.Patient was given	29/08/2023 At 10:30am	Goal fully met as; 1. Patient verbalized she has understood the new situation and treatment. 2. Nurse observed patient make adjustment in her eating habit.	A.P

		management of condition. 2. Nurse observing that patient has made adjustment in her eating habit.	5.Encourage them to ask questions for clarification. 6.Provide informational resources of learning materials.	time to ask questions in between discussions and was answered appropriately. 6.Books and leaflets were provided to ease teaching and learning.			

Table 3.6 Patient/Family Nursing Care Plan for Miss. O.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
25/08/2023 At 9:20 am	Altered tissue perfusion related to inadequate haemoglobin and haematocrit.	Patient would attain and maintain adequate tissue perfusion within 48 hours as evidenced by; 1. Patient having vital signs within normal ranges. 2. Nurse observing her pulse oximetry value within normal limit	1. Reassure patient of competent care. 2. Transfuse blood as ordered. 3. Monitor vital signs. 4. Monitor pulse oximetry. 5. Administer IV fluids as ordered 6. Serve prescribe medication.	1. Patient was reassured of competent care. 2. Blood was transfused as ordered. 3. Vital signs were monitored. 4. Pulse oximetry were monitored. 5. IV fluids were administered as ordered. 6. Prescribed medications were served.	27/08/2023 At 9:20am	Goal fully met as; 1. Patient having vital signs within normal ranges. 2. Nurse observed that her pulse oximetry value within normal limits.	A.P

CHAPTER FOUR

IMPLEMENTATION OF PATIENT AND FAMILY CARE

4.0 INTRODUCTION

According to Mish (2019), implementation is making something that has been officially decided start to happen or be used. Implementation is the fourth nursing process. It refers to carrying out of proposed plan of care. The nurse takes responsibility including the family and other health team members. While implementing care, the nurse should assess the patient's response to the nursing care and make alteration when necessary.

All vital signs checked have been documented in the appendix. Implementation is the process of putting the nursing care plan into action. It is the actual nursing rendered to the patient and family throughout the period of hospitalization. This may be categorized into summary of actual nursing care rendered, preparations towards patient and family discharge, rehabilitation and follow up visits or continuity of care.

4.1 SUMMARY OF THE ACTUAL NURSING CARE RENDERED TO PATIENT/FAMILY

4.1.1 Day on Admission (22/08/2023)

Miss O.A was trans into the female's medical ward from the accident and emergency unit on 22nd August, 2023 at 3:00pm accompanied by a staff nurse and the boyfriend. Patient was ambulant. They were warmly welcomed by the staff on duty and a confirmation was done on the system to know that indeed the patient was trans in to the female's ward. A well-prepared admission bed, free from creases and cramps was given to make the patient comfortable because she was feeling dizzy. The patient and her boyfriend were introduced to staff on duty. Tight clothes were removed from patient. They were reassured that the patient was in competent hands and everything possible will be done to ensure her recovery. The patient particulars such as name, date of admission, time, age, and next of kin among others were taken and recorded in the ward admission and discharge book. A quick assessment of the patient general appearance was made and vital signs were checked and recorded accurately as follows;

Temperature……37.5℃

Pulse……127bpm

Respiration……. 23cpm

Blood Pressure……149/93mmHg

SPO2……96%

Weight…….85kg

Patient treatment plan are as follows;

1.IVF Dextrose in Normal Saline 1L Overnight

2.Hydroxide Polymaltose complex 20mg BID x 30days

3.IVF Normal saline 500mls stat

4.Oral tothema 1 vial BD x 14days

5.IV paracetamol 500mls 1G stat

Laboratory Investigation Ordered Includes;

1. Full blood count

2. Blood film test for malaria

3. Grouping and cross matching

The need for blood transfusion was explained to her. Four unit of blood was ordered for patient and one unit was retrieved from the blood bank. Patient was educated on the blood transfusion and pretransfusion vital signs was done and recorded as

Temperature……. 38.8^0C

BP……. 130/90mmHg

Pulse…… 127bpm

SPO2…… 92%

Respiration……. 30cpm

Teachings was done prior to transfusion about the possible reaction that may occur during the transfusion process such as rashes, chills, itching, and fever and documented accordingly. Afterwards blood was set up at 7:00pm and completed successfully at 9:10pm. Upon interaction with patient and observation and assessment made during the transfusion process there was no post transfusion reaction. Intravenous paracetamol 500mls in 1G was administered accordingly to alleviate pains and to control the high body temperature of 38.8^0C.

Miss O.A. was asked if she has any valuable items with her that the ward can keep safe for her but she insisted she would like to keep everything with her. Miss O.A. boyfriend was informed about the ward policy on visiting hours, ward rules, items that were needed during hospitalization. He was oriented to the ward by showing them the toilet and bathroom, and the nurse's station. They were also introduced to other patient at the ward. Miss O.A. and the boyfriend was informed of the ward routine such as time of the doctor's rounds, serving medications, checking vital signs and was encourage to call the nurses whenever the needs arose. Patient was already a registered member of the National Health Insurance Scheme so she was advised to continue renewing whenever it expires. Patient and the boyfriend were briefed on visiting hours which were 5:30am-6:30am in the morning, 12:30pm-1:30pm in the afternoon and 4:30pm-5:30pm in the evening each day. Discharge planning was also initiated between the patient and relative by telling them that the hospitalization is temporary period and that patient will be discharged home after the treatment.

An introduction of self was done to the patient again as a student nurse of Holy Family Nursing and Midwifery Training College, Berekum who would like to use her and her family for care study. An explanation was given to the patient and her family, to seek consent and the concept of the patient/family care study and assured them of privacy and confidentiality. The patient and family were informed that they will be visited in their homes during admission and after discharge. Consent was inquired from Miss O.A. and her family accepted the request and promised to offer the necessary information and assistance that will needed throughout the entire study. Patient and family were congratulated on their decision made. The family was made aware that Miss O.A. admission to the ward was temporal one and so will be discharged to continue care at home once she is well. This condition was chosen because it is a common condition in society, so having a patient with this condition will create the opportunity to enrich more knowledge base concerning the cause of the disease, its signs and symptoms, and the treatment.

On admission at 5:30pm, patient complained of dizziness. Therefore, a nursing diagnosis of Activity intolerance related to decrease tissue oxygen perfusion was made. An objective was set to help patient perform activity unaided within 48 hours. Nursing interventions implemented are as follows: Patient was nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept on patient bed side lockers.

Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4hourly. Patient was assisted to perform some activities of daily living like oral care and bath.

During the interaction with the patient at 5:45pm, she also complained of general malaise. A nursing diagnosis of fatigue related to decreased haemoglobin and diminished oxygen-carrying capacity of blood was established and an objective was set to help patient report less fatigue throughout her stay at the hospital. Nursing interventions implemented are as follows: Activities were prioritized. Balance between activity and rest were provided. Active and passive exercise were performed. vital signs were monitored. Patient was educated not to move around without assistance. Prescribed medications were served.

On assessment Miss. O. A. was observed to have poor nutritional status. Therefore at 5:45pm, a nursing diagnosis of Imbalanced nutrition; less than body requirements, related to inadequate intake of essential nutrients was made and an objective to help patient attain and maintain adequate nutrition throughout the period of hospitalization was commenced. The following interventions were carried out; Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables. Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12. Dietary supplement (iron, vitamins) were provided. Healthy diet was provided to patient.

At 6:00pm, vital signs were checked and recorded. At 6:45pm, patient was convinced to try and eat some small food being served to her.

At 10:00pm, vital signs were checked and recorded and due medications served. Patient slept at 11:00pm.

4.1.2 Second Day on Admission (23/08/2023).

Patient woke up at 5:20am, brushed her teeth and took her bath which was assisted by her mother. Her bed was well laid before she returned from the bathroom. By 7:00am her breakfast which was white porridge and bread was ready. Her vital signs were checked and recorded at 6:00am as follows;

Temperature……. 37.2^0C

BP……. 120/70mmHg

Pulse…… 94bpm

SPO2…… 94%

Respiration……. ..21cpm

During ward rounds at 8:00am, after assessment the doctor ordered to continue her medications for the next few days.

At 9:35am patient complained of uncertainty about possible outcome of condition. A diagnosis of Anxiety related to unknown outcome of disease condition was made and objective was set to relived patient anxiety within 24 hours. Nursing intervention implemented included; Complication of anaemia (enlarged liver) was identified as triggering factor of anxiety. Patient was nursed in a noise free environment and privacy and confidentiality assured. Respect for patient opinions and allowing her to speak up during interaction were utilized. Patient relatives were engaged in her care. Patient was oriented to the ward to relieve anxiety. Patient was introduced to patient who have recover from the same condition.

At 10:00am patient vital signs were checked and recorded and due medications were served.

Patient took "ampesi and Kontomire stew" with an egg at 12:00pm in the afternoon. Miss. O.A showed great interest in taking food because of the education given to her on her diet.

At 2:00pm, vital signs were checked and recorded and due medications were served.

At 2:50pm, the second unit of B-positive blood with batch number FR-92 was set with pre-transfusion vital signs checked and recorded as follows;

Temperature……38.8^0C

Blood pressure……130/90mmHg

Pulse……127bpm

Respiration……...30cpm

SPO2…….92%

Patient was educated on hemotransfusion reaction and she was told to alert any nurse when she sees reaction such as rushes and chills. She was reassured and was kept under close monitoring.

At 4:50pm, transfusion was successfully completed with on transfusion reaction. Post transfusion vital signs was checked and recorded as follows;

Temperature……. 37.5^0C

Blood pressure…...130/70mmHg

Respiration…….26cmp

Pulse…… 128bpm

SPO2…… 94%

At 5:30pm, patient had her bath and took rice and stew for supper. The vital signs were checked and recorded and evening medications served at 6:00pm.

At 10:00pm, vital signs were checked and recorded and due medications were served. Patient slept at 10:50pm.

4.1.3 Third Day on Admission (24/08/2023)

Miss O.A. was out of bed around 5:30am, she brushed her teeth, emptied her bowel and took her bath. Her bed was laid and the locker cleaned. Her vital signs were checked and recorded at 6am as;

Temperature……36.5^0C

Blood pressure….120/60

Pulse…….67bpm

SPO2…… 96%

Respiration…… …18%

Patient took brown porridge and bread as breakfast around 7:40am. During ward rounds at 9:00am, patient was reviewed by doctor E.A. who ordered for the treatment to be continued.

At 9:35am, during an interaction with patient an observation was made that patient had little knowledge about disease condition (Anaemia). A nursing diagnosis of Knowledge deficit related to cause, sign and symptoms and management was formulated. An objective was set to help patient verbalize accurate information about condition and treatment. The following interventions were put in place; Patient and relative previous knowledge were assessed. Pain and anxiety were observed as a barrier to the learning process. Introduction of staff and addressing of patient by the correct tittle was done to create a friendly environment. Keywords were explained in clear simple terms. Patient was given time to ask questions in between discussion and was answered appropriately. Books and leaflets were provided to ease teaching and learning.

At 9:35am, an objective that was set on (23/08/23) to help patient relieved of anxiety within 24hours was evaluated and goal fully met as patient acknowledge and discussed fears and concerns and nurse observed that patient maintains a regular daily routine throughout hospitalization.

At 1:00pm, patient took rice with tomato sauce for lunch with two slides of apple.

At 2:00pm, vital signs were checked and recorded and due medications were served. Patient took a nap around 3:15pm.

At 5:00pm, patient took banku with okoro soup for supper and had her bath after supper.

At 5:30pm, an objective set on (22/08/23) to help patient perform activities unaided within 48 hours was evaluated and goal fully met as patient verbalized absence of dizziness and nurse observed patient performing some self-care activities without assistance but not all activities.

Patient vital signs were checked and recorded and evening medications were served at 6:00pm. Patient slept at 11:00pm.

4.1.4 Fourth Day on Admission (25/08/2023)

Patient woke up at 5:40am, she took her bath and brushed her teeth. The night nurse reported that the patient had a good night sleep. Morning ward routines such as straightening of bed linens, changing of soiled bed linen were done. At 6:00am, vital signs were checked and recorded as follows;

Temperature……. .36.5^{0}C

Blood pressure…… 120/70mmHg

Respiration……. 20cpm

Pulse……68bpm

SPO2…….....96%

Patient took in tea with bread for breakfast after which prescribed medications were served and recorded. She was made comfortable in bed waiting for doctor's rounds. Dr. E.A. reviewed her and ask for the third unit of blood to be transfused.

During an interaction with Miss O.A. she was observed to have low-level of haemoglobin.

At 9:20am a diagnosis of Altered tissue perfusion related to inadequate haemoglobin and haematocrit was made. An objective was set to help patient attain and maintain adequate tissue perfusion within 48hours. The following nursing intervention were put in place; Patient was reassured of competent care. Vital signs were monitored 4hourly to determine any deviation in condition. Blood were transfused as ordered. Pulse oximetry were monitored. IV fluids were administered as ordered. Prescribed medications were served.

At 10:00am, vital signs were checked and recorded. At 12:00pm, patient was encouraged to take her lunch which was" ampesi with stew". At 2:00pm pretransfusion vital signs was checked and recorded as follows;

Temperature……... 36.5^0C

Blood pressure…….. 120/70mmHg

Respiration…… 21cpm

Pulse……. .94bpm

SPO2……. …95%

The third unit of blood with batch number FR-93 was set up and education was made to patient about the hemotransfusion reaction and was told to report when she sees reaction such as rashes and chills. She was then reassured and was kept under close monitoring.

At 5:00pm, transfusion was successfully completed with no transfusion reaction. Post-transfusion vital signs were checked and recorded as follows;

Temperature……. 36.4^0C

BP…… 120/90mmHg

Pulse…….90bpm

SPO2…….97%

Respiration……20cpm

At 6:00pm patient took her bath and took fufu with light soup" for supper. The evening medications were served and recoded. Patient charted with other patient at the ward during the rest of the evening.

At 10:00pm, vital signs were checked and recorded and due medications were served. Patient went to bed at 10:45pm.

4.1.5 Fifth Day on Admission (26/08/2023)

Patient woke up at 5:30am, she took her bath and brushed her teeth and the morning duties follows; bed laid, lockers clean.

At 6:00am, due medications were administered and vital signs were checked and recorded as follows;

Temperature…….36.0^0C

BP…… 120/60

Pulse……. 60bpm

Respiration…… 20cpm

SPO2…….. 96%

Patient took rice porridge and bread as breakfast around 7:30am. During ward rounds at 9:00am, patient was reviewed by doctor E.A. who ordered for treatment to be continued. Banku with groundnut soup was served as lunch. At 2:00pm, vitals were checked and recorded and due medications were served. Patient had rice and stew for supper and after which she took her bath. Patient took a walk around the hospital to strengthen herself.

At 6:00pm, vital signs were checked and recorded and due medications were served.

At 10:00pm, vital signs were checked and recorded and due medications were served. At 10:30pm patient went to bed.

4.1.6 Sixth Day of Admission (27/08/2023)

Patient woke up at 5:40am, she brushed her teeth, ease herself, and took her bath. Patient bed was well laid and lockers were clean.

At 6:00am, vital signs were checked and recorded as follows;

Temperature…… 36.5^0C

BP……... 116/60mmHg

Pulse……60bpm

SPO2……... 96%

Respiration……...20cpm

Patient took tea with bread as breakfast and afterwards due medications were served.

At 9:20am, an objective set on (25/08/23) to help patient attain and maintain adequate tissue perfusion within 48hours was evaluated and goal fully met as evidence by patient having vital signs within normal ranges and nurse observing her pulse oximetry value within normal limits.

During the ward round at 8:30am, the doctor ordered to continue the treatment.

At 1:40pm, patient took fried plantain with beans stew for lunch.

At 2:00pm, vital signs were checked and recorded and prescribed medications were served. Patient took a nap during the whole afternoon.

Patient woke up around 5:00pm and took her bath before taking in her supper, which was fufu with light soup and two slides of apple.

At 6:00pm, vital signs were checked and recorded and due medications were served.

At 10:00pm, vital signs were checked and recorded and due medications were served. Patient slept at 11:00pm.

4.1.7 Seventh Day of Admission (28/08/23)

Miss O.A. woke up around 5:30am in the morning and had her bath and mouth care carried out. The night nurse reported that patient had a good night sleep. She was doing well and wanted to know when she would go home. I explained to her that she will be discharged as soon as the doctor declares her fit to go home and I also told her that the way things are going it will be possible that she will be going home by the end of the day. Morning ward routines such as straightening of bed sheet, changing of solid bed linen were done. Her vital signs were checked and recorded at 6:00am as follows;

Temperature…….36.6^{0}C

BP…….110/70mmHg

Pulse…….60bpm

SPO2…….98%

Respiration……..18cpm

Patient took Hausa porridge and koose for breakfast after which prescribed medications were served and recorded. She was made comfortable in bed waiting for doctor's rounds.

During the ward rounds at 8:30am, patient had no complains so Dr E.A. ordered a continuation of the patient care and told her that she will be discharge tomorrow. Rice with kontomire stew was served as lunch. Afternoon medications were served, vital signs were checked and recorded. I told Miss O.A. and relatives that they should get prepared in the need of money to settle for their hospital bills so that they can go home. Patient took Banku with Okro soup for supper.

At 6:00pm, patient's medications were served and vital signs were checked and recorded.

Miss O.A. took a warm bath at 7:00pm. At 10:00pm, vital signs were checked and recorded and due medications served. Patient slept at 10:40pm.

4.1.8 Eighth Day of Admission (Day of Discharge) – 29/08/23.

I arrived at the ward at 7:30am on this day to find Miss O.A. looking cheerful and fit. Patient told me she had a sound sleep throughout the night. She had her mouth care, had her bath and had emptied her bowel. She took porridge and bread for breakfast.

Vital signs checked and recorded at 6:00am were as follows;

Temperature……36.6^0C

BP…….. 110/70mmHg

Pulse …….74bpm

SPO2…….98%

Respiration…….. 22cpm

At 8:30am, objective set on (22/08/23) to help patient attain and maintain adequate nutrition throughout the period of hospitalization was evaluated and goal fully met, as evidence by patient eats enough food served and nurse observed that patient showed adequate interest towards food intake.

During ward rounds at 8:40am, patient had no complains so she was discharged home to continue treatment with already prescribed medications and to come for review on 8th September,2023. Education was given to patient on the need to complete the prescribed medication, diet and the need to report any observed ailment and side effect of drugs. I also explained her medications and its dosage to her and relative. The date for review which was 8th September,2023 was again mentioned to patient and relative.

Her particulars were entered into admission and discharge book as well as the daily census records. Patient was discharge with the following additional drugs;

1. Tab folic acid 5mg daily x 3days
2. Tortema Syrup 1 Vial x 30days

At 9:00am, objective that was set on (22/08/23) to help patient report less fatigue throughout her stay at the hospital was evaluated and goal was fully met, as evidence by patient performing activities without complaining of fatigue and nurse observing patient verbalize she has the ability to work and participate in activities.

At 10:30am, objective that was set on (24/08/23) to help patient verbalize accurate information about condition and treatment by the end of hospitalization was evaluated and goal fully met, as evidenced by patient verbalized she has understood the new situation and treatment and nurse observed patient make adjustment in her eating habit.

After she had settled her bills. I helped her to pack all her belongings. Miss O.A. and her family thanked the staff present and other patient at the ward and bid them goodbye. I came back to the ward to remove patient's bed linen and put into the laundry container, then patient's bed was

carbolized with already prepared breach solution, cleaned and left to dry. All care done was documented.

4.2 PREPARATION OF PATIENT/FAMILY FOR DISCHARGE AND REHABILITATION

This is aimed at enhancing or giving the client and family insight into the condition and measures that already have been taken, as well as helping the client to have a normal or near normal life again after her illness. Preparation of patient and family towards discharge and rehabilitation started on the day of admission. This was to educate the patient and family on the condition and to ensure an early discharge. Patient and family were reassured that, patient was in the hands of competent staff and that everything possible would be done to ensure her speedy recovery and discharge. Miss. O.A. Family were educated on the following areas;

a) Drugs

Patient was educated on the dosage, timing and side effect of her medications during discharge. She was advised to adhere to treatment regimen and also report to the hospital if condition worsens before the review date.

b) Diet

Patient was advised to take diet rich in proteins, carbohydrates, vitamins and iron. Patient was also encouraged to maintain proper oral care to boost patient's appetite. Adequate fluid intake was also encouraged.

c) Personal and Environmental Hygiene

Patient was educated on the importance of maintaining personal hygiene. She was encouraged to bath twice daily and also care for her nails and skin to prevent infection. Patient and family were advised to maintain clean environment clean by sweeping, removing all nauseating objects from the environment to make patient comfortable. Patient was advised to have enough rest.

4.3 FOLLOW UP/HOME VISITS/CONTINUITY OF CARE

Follow up or home visit is a friendly but purposeful visit to the home of the patient and family with the aim of preventing diseases, promoting and maintaining health and prolong life through health education, counseling and nursing care. It helps to know the resources at home as well as in the community that can be used to solve actual and potential health problems.

4.3.1 First Home Visit (23/08/2023)

My first visit to the patient's house was on 23rd August,2023 while patient was still on admission. Patient was informed about my intension to visit her house; she agreed and gave me directions to her house. The aim of the visit was to find out the factor that could contribute to patient health and to identify vulnerable people in her house. This home visit was also done to help me confirm certain information given to me by my patient. I made a successful journey to her home around 11:00am. It was a 15munites drive to the town that is Kutre number 2, a suburb of Berekum district. I was welcomed by Mr. A.P. who happens to be her boyfriend, he took me to the house, gave me a seat and offered me some water. Communication was not a problem since we all speak Twi.

An introduction of self to Mr. A.P the boyfriend of Miss. O.A. as a student of Holy Family Nursing and Midwifery Training College Berekum, who was rendering care to Miss. O.A as a fulfillment of my care study project and he was glad to see me and ask me about Miss O.A. wellbeing, which I told him she was doing well. Various observation was made on the compound during the visit. Miss. O.A. and boyfriend live in a compound house which is made up seven (7) bed rooms, with one bathroom. They use the public toilet. The house is plastered, painted and roofed with aluminum sheet. The windows were made of wood with net in the windows. They obtain their water from a pipe and have a borehole around and they dump their refuse at the public refuse dump which is frequently emptied by the Zoom lion company. The source of light to the house is electricity (PREPAID) from the Volta River Authority (VRA). On observation, I realized that the drainage system from the bathroom was poor. Water from the bathroom was choked behind the house which formed a stagnant pit. There was rubbish which was gathered in the stagnant water behind the house. The environment behind and in-front of the house was also bushy and full of cow's feces since a lot of cow's pass there.

I educated my patient's boyfriend and the neighbour around to drain the stagnant water behind the bathhouse because it could serve as a breeding place for mosquitos which may bring conditions like malaria. I advise that they should redirect the water into a larger pit which could be covered with concrete. I advised that they weed around their compound to prevent habitation of dangerous animal like snakes and also breeding grounds for mosquitoes and also ask them to prevent the cow's from passing there by talking to the community head. I also educated them on

personal hygiene. Emphasis was made on the need to avoid self-medication but rather visit the hospital for treatment if any conditions arises. I then encourage Mr. A.P. and the neighbours to ask questions and they were answered tactfully.

During interaction with the patient's boyfriend, patient dietary habits was asked and the boyfriend stated that her diet are mostly carbohydrate and protein. He clearly stated that Miss O.A mostly cook "fufu" with "groundnut" soup and that is what she takes for super. Mr. A.P. was much grateful and thanked me. I also thanked him and applaud him for his cooperation. At 12:30pm, permission was sought to leave. I promised him of another visit to their house after discharge of Miss. O.A. I went around the community to see if there is any clinic around, so that I could hand Miss. O.A. to the community nurse after her discharge. There was no clinic around the community but I sported one on my way back which was closer to the community. I introduced myself to the community nurse who is in the person of Mrs. A.O.Y and stated my visit to her.

4.3.2 Second Home visit (31/08/2023)

My second visit to Miss. O.A home after her discharge that was on the 31st August 2023 at 2:30pm. This visit was aimed at assessing the patient's health status and also to find out whether she is taking her medications as ordered and also remind her of her review date. On arrival at 1:30pm, I met Miss O.A. and her boyfriend, we exchange greetings. I was warmly welcomed. Miss O.A. said she had no complains and because she wanted a speedy recovery, she takes her drugs as prescribed. I was very pleased to know that she was feeling much better without any complaints and was taking her medications as directed. I was also happy for seeing that the bushy area behind their house was cleared and also the rubbish was gathered in the stagnant water behind the bathhouse was dealt with. She assured me that she will practice the health education given her. They were informed that they will be paid a final visit during which patient will be handed over to community health nurse for continuity of care.

She was reminded of the date of review (8th September,2023) which she assured me would comply and I promised her to meet her on that day. I asked permission to leave and they thanked me for the visit and she accompanied me to the road side. I left around 3:00pm.

Day of Review (08/09/2023)

Miss O.A. reported to the out-patient department of the Holy Family Hospital Berekum on the 08/09/2023 at 7:30am. I met her and the boyfriend at the out-patient department where we exchanged pleasantries. I help her activate her hospital care from the records department. Her vital signs were checked and recorded as follows;

Temperature ……... 36.4 ^{0}C

Pulse……. 80bpm

Respiration ……. 19cpm

Blood pressure …… 120/70mmHg

SPO2……. 98%

We proceed to the consulting room where she was reviewed by Dr. M.A. There were no complaints on the day of review so no new drugs were prescribed for her. Miss O.A. was encouraged to complete her medication and to take her daily meals with the right nutrient (iron and vitamins) as expected and practice good personal hygiene. Patient was reminded of the third visit which will be my last visit. I congratulated her for paying heed to the treatment plan. Miss. O.A. was accompanied to the entrance where I asked her to extend my greetings to her family and bid her goodbye.

4.3.3 Third home visit (12/09/2023)

The third home visit was on the 12th of September, 2023 after patient's review. The purpose of the visit was to terminate care and hand over patient and family to the community health nurse. I visited my patient in the company of the community health nurse from Clean hands Clinic at Brenyekwa which is closer to Kutre number 2 since there is no health Centre at that community. Mrs. A.O.Y. is the name of the community health nurse, since arrangement were done for patient hand over. We were warmly welcomed by patient and her family. They offered us a comfortable seat and gave us the best hospitality. I was very happy on seeing Miss. O.A. as observation showed that patient and family had really adhered to the pieces of advice given to them during the first and second home visit. Patient's conditions had improved and no complaints were made. Since this was my last visit, I took my time and highlighted on the various health education that I had previously given.

They were also advised to seek medical treatment whenever they fall sick to prevent complications and should not practice self-medication. Patient was advised again on her diet and the need to have enough rest. They were grateful and promised to adhere to the education given. I educated patient on need for continuity of care and the importance of the community health nurse. The community health nurse was again introduced and patient/family were handed over to her for continuity of care. Patient and family were encouraged to give their maximum co-operation to the community health nurse. She promised to do follow up visits and give any information which would be needed by the family members. I congratulated them for that and I made them aware that it was my last visit but I may come around anytime to say hello to them. I thanked Miss O.A. and the family for the co-operation and opportunity offered me to take her and the family for the care study and promised to keep any information confidential. We then asked for permission to leave and Miss O.A. escorted us to the road side. I thanked her for her hospitality rendered to me, and finally we exchanged goodbye. I left around 4:00pm.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/FAMILY

5.0 INTRODUCTION

Evaluation is the determination of the patient's responses to the nursing interventions and the extent to which the outcomes have been achieved (McIntosh, 2021). Evaluation, as part of the nursing process, is the last stage. Evaluation in nursing care seeks to measure the effectiveness of assessment, diagnoses, and implementation. Patient's health status is compared to the goals of health to determine goals achieved. It involves the members of the health team, patient, and family. Unachieved goals of nursing care plan are amended and care is terminated afterward.

5.1 STATEMENT OF EVALUATION

After nine days of admission and maximum cooperation from patient, family, and staff at the Holy Family Hospital, Berekum, six problems were identified and objectives were set to solve them. Patient fully recovered from her illness and was finally discharged with all goals fully met. The degrees to which the problems were solved are as follows;

1. **Patient was able to perform activity unaided within 48 hours. (24/08/2023).**

   On the 22nd August 2023 at 5:30pm, patient complained of dizziness. Therefore, a nursing diagnosis of Activity intolerance related to decrease tissue oxygen perfusion was made. An objective was set to help patient perform activity unaided within 48 hours. Nursing interventions implemented included; Patient was nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4hourly. Patient was assisted to perform activities of daily living like oral care and bath.

On 24th August, 2023 at 5:30pm an evaluation was made on the objective and goal was fully met as evidenced by patient verbalized absence of dizziness and nurse observed patient performing some self-care activities without assistance.

2. Patient report less fatigue throughout the period of hospitalization (29/08/2023).

On the 22nd August, 2023 at 5:45pm, patient complained of general malaise. A nursing diagnosis of fatigue related to decreased haemoglobin and diminished oxygen -carrying capacity of blood was established and an objective was set to help patient report less fatigue throughout her stay at the hospital. Nursing interventions implemented included; Activities were prioritized. Balanced between activities and rest were provided. Active and passive exercise were performed. Vital signs were monitored. Prescribed medications were served.

On 29th August, 2023 at 9:00am an evaluation was made on the objective and goal fully met as patient performed activities without complaining of fatigue and nurse observed patient verbalize she has the ability to work and participate in activity.

3. Patient regained adequate nutrition throughout the period of hospitalization (29/08/2023).

On the 22nd August, 2023 upon assessment Miss. O. A. was observed to have less interest in taking food. Therefore at 5:45pm, a nursing diagnosis of Imbalanced nutrition; less than body requirements, related to inadequate intake of essential nutrients was made and an objective to help patient attain and maintain adequate nutrition throughout the period of hospitalization was commenced. The following intervention were carried out; Patient was educated on the intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables. Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12. Dietary supplement (iron, vitamins) were provided. A healthy diet was provided.

On 29thAugust, 2023 at 8:30am the objective that was set to help patient regain adequate nutrition throughout the period of hospitalization was evaluated and goal fully met as Patient eats enough food served and nurse observed patient showing adequate interest towards food intake.

4. Patient anxiety was relieved within 24 hours (24/08/2023).

On the 23rd August at 9:35am, patient complained of uncertainty about possible outcome of condition. A diagnosis of Anxiety related to unknown outcome of disease condition was made and objective was set to resolved patient anxiety within 24 hours. Nursing intervention implemented included; Complication of anemia (enlarged liver) was identified as triggering factor of anxiety. Patient was nursed in a noise free environment and privacy and confidentiality assured. Respect for patient opinions and allowing her to speak up during interaction were utilized. Patient relatives were engaged in her care. Patient was oriented to the ward to relieve anxiety. Patient was introduced to patient who have recovered from the same condition.

On 24th August, 2023 at 10:30am the objective set on the previous day to help resolve patient anxiety within 24 hours was evaluated and goal fully met as patient acknowledged and discussed fears and concerns and nurse observed patient maintains a regular daily routine throughout hospitalization.

5. Patient verbalized accurate information about condition and treatment by the end of hospitalization (29/08 /2023).

On 24th August, 2023 at 9:35am, it was also observed that patient and relatives had no insight on how to manage her condition. Therefore, a nursing diagnosis of knowledge deficit related to lack of information on cause, signs and symptoms and management of codition was made. An objective was set to enable patient verbalize accurate information about condition and treatment by the end of hospitalization. The following interventions were carried out. Patient and relative previous knowledge was assessed. Pain and anxiety as a barrier to the learning process was resolved. Introduction of staff and addressing of patient by correct title were done to create a friendly environment. Key words were explained in clear simple terms. Patient was given time to ask question in between discussion and was answered appropriately. Books and leaflets were provided to ease teaching and learning.

On 29th August, 2023 at 10:30am, the objectives set on 24th of August, 2023 to help patient verbalize accurate information about condition and treatment by the end of hospitalization

was evaluated and goal fully met as Patient verbalized she has understood the new situation and treatment and nurse observed patient make adjustment in her condition.

6. Patient attain and maintain adequate tissue perfusion within 48 hours (27/08/23)

On 25th August,2023 at 9:20am, patient was observed to have low-level of haemoglobin. A diagnosis of altered tissue perfusion related to inadequate haemoglobin and haematocrit was made and an objective was set to help patient attain and maintain adequate tissue perfusion within 48hours.The following nursing interventions were carried out; Patient was reassured of competent care. Vital signs were monitored. Blood was transfused as ordered. Pulse oximetry were monitored. IV fluids were administered as ordered. Prescribed medications were served.

On 27th August,2023 at 7:30am the objective set to help patient attain and maintain adequate tissue perfusion within 48hours was evaluated and goal fully met as patient having vital signs within normal ranges and nurse observing her pulse oximetry value within normal limits.

5.2 AMENDMENT OF NURSING CARE PLAN FOR PARTIALLY MET OR UNMET OUTCOME

There were no partially met or unmet objectives; hence there was no need for amendment of care plan.

5.3 TERMINATION OF CARE

Termination of care is the ending of care and the relationship between the patient, relatives and the nurse. Since separation can sometimes bring about anxiety and depression due to its accompanied psychological pain, Miss. O.A. family members whom she lives with and was always at the patient's side was given a gradual psychological preparation from the day of admission to the day of discharge. They were told that hospitalization was just a temporal measure to improve their relative's condition and that she would be discharged and handed over to a community health nurse to continue with the care.

Interactions with Miss. O.A and family started on the day of admission, 22nd August, 2023 through to the discharge date, 29th August, 2023. Her condition had improved as a result of good nursing care and medical care rendered. Three home visits were embarked on before rendered

care was terminated. The first home visit was on the 23rd August, 2023. This was done when my client was still on admission. The purpose of the visit was to assess the patient's home environment for factors that contributed to the illness and also to educate her family members. The family members of Miss. O.A were educated on the importance of good nutrition. The second home visit was carried out on the 31st of August, 2023. An assessment and evaluation of the patient's health status was done and to comprehend whether patient and relatives were adhering to the education given to them. This home visit was embarked with Mrs. A.O.Y a community health nurse for her to know the family members of the patient she will be taking care of after her discharge. Mrs. A.O.Y was introduced to the patient and relatives of the patient and her inclusiveness towards the patients care. Patient and relatives were adhering to the education given to them which was exciting to hear. Miss. O.A was reminded on the review date. Finally, the care of the patient and family was terminated on the third home visit (12/09/2023) when the patient and family were finally handed over to the community health nurse Mrs. A.O.Y who had already being introduced to them during the second home visit. I thanked them and promised to call anytime I had the chance. They were grateful and happy.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 INTRODUCTION

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

6.1 SUMMARY

Summary according to Papandrea (2020) is a comprehensive and usually brief abstract, recapitulation or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with
the situation.

Miss. O.A. is a 25 years old Ghanaian and a student tailor who lives at Kutre-2 near Abrodwam in the Bono Region. She was admitted on the 22nd August, 2023 into the accident and emergency ward of the Holy Family Hospital, Berekum with the diagnosis of Severe Anaemia by Dr. A.M. On admission; She complained of dizziness, general body weakness, difficulty in breathing, general malaise and loss of appetite and on assessment had paleness of the conjunctiva. The patient was managed on the following treatment plan throughout her hospitalization

- IVF DNS 1L Overnight
- Hydroxide Polymaltose complex 20mg BID x 30days
- IVF Normal saline 500mls Stat
- Oral tothema 1 vial bd x 14days
- IV paracetamol 500mls 1G stat.
- Blood transfusion 4 pints.

The following laboratory investigations were requested:

- Blood for grouping and cross matching.
- Full blood count.
- Blood film test for malarial parasite.

The following problems were identified within the period of hospitalization; dizziness, general malaise, poor nutritional status, uncertainty about possible outcome of condition, little knowledge about disease condition, low-level of heamoglobin. Based on the problems identified, nursing diagnosis were made and continue her medication and report to the hospital for review all aimed towards a successful recovery. Three home visits were carried out during the care. The first home visit was done when she was still on admission on the 23rd August, 2023, aimed at assessing the patient's home environment. The second visit was made on the 31st of August, 2023, to enquire about the health status of the patient whilst the last home visit was on the 12th September, 2023 to terminate care and hand over client to the community health nurse. The care was successfully terminated when the patient and family were handed over to a community health nurse.

6.2 CONCLUSION

McIntosh (2021) defines conclusion as the final decision, reached by reasoning. Generally, the study on Miss. O.A has been a successful one because she recovered and regained strength in the end and resumed her normal daily activities. This write up has enabled to put into practice the nursing process learned during the three-year study. It has broadened the knowledge on anaemia especially the causes, clinical manifestations, complications and the management of client with anaemia. The study has helped to boost confidence and improved communication skills. It has also helped to understand comprehensive nursing care rendered to the client and family as well as developing a cordial relationship with client and family to provide effective care. This study has also helped to provide a holistic nursing care to client and to be a useful member of the health team. The study has benefit client and family to meet their health needs.

Hereby, it is recommended that the patient and family care study should be maintained as a facet of the nursing training and fully establish in the country health care delivery system to aid in the improvement of health care.

APPENDIX

Table 12: Vital signs chat for Miss. O.A throughout hospitalization;

Date	**Time**	**Temperature(^{0}C)**	**Pulse(bpm)**	**Respiration (cpm)**	**Blood Pressure(mmHg)**	**Oxygen saturation (%)**
22/08/2023	3:105pm	37.5^{0}C	127bpm	23cpm	149/93mmHg	96%
	6:40pm	38.8^{0}C	127bpm	30cpm	130/90mmHg	92%
	9:10pm	37.5^{0}C	120bpm	20cpm	120/80mmHg	97%
	10:00pm	36.5^{0}C	85bpm	16cpm	120/80mmHg	97%
23/08/2023	6:00am					
	10:00am	36.5^{0}C	67bpm	18cpm	120/60mmHg	96%
	2:00pm	36.8^{0}C	85bpm	16cpm	110/80mmHg	97%
	6:00pm	37.7C	89bpm	15cpm	120/80mmHg	98%
	10:00pm	36.4^{0}C	84bpm	15cpm	110/90mmHg	96%
		36.5^{0}C	89bpm	17cpm	120/80mmHg	97%
24/08/2023	6:00am					
	10:00am	36.5^{0}C	67bpm	18cpm	120/60mmHg	96%
	2:00pm	36.5^{0}C	83bpm	18cpm	110/90mmHg	99%
	6:00pm	37.0C	85bpm	19cpm	120/70mmHg	99%
	10:00pm	36.4^{0}C	90bpm	17cpm	120/80mmHg	98%
		36.9^{0}C	87bpm	19cpm	120/80mmHg	97%
25/08/2023	6:00am	36.5^{0}C	68bpm	2ocpm	120/70mmHg	96%
	10:00am	37.0^{0}C	94bpm	19cpm	110/80mmHg	99%
	2:00pm	36.50C	94bpm	21cpm	120/70mmHg	95%
		36.7^{0}C	85bpm	20cpm	120/70mmHg	99%

	6:00pm 10:00pm	37.0^{0}C	90bpm	19cpm	110/70mmHg	97%

Vital signs chat for Miss. O.A throughout hospitalization; cont'

Date	Time	Temperature(^{0}C)	Pulse(bpm)	Respiration(cpm)	Blood Pressure(mmHg)	Oxygen saturation (%)
26/08202 3	6:00am 10:00am 2:00pm 6:00pm 10:00pm	 36.0^{0}C 36.1^{0}C 36.7C 37.1^{0}C 36.9^{0}C	 60bpm 89bpm 92bpm 87bpm 90bpm	 20cpm 20cpm 21cpm 19cpm 20cpm	 120/60mmHg 120/70mmHg 120/80mmHg 120/80mmHg 110/80mmHg	 96% 97% 97% 98% 98%
27/08/202 3	6:00am 10:00am 2:00pm 6:00pm 10:00pm	 36.5^{0}C 36.2^{0}C 37.0C 36.8^{0}C 37.0^{0}C	 60bpm 90bpm 92bpm 89bpm 86bpm	 20cpm 17cpm 18cpm 20cpm 19cpm	 116/60mmHg 110/70mmHg 110/70mmHg 120/70mmHg 120/90mmHg	 96% 98% 96% 97% 98%
28/08/202 3	6:00am 2:00pm 6:00pm 10:00pm	36.6^{0}C 36.5C 36.9^{0}C 36.7^{0}C	60bpm 89bpm 84bpm 90bpm	18cpm 19cpm 20cpm 19cpm	110/70mmHg 110/80mmHg 120/90mmHg 110/90mmHg	98% 97% 98% 97%
29/08/202 3	6:00am 10:00am	36.6^{0}C 36.8^{0}C	74bpm 84bpm	22cpm 19cpm	110/70mmHg 120/80mmHg	98% 99%

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SIGNATORIES

The Principal; Holy Family Nursing and Midwifery Training College, Berekum

NAME OF CANDIDATE: AGYEIWAA PRISCILLA

SIGNATURE: .....

DATE: 8th June, 2024

The Supervisor; Holy Family Nursing and Midwifery Training College, Berekum

NAME OF SUPERVISOR: RITA AGYEI BOAKYE

SIGNATURE: .....

DATE: 08-06-24

The Ward in Charge; Holy Family Hospital Berekum

NAME OF WARD NURSE IN-CHARGE: GRACE DEDE

SIGNATURE: .....

DATE: 8th June, 2024

The Principal; Holy Family Nursing and Midwifery Training College Berekum

NAME OF PRINCIPAL: MONICA NKRUMAH

SIGNATURE: .....

DATE: 8/06/2024

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM