HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM A

PATIENT / FAMILY CARE STUDY ON BRONCHOPNEUMONIA

BY

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

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PREFACE

The Patient/Family Care Study is a detailed written report of nursing care rendered to a patient and his/her family within a specific period of time. It explores nursing care rendered from the time of admission to termination of nurse-patient relationship. It gives an in-depth description and explanation of how a patient response to a specific condition.

The Patient/Family Care Study involves a record nursing care, documenting the problems of a nursing patient and how they are dealt with by the nurse in the course of finding solution to the problems. It provides a systematic way of collecting data, analyzing information, and reporting the results of nursing care. This Patient/Family Care Study is based on the concept of holistic care, taking into account all factors impinging on the health of the individual. It includes a study of the interaction between the patient, the family, the community and the health team. It is done using the nursing process approach.

This care study was carried out in partial fulfillment of requirement for the award of professional license by the Nurses and Midwifery Council of Ghana. It is an integral part of the curriculum for educating nursing students hence a prerequisite for completing the nursing course. Care study offers the nursing student the opportunity to combine classroom academic work with clinical study of the practices of the nursing profession. It encourages learning by doing, the development of analytical and decision-making skills as well as reporting skills. Being based on the nursing process, the students become familiar with the use of the nursing process as a basis for practice thereby encouraging evidence-based nursing care.

ACKNOWLEDGEMENT

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

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

Exceptional thanks go to the nurse-in-charge and the nursing staff of the medical ward at St. Theresah's Hospital Nkoranza. They gave me support and morale for this care study. The supporting staff and colleague students whom I worked with on the Medical Ward have not been forgotten for various manners of help.

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

INTRODUCTION

"The unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, knowledge or will, and to do so in such a way as to help him regain independence as quickly as possible" ─Virginia Henderson, 1966.

The rationale behind a care study is to assist a patient to regain health (or peaceful death) and present a report of that assistance giving account of problems that were identified and how solutions were worked out from a nursing process perspective. Presented in this care study is a report of nursing care rendered to Miss F.P who was diagnosed of Bronchopneumonia. She was admitted to the medical ward of St. Theresa's Hospital, Nkoranza on Tuesday 23rd November, 2021 at 12:00 pm, Miss F.P arrived at the ward accompanied by her mother through the out-patient- department (O.P.D).

She was conscious, alert and well-oriented to time, place and person although she was weak and restless Happening to be at the nurses' station with the nurse in charge at the time of her arrival, I was then charged with the responsibility to carry out her admission to the ward. That began my therapeutic relationship with the patient which resulted in this care study nursing care spanned close to one week from the time of admission to the ward till discharge on 27th November, 2021. Her condition at the time of discharge was satisfactory.

Interaction with Miss F.P and her family continued after discharge with three (3) home visit and regular phone communication till nurse-patient relationship was terminated finally on 7th December, 2021.

This care study report has been organized into five chapters in line with the five phases of the nursing process.

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

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

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

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

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

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY ON ADMISSION

1.0 Introduction

This is the first phase of the nursing process and information is obtained through assessment of patient and family on their entrance to the health facility as well as the community in which they reside. It is obvious that accurate data is essential in order to provide an effective individualized nursing care for the patient. The data collected is then communicated to other health team members through validating and recording of the data. The sources of this information are obtained through health history, performing a physical examination, reviewing client's records or literature and consulting support from people and other health professionals.

1.1 Patient's Particulars

Particulars is defined as details or information about a person, especially when officially recorded (McIntosh, 2013). Miss F. P is the name of my patient born to Mr. K.F and Mrs. A.K. She is a 19year old girl and was born on 6th July,2002. She is Ghanaian by nationality and a Bono by ethnicity. She comes from Domase, a suburb in Nkoranza District in the Bono- East region of Ghana. She lives at Domase in a house near the town park with house number NWO-43 with her parents and siblings. Miss F.P is the first born to her parents and has four siblings (three girls and one boy). She is dark in complexion and about 1.65m tall and weighs about 62kg. She stated that she was single and she is a Christian by religion and a member of The Divine Healers Church. Miss F.P is a student at Serwaa Kesse Senior High School at Duayaw Nkwanta and she is in SHS 2. Her in-patient number is 11254/17. Miss F. P revealed that her next of kin is her mother, Mrs. A.K.

1.2 Family's Medical History

Medical/surgical history provides information about illness and surgery which have familial or genetic tendencies (Weller, 2014). This includes; current state of health of grandparents, parent and siblings, deceased members of the family and cause of death, disorder in the family, mental illness, hospitalization, any known allergies and the use of over-the-counter drugs. From F. P's mother, there are no known genetic or familial disorders such as sickle cell disease, hemophilia, mental illness as well as any chronic disease like diabetes and hypertension in her family. There are no known allergies in their family. Madam A.K. revealed that Miss F. P's grandparent are alive, however, her aunt died of pneumonia. Madam A.K. stated that apart from F.P. and her aunt, no other family member has ever been hospitalized and have no history of surgery. Occasionally, members of the family suffer attacks of headache, chills and fever which they resort to over-the-counter drugs such as paracetamol as a means of treatment. She also added that when such conditions do not improve, they sometimes resort to herbs and traditional medicine or seek medical attention at St Theresa's Hospital. Education on the need to visit the health facility for their health problems was given.

1.3 Family's Socio-Economic History

Socio-Economic history is the social science that studies how economic activities are affected and shaped by social processes. In general, it analyzes how families progress, stagnate, or regress because of their local economy (Hellmich & Simon, 2015). From Madam F.P., the relationships between their family members are cordial and friendly. They are Christians and attend church at The Divine Healers Church on Sundays. The mother said if it had not been the National Health Insurance Scheme (NHIS), they (father and mother) would not have been able to pay for the hospital bills.

According to Madam F.P. (mother) she and her husband are farmers. They sometimes suffer from occupational hazards like cutlass cuts. They cultivate crops such as cassava, maize, plantain and yam. They also cultivate vegetables like garden eggs, pepper, okro, tomatoes and rear domestic animals like poultry. Madam F.P. said, they sometimes sell some of the crops for the up keep of the family. Aside farming, she also said she sells kenkey and her husband also sells bags. The mother said, the family depends on the money generated from the sale of the farm produce. Though the income earned is not sufficient for the family, there is no financial support from other family members. The money is used to cater for the family. They are exposed to so many dangers in relation to their work such as cuts from cutlasses been used, bite from snakes, sting from scorpions and so many others. According to Madam F.P, she believes there are family values, taboos and cultural practices but they are not known to her.

1.4 Patient Developmental History

Growth is the gradual increase in the size of the body and its organs (Weller, 2014). Development is the biological and psychological changes that occur in human beings between birth and the end of adolescence, as the individual progresses from dependency to increasing autonomy (Weller, 2014).

Maturation is the change in the function of an organism, starting from the molecular level and involves various organs, both metabolically and physically-changing gradually from a simple to a more complex level (Weller, 2014).

Miss F. P said her mother use to tell her that, she went through nine months of normal pregnancy and was delivered by Spontaneous vagina delivery (SVD) on the evening of 6th July 2002 at St. Theresa's Hospital, Nkoranza. Her mother delivered successfully by the Midwife on duty without any complications, abnormalities, or deformities. She also confirmed that she was born without

any congenital abnormalities such as cleft lip or palate. The client also revealed that she was exclusively breastfed for about three (3) months and was introduced to complementary feed such as tom brown and wheat in the fourth month but had immunization against the six-killer disease such as Measles, Tetanus, Whooping cough, Tuberculosis, Poliomyelitis, and Diphtheria.

Moreover, Mrs. A. K added that Miss F. P went through all the developmental process without problem. She was able to suck her mother`s breast well during breastfeeding and also gain neck and head control when put to sitting position (Gross Motor Development). She sat at the age of six months with support and the seventh month, she could sit without support. She started crawling in the eight months, stood up with support in the ninth month, stood up without support in the tenth month, and at the eleventh month, she started walking. She started joining words at the age of one year seven months.

Miss F. P commenced her education at age of four years at Domase D/A Basic School from nursery through middle school after which she is continuing at Serwaa Kesse Senior High school. Miss F. P indicated she saw the development of her secondary sexual characteristics at the age of 15 years which includes the growth of pubic hairs and enlargement of breast. According to Erik Erikson's psychological theory, individual goes through eight (8) stages of development with their corresponding ages. These stages are; Trust versus Mistrust, [0-18months], Autonomy versus Shame and Doubt [18 months -3 years], Initiative versus Guilt[3-6years], Industry versus Inferiority [6-12 years], Identity versus role confusion [12-18 years], Intimacy versus Isolation [18-35 years], Generativity versus Stagnation [35-60], Integrity versus Despair [60 years +]. Miss F. P is 19 years old so she is in Intimacy versus Isolation. This is the sixth stage of Erik Erikson's theory of psychosocial development. This stage takes place during young adulthood between the

ages of [18-35 years]. During this stage, the major conflict centers on forming intimate, loving relationships with other people.

1.5 Patient Lifestyle/Hobby

Lifestyle is defined as the pattern of daily living that an individual develops (Weller, 2014). Miss F.P. goes to bed around 10:30p.m and wakes up around 5: 30a.m to clean the house or prepare for class when she is in school. She brushes her teeth, visit the toilet and takes her bath twice daily. Miss F.P. usually takes porridge and bread as breakfast. She has no known allergies. Her favorite food is fufu and palm nut soup. She eats three times daily, that is morning, afternoon and evening. She does not smoke nor drink alcohol. Patient usually plays ludo with her mother during her leisure hours because it is her favorite. She likes to attend social activities like weddings and church meetings. She usually uses both verbal and non – verbal communication styles such as eye movement and gestures when speaking and also, she is an extrovert, kind and generous. She likes people who are hardworking and dislikes fighting and gossiping. My personal impression about the patient is that, she is kind and hardworking and aims to work harder to support her family.

1.6 Patient's Past Medical History

Past medical/surgical history describes the significant past diseases or illnesses and surgeries; including complications or trauma that are relevant to a patient's current state of health (Tidy, 2019).

During my interactions with my patient and references made from the patient's folder, she admitted that she has been brought to the Hospital for admission three times. Following my patient's past medical history, the first admission was on a diagnosis of bronchitis, second was uncomplicated malaria, respiratory tract infections including this last and current admission with

Broncho pneumonia. Apart from this, Mrs. F.P said there has not been any ailment about her since she was born.

1.7 Patient's Present Medical History

According to Miss F. P, she was well until 23rd of November, 2021 around 7:20am she started experiencing high body temperature, general weakness and also was having difficulty in breathing. These are the health problems that prompted her to seek treatment at 9:05am at St Theresa's hospital, Nkoranza. Miss F. P added that she has being coughing for the past 3 days, but was not profound. On assessment and consultation at the Out Patient Department (OPD), the clinical features presented were as follows; Fever, Cough, Difficulty in breathing (dyspnea), Poor appetite, Chest pains and General weakness and pallor

My patient, according to the mother presents these features within 3 days before they came to the hospital. However, she said no medications were given at home before attending to this hospital. Also, on assessment of my patient there has not been any surgical interventions performed on her. Patient's blood sample was taken to the laboratory for FBC, BF for MPs, and also urine R/E at the Out Patient Department.

1.8 Admission of Patient

Admission is defined as allowing a patient to stay in hospital for observation, investigation, treatment and care (Davis, 2020). Miss F. P was brought into the ward of St. Theresah's Hospital, Nkoranza for admission (medical ward) on 23rd November, 2021 at 12:00 pm. She was brought in by the mother. They were welcomed and offered a seat. Patient's document regarding her care were collected and confirmed name of patient and other related information.

I proceeded and introduced myself to them and then asked them of their ward's condition including any problems, they have regarding their daughter's illness. Both parents including their

daughter were reassured of competent staff and quality service. Miss F. P was put to bed FMW-12 to rest and the vital signs were checked and recorded as;

Temperature	38.2^0C
Pulse	80 beats per minute
Respiration	21 cycles per minute
Blood pressure	120/80 milliner mercury

The orders given her were to do FBC, BF for MPs, chest X-ray, IV fluid ringers lactate 2L for 24hours, IV dextrose normal saline 2L in 24hours, IV ceftriaxone 2g daily in 72hours, IV paracetamol 1g 8hourly in 24hours, and admit to medical ward.

All particulars about my patient were entered into the admission and discharge book and I continue to reassure parents about the possible interventions of the competent staff in the recovery of their daughter without any complication.

Miss F.P was provided with bed free from creases in a prop up position to enhance respiration. An IV line assessed and secured with adhesive tape. Patient was given IV paracetamol 1g 8hourly x 24hours, IV ceftriaxone 2g daily x 72 hours, IV R/L 500mls was set up.

The hospital policy concerning payment was explained to them that without national health insurance they have to make deposit of some amount to be paid at the cash point. The patient's personal belongings were sent to bed side and patient's mother was orientated to the ward, bathrooms, lavatory, litter bins, source of water and nearby wards and units. She was also informed of the visiting hours, meal, and time for inpatient review.

I reintroduced myself as a Final-year student nurse of Holy Family Nursing and Midwifery Training College Berekum. I told her mother that as part of the training, Final year students are to take a patient each, and render individual care to the patient and family with the help of staff from

time of admission till discharge and to do follow-up and home visits during the period of admission and after discharge. This is in partial fulfillment of the requirements of Nursing and Midwifery Council for the award of license to practice as a professional nurse. For this reason, I sought her permission to use her child for the patient and family care study of which she agreed and promised to participate fully in care of the patient. I made patient/family comfortable and understand that the hospital is a temporal place for health care and would be discharged home when the condition improves. The reason for choosing this condition was that, although it is not a chronic disease, it accounts for numerous death cases. Having Bronchopneumonia for a care study is a great opportunity for me to have an in-depth knowledge about the condition in order to educate people on the condition and also to contribute to the existing literature of the condition, this will help nursing profession and rendering of care. I thanked them for their cooperation and patient was put to bed and handed them to the afternoon nurses when leaving the ward and I could see that patient was stable during the handing over.

1.9 Patient's Concept of Illness

This talk about the patient's idea or perception about her condition (Weller, 2014). My patient could not tell me anything regarding the cause of her illness. However, her parents admitted that the illness could be due to the constant changing of the weather especially extreme cold after rain.

However, they do not attribute the cause to any other thing apart from what is said above and then hope is all dependent upon the health staff for their daughter's recovery.

This was an opportunity for me and I gave health educations to the parent concerning the disease which includes the causes, signs and symptoms complication, treatments and preventions or total recovery or cure of her disease.

1.1.0 Literature Review of Bronchopneumonia

Definition

Smeltzer and Bare (2017) defined pneumonia as an inflammation of the lungs parenchyma that is caused by a microbial agent.

Types/Classification of Pneumonia

From Smeltzer and Bare (2017), there are two classifications;

1. According to the causative agent (bacterial and atypical pneumonia)
2. According to the anatomical distribution (Lobar and Bronchopneumonia)

By causative agent, the commonly uncounted bacterial pneumonias include;

1. Streptococcal pneumonia
2. Staphylococcal pneumonia
3. Klebsiella pneumonia
4. Haemophilus influenza

Atypical pneumonia includes the following

1. Viral pneumonia
2. Fungal pneumonia
3. Legionaires disease
4. Mycoplasma pneumonia
5. Chlamydial pneumonia
6. Pneumocystic carinii pneumonia (PCP)

According to the anatomical distribution, pneumonia is categorized into two types

1. Lobar pneumonia: this describes pneumonia occurring in a substantial portion of one or more lobes.

2. Bronchopneumonia: this is used when the infections distributed in a patchy fashion, having originated in one or more localized areas within the bronchi and extending to the adjacent surrounding lung parenchyma. The authors' comparatively said bronchopneumonia is more common than lobar pneumonia.

Atindanbila (2006), also indicated that Broncho pneumonia affects mostly babies and children who are already weak and debilitated due to conditions like measles and severe burns.

Incidence

Pearce (2018) stated that pneumonia affects all ages and all sexes equally. However, certain groups of people are more susceptible to the disease particularly very young children; the elderly, the terminally ill and patient reduce resistance as a result of treatment with cytotoxic drugs as corticosteroids (people with poor immune system). According to Berkow et al (2017), some people are more susceptible to pneumonia than others as in cigarette smoking, diabetes, heart failure, chronic obstructive pulmonary disease and alcoholism. Atindanbila (2006), similarly stated that the incidence is also high in preterm babies, families with low socio-economic status and overcrowded places, poor environmental areas and occurs in 4% of children under 4 years.

Aetiology

Berkow et al (2017), stated that pneumonia isn't a single illness but many different illnesses, each caused by a different microscopic organism. The following are usually common;

1. Bacteria such as streptococcus pneumonia (pnemococcus pneumonia), staphylococcus aureus, legionella and haemophillus influenza
2. Viruses such as influenza virus and varicella zoster virus
3. Fungi: such as Aspergillus fumigates

4. Mycoplasma pneumonia, a bacteria-like organisms. Smeltzer and Bare (2017), added that other non-pathologic causes also bring about pneumonia including adiation therapy as in lung and breast cancers. Pneumonia usually develops six weeks or more after completion of the therapy, inhalation (aspiration) of stomach contents into the lungs as in unconscious patients.

Pathophysiology

Smeltzer and Bare (2017), it is an inflammatory reaction which may occur in the alveoli and produce exudates that interferes with the diffusion of oxygen and carbon dioxide. Mostly, neutrophils, white blood cells migrate into the alveoli and fill the normal air contained spaces. The surroundings of the lungs heave no proper ventilations because of the secretions and mucosal oedema that cause partial occlusion of the bronchi or air sacs with a resultant decrease in alveoli oxygen tension. Spasms of the bronchioles can also occur in patients with reactive air ways disease.

Since ventilations, perfusion mismatching occurs in the lungs and venous blood entering the pulmonary circulation passes through the under ventilated area and out to the left side of the heart which is poorly oxygenated. The mixture of oxygenated and deoxygenated blood eventually results in arterial hypoxaemia.

Clinical Manifestations

A person with pneumonia will manifest some or most of the following signs and symptoms. (MOH, 2016);

1. Fever which maybe sudden onset
2. Productive or nonproductive cough
3. Sputum produce may appear yellowish, or blood stained green, rusty.
4. Fast breathings (tachypnoea) accompanied by respiratory grunting.

5. Chest pain which is worse on deep breathing or cough
6. Signs of consolidation or effusion in the chest.
7. Breathlessness
8. Cyanosis
9. Fast pulse rate

According to Smeltzer and Bare (2017), the above signs and symptoms are inpatient including the following. They stated that, a typical pneumonia varies in signs and symptoms depending on the causative organism and the patient underlying disease. Some patients may exhibit an upper respiratory tract infection (URTI), nasal congestion, sore throat and onset of symptoms of pneumonia is insidious.

The following signs and symptoms predominate

1. Low grade fever
2. Headache
3. Pleuritic pain
4. Myalgia
5. Rash
6. Pharyngitis and mucoid or mucopurulent sputum is expected after few days.

Complications of Pneumonia

Smeltzer and bare (2017), outlined that the following complications may develop if the proper and appropriate treatments are not given

1. Respiratory failure
2. Hypotension and shock
3. Pleural effusion ad emphysema

4. Delirium
5. Atelectasis
6. Super infection

Waugh and Grant (2018), indicated that cardiac complications such as;

7. Meningitis and arthritis, resulting from spread of infections.
8. Acute Otitis media
9. Endocarditis and toxic myocarditis

Diagnostic Investigations

The ministry of health, Ghana (2016), indicates that diagnosis of pneumonia is made through the following ways/laboratory findings;

1. Sputum for culture and sensitivity
2. Full blood count
3. Chest x-ray
4. History taking and clinical manifestations by Atindanbila (2006)
5. Taking a pleural fluid culture of the fluid surrounding the lungs
6. Blood sample for culture and sensitivity.

Specific medical/surgical treatment

Ministry of health, Ghana (2016), indicates that identifications and correction of the underlying cause is the key to correct treatment. However, antibiotic treatments are indicated immediately even before laboratory confirmation.

Atindanbila (2006), indicated that the following medications are used in the treatment of pneumonias;

1. Antibiotics e.g., Penicillin is the first and last drug of choice.

2. Rehydration, oral or intravenous fluid given because of dehydration
3. Oxygen therapy to treat the hypoxaemia
4. Thoracentesis is indicated if there is dyspnoea resulting from fluid accumulation in the pleural cavity.

   Smeltzer and Bare (2017), suggested that the treatment of pneumonia includes administering the appropriate antibiotics as determined by the gram stain. The commonly used chemotherapies are

5. Benzylpenicillin (Penicillin G) is usually the antibiotics of choice against streptococcus pneumonia
6. Clindamycin
7. Erythromycin if patient is allergic to penicillin
8. Tetracycline and any of its derivative such as doxycycline.

   Bronchial irritation can be relieved by administering warm, moist inhalations.

9. Surgically, treatment involves passing a chest tube with under seal water drainage to drain pleural effusion from pleural space.

Nursing Management of Pneumonia

The main aims of providing nursing management are to give holistic and supportive care and to prevent or monitor for any complications.

The nursing management is categories under the following;

1. Psychological care

a. Reassure patient and family that they are in competent hand and care to allay anxiety.
b. Explain all procedures to patient before carrying out to ensure cooperation.
c. All patient and family to ask any questions that bothers their mind and answer them in simple terms and clearly.

2. Rest and sleep

a. Admit patient to a quiet, well-ventilated room

b. Provide a comfortable bed free from creases

c. Group and perform nursing activities together to avoid disturbing patient's sleep

d. Restrict visitation when patient is sleeping

e. Undo all light clothing to promote comfort

3. Observations

a. Observe and record vital signs regularly especially temperature for at least 4 hourly, serve antipyretic as ordered and tepid sponge the child if temperature is above 39^0C

b. Observe the breathing pattern and institute deep breathing exercise every 2-4 hours

c. Observe for difficulty in breathing (dyspnoea), and put the child in a sitting position or lying with the affected lung down.

d. Ensure patient airway, observing the child to verify if oropharyngeal suctioning is needed.

e. Maintain adequate hydration and monitor intake and output chart

f. Observe the skin for cyanosis and treat as indicated or ordered.

g. Observe the child for delirium. Due to the fever, delirium is common so observe for early sings.

h. Observe and monitor IV fluid for proper flow rate

4. Nutrition

a. Server a well balance diet, rich in protein, non-vitamins, carbohydrate etc. attractively and in bits.

b. Oral toileting should be done to improve patient appetite.

c. All nauseating objects should be removed before diet is patient

d. A liquid die may be given if patient is experiencing dyspnoea.

e. Serve fruits and fruit juices and vitamins to boost patient immunity.

5. Patient health education

a. Educate parents about the disease condition and explain to them the reasons for the various treatments of the child.

b. Educate the parents the need to ensure personal hygiene all the time

c. Educate them the need for a quiet and restful environment to maximize rest period

d. Explain to the need to isolate the child as indicated especially patient with oral and nasal secretion provide for proper disposal.

e. Explain the need to comply with all treatment regimen and follow ups visits.

f. Explain the need to change the child's position every 2 hours to prevent pooling of secretions.

g. Educate parents on the need to avoid the precipitating factors or causes of this condition

6. Personal hygiene

a. Maintain mouth hygiene

b. Hand washing should be done frequently especially before and after eating and visit toilet

c. Soiled linen of the patient should be soaked and decontaminated in parazone solution before washing and drying

d. Patient should be encouraged to take regular bath.

e. Promote grooming

7. Prevention of pneumonia

Smeltzer and Bare (2017), recommended the following preventive measures

a. Initiate special precautions against infection by encouraging prompt and adequate treatment of upper respiratory infections (URI)

b. Promote coughing and expectation of secretions

c. Promote frequent turning, early ambulation and mobilization, in bed ridden patient's
d. Encourage reduction or moderate alcohol intake and stop smoking.
e. Promote frequent and adequate oral hygiene for patients who are on nothing by mouth or antibiotics to minimize colonization of organisms.

Also, Anane Darko (2017), indicated the following preventive measures;

f. Avoidance of overcrowding especially in population with low resistance such as medical wards and secondary institutions
g. Educate people to the chest well especially when the weather is cold.
h. Vaccination for high-risk individuals including the elderly, the debilitated and alcoholics is recommended in advance countries.

1.11 Validation of the Data

This involves confirming all the information gathered about the patients, from standards and authorities including hygiene relatives, text books patient's folder and other members of the health team. This helps to avoid errors; misinterpretation of data collected and gain better understanding.

Therefore, all these sources established that the information gathered are reliable and authentic.

CHAPTER TWO

2.0 Introduction

Analysis of data is a systematic examination and evaluation of data or information by breaking it into its component parts to uncover their interrelationship, thus providing basis for problem solving and decision making (Weller, 2014). This chapter deals principally with analysis of data collected in chapter one. Areas to be analyzed under this chapter consist of;

1. Diagnostic investigations
2. Causes
3. Clinical features
4. Treatment
5. Complications

2.1 Comparing Data with Standards

This involves the study and comparing of the patient's health problems with what is in textbooks. It covers all aspect of the disease condition including aetiology, clinical manifestations, diagnostic investigations, treatments and complications.

2.1.1 Diagnostic Investigations/Test

As defined by (Weller, 2014), diagnosis as the determination of the nature of a disease and test is defined as an examination or trial. Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment. The following laboratory investigations were ordered and carried out for patient:

1. Full blood count
2. Chest x-ray

3. Blood Film for malaria parasites
4. Urine R/E

Table 1: Comparison of laboratory investigations done on patient with literature or standards.

Test outlined in literature review	Test carried out on patient
1. Full blood count	1. Full blood count was conducted on patient
2. Chest x-ray	2. Chest x-ray was done.
3. Blood for culture to detect any systemic infections	3. Blood for culture to detect any systemic infections was not carried out on patient
4. Pleura Biopsy (Lung biopsy)	4. Pleura Biopsy (Lung biopsy) was not conducted on patient
5. Gram stain Sputum to isolate the organism	5. Gram stain Sputum to isolate the organism was not conducted on patient
6. Bronchoscopy	6. Bronchoscopy was not done on patient
7. Physical examination	7. Physical examination (auscultation) was conducted on patient

All diagnostic measures carried out on Madam F.P. were in line with literature with the exception of blood film for malaria parasites done to rule out malaria.

Also, Urine R/E was ordered for patient but patient and family could not afford, therefore, it was not done.

Table 2 Diagnostic Investigations Conducted on Miss F. P

Date	Specimen	Investigation	Result	Normal values	Interpretation	Remarks
23/11/21	Blood	Haemoglobin level estimation	10.3 g/dl	Males: 12-18 g/dl Females: 11.6-15 g/dl	Hemoglobin (Hb) level was below normal values	Patient should be given adequate proteins, well balanced diet
23/11/21	Blood	Presence of malaria parasite	No malaria parasites seen	Malaria parasite should not be in the blood	Malaria parasite is absent in the blood	No treatment was given
24/11/21	Chest	Chest X-ray	Reveals patchy consolidation of the right lungs	The lung tissue should not have any patchy consolidation	Patchy consolidation of the lung tissue shows presence of pneumonia (Bronchopneumonia)	Antibiotics were patient as ordered.

2.1.2Aetilogy/Causes

With reference to the causes of pneumonia from the textbooks, my patient, Miss F. P's condition can be due to the following; overcrowding, poor environment and personal hygiene, lower socioeconomic status of his parents hence Miss F. P's condition could be as a result of exposure to pathological or non-pathological. The table below the diagnostic investigations that were carried out on my patient.

2.1.3 Clinical Features

The table below illustrates the comparison of the clinical manifestation outlined in the literature review with those manifested by Miss F.P

TABLE 3: Comparison of Miss F. P's Clinical Features with Standards

Clinical Manifestations in Literature Review	Clinical Manifestations Presented by Miss F. P
Difficulty in breathing	Patient had difficulty in breathing (dyspnoea)
Fever which may be sudden onset	Patient had high body temperature (fever)
Cough which may be productive or non-productive	Patient had dry and non-productive cough
Chest pain which is worse on deep breathing or cough	Patient had chest tenderness/pain due to cough
Cyanosis	There were no signs of cyanosis in patient.
Loss of appetite	Patient had poor appetite

Clinical Manifestations in Literature Review	**Clinical Manifestations Presented by Miss F. P**
Fast pulse rate (Tachycardia)	Patient's pulse was normal
Signs of consolidation or effusion in the chest	None was observed in patient

2.1.4 Specific Medical Treatment

With reference to the literature review, treatment of pneumonia is based on eliminating the underlying cause and appropriate treatment with antibiotics is the major aim. The following treatment was given to Miss F.P

1. IV Ceftriaxone 2g daily x 72 hours, (23/11/21)
2. IV paracetamol 1g 8hourly x 24hours (23/11/21)
3. IV fluids ringer's lactate 2 liters x 24hours (23/11/21)
4. IV dextrose normal saline 2L x 24hours, (23/11/21)
5. Intranasal oxygen 3L/min x 24 hours (23/11/21)
6. Tablet Paracetamol TDS 1000mg x 4days (24/11/21)
7. Tablet Azithromycin OD 500mg x 3 days (24/11/21)

Table 4: Medical treatment administered to Miss F. P. as compared with literature.

Medical treatment in Literature Review	**Medical treatment given to Miss F. P**
1. Antibiotics e.g., Penicillin, Macrolide, Aminoglycosides, and Cephalosporin	1. IV Ceftriaxone 2g, Tablet Azithromycin 500mg were administered to patient.
2. Anti–pyretics. E.g., Paracetamol	2. IV paracetamol 1g was administered.
3. Antitussives medications. E.g., Simple Linctus	3 No Antitussives was administered to patient
4. Oxygen therapy	4. Intranasal oxygen 3L/min was administered to patient
5. Analgesics/ Anti-inflammation E.g., Ibuprofen, Aspirin.	5. None was administered to my patient

The drugs that were administered to Miss F.P were in line with those in literature with the exception of Ringers lactate to maintain her fluid and electrolyte levels respectively.

TABLE 5: Pharmacology of Drugs Administered to Miss F. P

Date	Drug	Standard Dosage and Route of Administration	Dosage/Route of Administration	Classification	Desired Effects	Actual Action Observed	Side Effects/ Remedies
23/11/21	Ceftriaxone	**Dosage** 1-2g once daily, 2g dose for severe cases **Route** Intravenous, intramuscularly	2g daily in 72 hours Intravenous injection	Cephalosporins Antibiotics	To treat bacterial infection	Helped in prevention of bacterial infection	Rash, diarrhea, nausea, vomiting, headache, dizziness. None was observed
23/11/21	Intravenous Dextrose normal saline	**Dosage** Depends on patient's fluid and electrolyte levels. **Route** Intravenous	2000mls x 24hours Intravenously	Isotonic solution (Glucose-Elevating Agent)	To correct fluid and electrolyte imbalance, increase blood volume in hypovolemia, correct dehydration, and elevate blood glucose.	Patient's hydration and energy level was improved.	Hypervolemia, oedema, shortness of breath, diarrhea, extravasation. None observed

TABLE 5: **Pharmacology of Drugs Administered to Miss F. P Continued**

Date	**Name of drug**	**Standard Dosage and Route of Administration**	**Dosage and route of administration to the patient**	**Classification of drug**	**Desired effect**	**Actual effect of the drug observed**	**Side effect(s)/ Remarks**
23/11/21	Paracetamol	**Dosage** Adult: 0.5–1 g every 4–6 hours to a maximum of 4 g daily **Route** Oral, rectal, intravenous	**Dosage** 1g 8hourly x 24hrs **Route** Intravenously	Antipyretic and analgesic	To reduce fever and pain by activation of descending serotonergic pathways and inhibition of prostaglandin synthesis.	Patient temperature reduced to normal range (between 36.2-37.2^{0}C).	Acute generalized exanthematous pustulosis, Malaise, skin reactions, Stevens-Johnson syndrome, toxic epidermal necrolysis, Haematological reactions, allergic reactions and liver damage following overdose. Patient experienced no side effects.

Date	Drug	Standard Dosage and Route of Administration	Dosage/Route of Administration	Classification	Desired Effects	Actual Action Observed	Side Effects/ Remedies
23/11/21	Intravenous ringer's lactate	**Dosage** Depends on patient's fluid and electrolyte levels. **Route** Intravenous	2000mls x 24hours Intravenously	Isotonic (Alkalinizing agents)	To correct fluid and electrolyte imbalance, increase blood volume in hypovolemia, correct dehydration, and provide energy	Patient's skin turgor was improved which is an indication of adequate hydration	Hypervolemia, oedema, shortness of breath, diarrhea, extravasation. None was observed

23/11/21	Oxygen	**Dosage** Depends on severity of patient's condition. **Route** Intranasally	3litres × 12hours nasally	Oxidant	It increases oxygen saturation of haemoglobin, It is necessary for metabolism.	Ineffective breathing pattern was corrected with the oxygen in situ.	Retinopathy of prematurity, seizures, oxidative damage. None was observed.
24/11/21	Tablet Azithromycin	**Dosage:** 500mg OD for 3days **Route:** oral, intravenous	500mg daily x72hours orally.	Antibiotic	It prevents bacteria from producing proteins that are essential to their growth.	To treat infection caused by bacteria	Allergic reaction, nausea, and vomiting. None was observed
24/11/21	Paracetamol	**Dosage** Adult: 0.5–1 g every 4–6 hours to a maximum of 4 g daily	**Dosage**	Antipyretic and analgesic	To reduce fever and pain by activation	Patient temperature reduced to	Acute generalized exanthematous pustulosis,

		Route Oral, rectal, intravenous	1000mg TDS x 4days **Route** Oral		of descending serotonergic pathways and inhibition of prostaglandin synthesis.	normal range (between 36.2-37.2^{0}C).	Malaise, skin reactions, Stevens-Johnson syndrome, toxic epidermal necrolysis, Haematological reactions, allergic reactions and liver damage following overdose. Patient experienced no side effects.

2.1.5 Complications

With reference sot the literature review, complications of bronchopneumonia include pleural effusion, emphysema, respiratory failure, atelectasis, and many others. However, my patient condition did not result in any complication because they reported early for early diagnosis and intensive care rendered to him. Due to this, my patient gained quick recovery without any of the complications in the literature review.

2.2 Patient/Family Strengths

1. Patient breathes easier when she leans forward.
2. Patient could tolerate cold drinks.
3. Patient described characteristics of the pain (location, intensity and frequency)
4. Patient could sleep for 3 hours at night and an hour during the day.
5. Patient could eat 7 table spoon full of rice and stew
6. Patient and relatives asked questions.

2.3 Patient's Health Problems

My patient presented the following health problems;

1. Patient had difficulty in breathing (Dyspnoea). (23/11/21)
2. Patient had high body temperature. (23/11/21)
3. Patient complained of chest pains. (23/11/21)
4. Patient was not able to sleep well. (24/11/21)
5. Patient had poor appetite. (24/11/21)
6. Patient and relatives were anxious. (24/11/21)

2.4 Nursing Diagnosis

These are statements that describe the patient's response which the nurse can easily identify and order definitive interventions to maintain health or reduce, eliminate or prevent alterations in patient conditions.

The nursing diagnosis that was formulated from the patient health problems are as follows;

1. Impaired gas exchange related to pulmonary congestions.
2. High body temperature (fever) related to infection.
3. Altered body comfort related to chest pains.
4. Altered sleep pattern (insomnia) related to persistent cough.
5. Imbalanced nutrition (less than body requirement) related to inadequate dietary intake.
6. Anxiety related to unknown outcome and diagnosis of bronchopneumonia.

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

Planning is the stage where goals and outcomes are formulated that directly impact patient care based on evidence-based practice (EDP) guidelines (Toney-Bulter & Thayer, 2021). This is the third phase in the nursing process which deals with setting of goals and objective/outcome criteria to meet the health needs of the patient. These objectives/outcome criteria are set in order of priority which can be long or short term. This is made possible based on the actual and potential problems identified.

Accurate assessment phase of data collection should be therefore be ensured for better planning. The component that makes up a detailed and comprehensive care plan include:

1. Date/Time
2. Nursing diagnosis
3. Nursing objectives /outcome criteria
4. Nursing orders
5. Nursing interventions
6. Evaluation of care plan
7. Signature

3.1 Nursing Objectives/Outcome Criteria

This aspect of the nursing care plan is aimed at achieving a goal set by the nursing after implementing the care plan for a particular nursing diagnosis. It can either be a short term or long-term nursing objectives. The following are the objectives set for my patient:

1. Patient would have improved gas exchange within 24 hours as evidenced by

a) Patient reporting that dyspnea has subsided

b) Nurse observing patient having a normal breathing pattern.

2. Patient would regain normal body temperature within 24 hours as evidenced by;

a) Patient verbalizing that her temperature has reduced.

b) Nurse recording temperature value within the normal range. (36.2^0C – 37.2^0C)

3. Patient would regain normal body comfort within 24hours as evidenced by

a) Patient verbalizing that there is reduced chest pain.

b) Nurse observing that patient is comfortable in bed.

4. Patient would regain normal sleep pattern within 48hours as evidenced by patient verbalizing a sound sleep at night and nurse observing patient sleep for at least 8 hours.

5. Patient's nutritional pattern would be restored within 24 hours evidenced by:

a) Patient verbalizing that she can now eat more than half of a bowl of meal served.

b) Nurse observing patient eat more than half of her meals served.

6. Patient/ family anxiety would reduce within 24 hours as evidenced by:

a) Nurse observing that patient and family have relaxed facial expressions.

b) Patient/family verbalizing that, they are no more anxious.

Table 6: Nursing Care Plan for Miss F. P

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
23/11/21 12:20 pm	Impaired gas exchange related to pulmonary congestions.	Patient would have improved gas exchange within 24 hours as evidenced by: 1.Patient reporting that dyspnea has subsided 2.Nurse observing patient having a normal breathing pattern.	1. Monitor vital signs, especially respiratory rate 2. Prop up patient in bed at an angle of 45^0. 3. Remove all tight clothes around patient neck and chest. 4. Open nearby windows for proper ventilations 5. Maintain a patent airway for patient. 6. Administer prescribed oxygen	1. Patient's temperature, pulse, respiratory rate and oxygen saturation were monitored. 2.Patient was propped up in bed at angle of 45^0 to aid breathing. 3. Tight clothes around neck and chest were removed and light clothes were put on. 4. Nearby windows were opened and proper ventilation was ensured. 5. Patient nostrils were checked and secretions were cleared to maintain patent airway. 6. Intranasal oxygen 3L/min was administered to patient.	24/11/21 12:20 pm	Goal fully met as patient no longer breath through mouth and nurse observing patient having a normal breathing pattern	F. F

Table 6: Nursing Care Plan for Miss F. P Continued

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
23/11/21 12:20pm	High body temperature (fever) related to infection.	Patient will regain normal body temperature within 24hours as evidenced by; 1. Patient verbalizing that her temperature has reduced. 2. Nurse recording temperature value within the normal range. (36.2^{0}C – 37.2^{0}C)	1 Reassure patient and family that with time and the interventions of the healthcare team, her temperature will reduce. 2. Open nearby windows to facilitate entry of fresh air. 3. Check vital signs every 15 minutes especially temperature. 4. Tepid sponge patient to reduce temperature. 5. Practice aseptic techniques in all procedures to minimize infections. 6. Serve cold drinks	1. Patient and family were reassured on reducing the temperature to normal again by the health team. 2. Nearby windows were opened to ensure fresh air. 3. Patient's vital signs were checked and recorded every 30minutes and reported as well. 4. Tepid sponging was done when temperature was high using 6 towels for body areas. 5. Aseptic techniques were also ensured to prevent infections. 6. Cold drinks were given to reduce patient's body temperature.	24/11/21 12:20 pm	Goal fully met as temperature reduced to normal when rechecked	F. F

Table 6: Nursing Care Plan for Miss F. P Continued

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
23/11/21 3:05 pm	Altered body comfort related to chest pains.	Patient will regain normal body comfort within 24hours as evidenced by 1.Patient verbalizing that there is reduced chest pain. 2. Nurse observing that patient is comfortable in bed.	1.Reassure patient and relative 2. Assess patient's level of pain using numerical pain rating scale of 0-10 3. Provide comfortable bed for patient. 4. Reduce external stimulation. 5.Educate patient on chest pain management 6. Administer prescribed analgesics to relief pain	1.Patient was reassured that measures such as rest and administration of drugs would be put in place to relieve her of chest pains. 2. Patient's level of pain was assessed and patient rated 6 on the numerical pain rating scale. 3. Patient was placed in a fowler's position to ensure rest. 4. External stimulation was reduced by restricting visitors to reduce noise. 5. Patient was educated on chest pain management and on assessment, patient correctly verbalized rational and measures of chest pain. 6. Prescribed analgesic, 1g of IV paracetamol was administered.	24/11/21 3:05 pm	Goal fully met as patient no longer expresses pain and no longer cough.	F. F

Table 6: Nursing Care Plan for Miss F. P Continued

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/21 8:05 am	Altered sleep pattern (insomnia) related to persistent cough.	Patient will regain normal sleep pattern within 48hours as evidenced by patient verbalising a sound sleep at night and nurse observing patient sleep for at least 8 hours.	1. Provide comfortable bed for patient 2. Elevate the head end of bed (45^0) 3. Provide quiet environment. 4. Assist patient to have warm bath 5. Restrict visitors during resting or sleeping time of patient. 6. Organize nursing activities to prevent interrupting patient at bed time.	1.Comfortable bed was provided free from creases and crumbs 2. Bed was elevated at head end at an angle of 45^0C to facilitate easy breathing. 3. Quiet and calm environment was provided for patient. 4. patient was assisted to have warm bath and warm beverages were served at bed time to induce sleep. 5. Visitors were restricted at sleep time. 6. Nursing activities were organized in such a way that they did not interrupt with patient's rest and sleep.	26/11/21 8:05 am	Goal fully met as patient verbalized, she had a sound sleep.	F. F

Table 6: Nursing Care Plan for Miss F. P Continued

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/21 8:30 am	Imbalanced nutrition (less than body requirement) related to inadequate dietary intake.	Patient's nutritional pattern will be restored within 24 hours evidenced by: 1. Patient verbalizing that she can now eat more than half of a bowl of meal served. 2. Nurse observing patient eat more than half of her meals served.	1. Reassure the patient. 2. Encourage patient to brush her teeth in the mornings and in the evenings and rinse each day after meals. 3. Serve vitamins and high carbohydrate containing diet with high protein attractively. 4. Plan menu with patient and serve small meal but at frequent intervals. 5. Do not serve patient meal at wound dressing time. 6. Serve fruits after meals.	1. Patient was reassured that with time her eating pattern will improve 2. Patient was encouraged to practice mouth care daily and rinse mouth after meals to boost her appetite for food. 3. Vitamins and high carbohydrate with high protein diet were served. 4. Menu was planned with patient and was served at frequent intervals. 5. Patient meal was served at the appropriate time as well. 6. Fruits such as oranges were served after each meal.	25/11/21 8:30am	Goal was fully achieved as patient verbalized that she has eaten more than half of a meal served.	F. F

Table 6: Nursing Care Plan for Miss F. P Continued

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/21 9:30 am	Anxiety related to unknown outcome and diagnosis of bronchopneumonia.	Patient/ family anxiety will reduce within 24 hours as evidenced by: 1. Nurse observing that patient and family have relaxed facial expressions. 2.Patient/family verbalizing that, they are no more anxious.	1. Reassure patient and family. 2. Explain to patient that the medical and nursing interventions are very effective to ensure her speedy recovery so that she can be discharged home early. 3. Introduce patient/family to other patients who are recovering from the same condition. 4. Educate patient and family on the disease condition in simple language. 5. Encourage them to ask questions and answer them correctly. 6. Explain all nursing procedures carried on patient and diagnostic tests to allay anxiety.	1. Patient and family were reassured that the healthcare team is competent. 2. Patient was made aware of the effective medical and nursing interventions that will ensure her speedy recovery. 3. Patient and family were introduced to other patients who were recovering from the same condition. 4. Patient and family were educated on the condition in simple language. 5. Patient and family were encouraged to ask questions and they were answered correctly. 6. All nursing procedures were explained to patient/family.	25/11/21 9:30am	Goal fully achieved as patient and family verbalized, they are no more anxious.	F. F

CHAPTER FOUR

IMPLEMENTATION OF NURSING CARE PLAN

4.0 Introduction

Implementation is the actualization of the nursing care plan through nursing intervention (Cheever & Hinkle, 2014). This chapter gives the vivid account of the actual nursing care that was given to the patient/family from the day of admission until discharge based on the patient's health problems identified. It also includes the preparation of the patient and her family towards discharge, home visits, review and continuity of care.

4.1 Summary of Actual Nursing Care

The actual nursing care rendered to patient and her family commenced on the day of admission 23rd November, 2021 to the time the care was terminated (7th December, 2021). The management of the patient and family was planned to meet the physiological, psychological, emotional and spiritual needs. Whiles on admission, routine nursing actions, for example, education, pain management and medication administration were done and the necessary documentations were also carried out.

4.1.1 First Day of Admission (23/11/21)

A detailed, comprehensive and individualized care rendered to my patient Miss F.P started on the 23/11/21 at 12:00pm at the St. Theresa's Hospital, Nkoranza in the medical ward. Miss F. P was brought to the ward for admission (medical ward) on 23rd November, 2021 at 12:00 pm. She was brought in by the mother. They were welcomed and offered a seat. Patient's document regarding her care were collected and confirmed name of patient and other related information.

I proceeded and introduced myself to them and then asked them of their ward's condition including any problems, they have regarding their daughter's illness. Both parents including their daughter were reassured of competent staff and quality service. Miss F. P was put to bed FMW-12 to rest and the vital signs were checked and recorded as;

Temperature	38.2^{0}C
Pulse	80 beats per minute
Respiration	21 cycles per minute
Blood pressure	120/80 milliner mercury

. The orders given her were to do FBC, BF for MPs, chest X-ray, and to do urine R/E, IV fluid ringers lactate 2L for 24hours, IV dextrose normal saline 2L in 24hours, IV ceftriaxone 2g daily in 72hours, IV paracetamol 1g 8hourly in 24hours, and admit to medical ward.

All particulars about my patient were entered into the admission and discharge book and I continue to reassure parents about the possible interventions of the competent staff in the recovery of their daughter without any complication.

Miss F.P was provided with bed free from creases in a prop up position to enhance respiration. An IV line assessed and secured with adhesive tape. Patient's blood sample was taken to the lab for FBC, BF for MPs. Patient was given IV paracetamol 1g 8hourly x 24hours, IV ceftriaxone 2g daily x 72 hours, IV R/L 500mls was set up.

The hospital policy concerning payment was explained to them that without national health insurance they have to make deposit of some amount to be paid at the cash point. The patient's personal belongings were sent to bed side and patient's mother was orientated to the ward, bathrooms, lavatory, litter bins, source of water and nearby wards and units. She was also informed of the visiting hours, meal, and time for inpatient review.

I reintroduced myself as a Final-year student nurse of Holy Family Nursing and Midwifery Training College Berekum. I told her mother that as part of the training, Final year students are to take a patient each, and render individual care to the patient and family with the help of staff from time of admission till discharge and to do follow-up and home visits during the period of admission and after discharge. This is in partial fulfillment of the requirements of Nursing and Midwifery Council for the award of license to practice as a professional nurse. For this reason, I sought her permission to use her child for the patient and family care study of which she agreed and promised to participate fully in care of the patient. I made patient/family comfortable and understand that the hospital is a temporal place for health care and would be discharged home when the condition improves. The reason for choosing this condition was that, although it is not a chronic disease, it accounts for numerous death cases. Having Bronchopneumonia for a care study is a great opportunity for me to have an in-depth knowledge about the condition in order to educate people on the condition and also to contribute to the existing literature of the condition, this will help nursing profession and rendering of care. I thanked them for their cooperation and patient was put to bed and handed them to the afternoon nurses when leaving the ward and I could see that patient was stable during the handing over.

At 12:20pm, a nursing diagnosis of "Impaired gas exchange related to pulmonary congestions." was made. An objective to improve patient's gas exchange within 24 hours was set. Nursing interventions carried out included; patient's temperature, pulse, respiratory rate and oxygen saturation were monitored, patient was propped up in bed at angle of 45^0 to aid breathing, tight clothes around neck and chest were removed and light clothes were put on, nearby windows were opened and proper ventilation was ensured, patient nostrils were checked and secretions were cleared to maintain patent airway.

Also, at 12:20pm, a nursing diagnosis of “High body temperature (fever) related to infection” was made. An objective to help patient restore a normal body temperature within 24 hours was set. The nursing interventions rendered to patient to achieve our objective included; patient and family were reassured on reducing the temperature to normal again by the health team, nearby windows were opened to ensure fresh air, patient’s vital signs were checked and recorded every 15minutes and reported and tepid sponging was done when temperature was high using 6 towels for body areas, aseptic techniques were also ensured to prevent infections,cold drinks were also given to reduce patient’s body temperature.

At 2pm, her vital signs were recorded as;

Temperature - 37.5°C

Pulse - 91 beats per minute

Respiration - 15 cycles per minute

BP - 120/80mmHg

At 3:05pm, a nursing diagnosis of “Altered body comfort related to chest pains” was made. An objective to regain patient’s normal body comfort within 24hours was set. Nursing interventions carried out included; Patient was reassured that measures such as rest and administration of drugs would be put in place to relieve her of chest pains, patient’s level of pain was assessed and patient rated 6 on the numerical pain rating scale, patient was placed in a fowler’s position to ensure rest, external stimulation was reduced by restricting visitors to reduce noise, patient was educated on chest pain management and on assessment, patient correctly verbalized rational and measures of chest pain, prescribed analgesic, 1g of IV paracetamol was administered.

At 7:30pm, I handed over the patient and mother to the night nurses and informed the mother that, I was going to rest and see them the following morning. She was informed to consult the night nurse in case she needs anything.

At 10pm, Miss F. P's vital signs were recoded per the appendix by the night nurse. She was keenly monitored during the hours of the night.

4.1.2 Second Day (24/11/21)

Patient woke up at 5:46am. Report from the night nurses indicated that patient had intermittent sleep. She was assisted to brush her teeth, empty her bowel and take her bath. At 6:00am, routine vital signs were checked and recorded in the appendix, due medication were served accordingly and recorded.

At 7:14am, patient was served porridge with bread. Patient and daughter were assessed and interacted with for new complaints and health problems. During ward rounds, patient expressed not being able to sleep well at night and also, not being able to eat well. The doctor on duty ordered for a chest x-ray be taken. Plan was to continue treatment. Patient and daughter were educated on the need to take the x-ray.

At 8:05am, a nursing diagnosis of "Altered sleep pattern (insomnia) related to persistent cough" was made. An objective was set to help patient regain normal sleep pattern within 48hours. The following interventions were carried out on the patient to achieve the set objective; comfortable bed was provided free from creases and crumbs, bed was elevated at head end at an angle of 45^0C to facilitate easy breathing, quiet and calm environment was provided for patient, patient was assisted to have warm bath and warm beverages were served at bed time to induce sleep, visitors were restricted at sleep time, nursing activities were organized in such a way that they did not interrupt with patient's rest and sleep.

At 8:30am, nursing diagnosis of "Imbalanced nutrition (less than body requirement) related to inadequate dietary intake." was made. An objective was set to help restore patient's nutritional pattern throughout her period of hospitalization. The following interventions were carried out on the patient to achieve the set objective; patient was reassured that with time her eating pattern will improve, patient was encouraged to practice mouth care daily and rinse mouth after meals to boost her appetite for food, vitamins and carbohydrate with high protein diet were served, menu was planned with patient and was served at frequent intervals, patient meal was served at the appropriate time as well, fruits such as oranges were served after each meal.

At 9:30am, nursing diagnosis of "Anxiety related to unknown outcome and diagnosis of bronchopneumonia." was made. An objective was set to reduce patient's/family's within 24hours. The following interventions were carried out on the patient to achieve the set objective; patient and family were reassured that the healthcare team is competent, patient was made aware of the effective medical and nursing interventions that will ensure her speedy recovery, patient and family were introduced to other patients who were recovering from the same condition and all nursing procedures were explained to patient/family.

At 11:37am, patient was taken to the radiology department for the chest x-ray to be carried out. Patient was brought to the ward after taking the x-ray to continue with her treatment.

At 12:00pm, she was served with kenkey and fried fish for her lunch, according to patient preference. She was able to consume one-third (1/3) of the served meal. She then took orange after eating the kenkey.

At 12:20pm, the objectives that were set on 23rd November, 2021, to relieve patient of breathing difficulty and restore normal body temperature was evaluated. Goals were fully met as

patient reported relief of dyspnea with normal respiratory rate of 19 cycles per minute and SPO_2 of 96% and a normal body temperature of 36.8^0C.

At 3:05pm, the objective that was set on 23rd November, 2021, to regain normal body comfort within 24hours was evaluated. Goal fully met as patient no longer expresses pain and no longer cough.

At 6:00 pm F. P's mother fed her with bread and 150ml of milo which was consumed. She was given token of Tampico at 6:45pm and she was able to take 350ml of the whole 500ml bottle given. On this day, I had a conversation with patient mother and sought her permission to embark my home visit the next day of which she agreed to it and gave me directives to their house and house number at Domase. Patient was positioned in a comfortable bed and was handed over to the night nurses for continuity of care.

At 10:00pm, patient vital signs were checked and recorded as indicated in the appendix. Due medications such as IV paracetamol 1g were administered as prescribed. Patient was made comfortable in bed and slept at 10:30pm according to the night nurses.

4.1.3 Third Day (25/11/21)

Report from night nurses indicated that patient woke up at 5:23am, she emptied her bowel and was assisted to take her bath, brushed her teeth and groomed. All her due medications such as IV paracetamol 1g, IV ceftriaxone 2g were administered and documented.

At 6:00am routine vital signs were recorded as;

Temperature - $36.6^{\circ}C$

Pulse - 100 beats per minute

Respiration - 20 cycles per minute

BP - 120/80mmHg

Miss F. P. was reviewed at 8:00am during ward rounds by the medical officer and she presented no new signs and symptoms. The doctor ordered for continuity of treatment.

At 8:30am, the objective that was set on 24th November, 2021, to restore patient's nutritional pattern within 24 hours was evaluated and achieved as patient verbalized that she has eaten more than half of a meal served**.** I congratulated the mother and patient for their efforts to help achieve the set goal for nutrition

At 9:30am, the objective that was set on 24th November, 2021, to reduce patient/family's anxiety within 24 hours was evaluated and achieved as patient and family verbalized, they are no more anxious. At 2:00pm, Miss F. P's vital signs were checked and recorded as indicated in the appendix. I handed patient over to the afternoon nurses for continuity of care and I set off for the first home visit.

In the evening around 5:32pm, patient was served with fufu and light soup ("nkrakra"). She was able to consume almost the bowlful of meal served according to afternoon nurses. She ate one orange after taking the meal and mother assisted her to perform mouth care. She also had her bed linen straightened and she was made comfortable.

. At 6:00pm her due medications were administered and vitals were checked and recorded as;

Temperature - 36.8°C

Pulse - 101 beats per minute

Respiration - 20 cycles per minute

BP - 120/80mmHg.

At 10:00pm, patient was engaged in a conversation with night nurses and other patients at the ward. Her vital signs were checked and recorded as indicated in the appendix and due

medication IV paracetamol 1g was administered. Patient was then made comfortable in bed and slept around 10:45pm.

4.1.4 Fourth Day (26/11/21)

Review from the nurse's notes indicated Miss F. P. woke up around 5:42am. Patient vital signs were taken at 6:00am and recorded. The patient condition was much stable with all medication's served to patient.

At 7:45am F.P. was served with 500ml bowl of "Hausa porridge" and "koose" and she was able to take half (250ml) of the food. All other nursing intervention for unevaluated goals was also carried out. On this day Miss F. P was reviewed by the doctor during ward rounds and the Miss F. P cheerfully told the doctor that she was well. The doctor declared his intention to discharge patient on the next day. I then discussed the discharge principles concerning payment and NHIS with the patient and mother.

At 8:05am, the objective that was set on 24th November, 2021, to restore patient sleep pattern within 48 hours was evaluated. Goal fully met as patient verbalized a sound sleep at night and nurse observing patient sleep for at least 8 hours. sleep.

In the afternoon the relatives brought bowl of rice and stew as lunch as lunch, this was served in small in small quantity of which she ate half. An orange was given after her meal. F. P's mother was very happy and verbalized that her daughter's appetite had return. I used the opportunity to tell them what I observed and my commendations during the home visit which she accepted in good faith

In the afternoon at 2:00pm patient prescribed medications were administered which was IV paracetamol 1g. Patient's vital sing was also checked and recorded as indicated in the

appendix. In the evening at 5:34pm, she ate fufu with light soup. At 6:00pm her vital signs were checked and recorded as;

Temperature - 36.4°C

Pulse - 101 beats per minute

Respiration - 25 cycles per minute

BP - 120/80mmHg

At 7:30pm, before handing over, patient looked cheerful, alert and calm in bed. Information gathered that day was entered and documented appropriately to ensure continuity of care

At 10:00pm, vital signs were checked and recorded as in the appendix and due medications were administered. Patient slept around 11:00pm

4.1.5 Fifth Day/ Day of Discharge (27/11/21)

Report from night nurses indicate that patient woke up around 5:33am. Miss F. P and mother were met early in the morning for final preparation towards discharge. On observation, F. P. and mother were looking cheerful. When I asked why they were cheerful, they responded that they were looking forward to be discharged home to continue treatment.

At 6:00pm patient vital signs were checked and recorded as;

Temperature 36.2^{0}C

Pulse 76bpm

Respiration 20cpm

Blood pressure 110/70mmHg

Patient's condition had improved tremendously. At 10:30 am, my patient was seen by Dr. E. A. on rounds mother gave no new complain. Upon review by the medical team, F. P. was

discharged at 10:45am to continue treatment at home. The review date was scheduled on 1st December, 2021. I took the opportunity to stress on the education given them so far especially on the need to continue the drug treatment. Her mother was also educated on the importance of good nutrition and the need to increase the protein content of F. P.'s diet. The need for review was also explained and with emphasis on the date, 1st December, 2021. I entered all particulars into the admission and discharge book and the doctors round book. I then picked the folder to the billing unit for the insurance form to be removed since he was insured

On my returns to the ward, Miss. F. P and her relatives had finished packing their belongings and all items given to them were washed neatly and disinfected including the bed used by my patient. I called my patient and relatives and re-encouraged the need to maintain proper ventilations, good personal hygiene, avoidance of overcrowding at home and other public places including educations on the predisposing factors, causes and possible prevention of the condition.

I emphasized on continued medications at home and the dosages were taught. Good nutrition and self- prescribed was to be stop and follow-ups/reviews was also touched on.

Finally, I escorted my patient and relatives to the hospital main gate where the father of my patient was waiting to send them off and that ended our interactions at the ward level. I promised to visit them in their home.

4.2 Preparation of Patient and Family Towards Discharge and Rehabilitation

The preparation of my patient and family towards discharge started on the very day she was admitted to the day of discharge. My patient and mother were congratulated for seeking early treatment. I made them to understand that the hospital was just a temporal place for the treatment and management of his condition and they would be discharged as soon as she regains

her strength. My patient's parents were involving in every aspect of care given to him hence I encouraged them to ask questions freely pertaining their daughter's illness.

Health educations where a priority as my patient was to be discharge home. The education given to my patient and relatives especially Miss. F. P about the disease condition includes; the causes, clinical manifestations, complications, preventions, the need for early treatment and the possible management of the condition to prevent complications.

Through the educations given to my patient's relatives, they were made to understand that exposure to cold weather predisposes the individual to getting pneumonia and infections such as upper respiratory tract infections. I also emphasized on good nutrition and adequate rest which will help painter strengthen his immunity and wellbeing.

Discharge was done on 27th November, 2021, where my patient was declared fit by the physician after nursing objectives were all fully met. I then made entries of the particulars into the admission and discharge book and they were informed of review plans for further assessment.

4.3 Follow Up/Home Visit/Continuity of Care

Home visit is a family-nurse contact which allows the health worker to assess the home and family situation in order to provide the necessary nursing care and health related services (Weller, 2014). The purpose of home visit is to find out needs of patient/family and community in relation to health, socio-economic and cultural aspects, to provide teaching regarding the prevention and control of diseases, and to assess the living condition of the patient/family.

4.3.1 First Home Visit (25th November,2021)

The first visit to my patient's home was on 25th November, 2021 at Domase in the Nkoranza District of Bono East region. The reason for my visit was to assess my patient's home environmental problems, living situation such as housing and the health facilities or services available in the community. This will help address my patient and relatives' health problems accordingly. I did not find it difficult in the location of the house because I went with patient's father since he came for a visit and was about leaving. We took a taxi at the Hospital gate at 2:50pm and got to Domase at 3:05pm

On arrival at my patient's hometown, we headed a house which is sited near the Akumsa Domase M/A J.H.S. It took us about 5 minutes to walk to Akumsa Domase M/A J.H.S where we branched and entered the house. I was welcomed by other members of the family who were present and I was offered a seat. They asked me of my mission and I proceeded by way of introduction and told them of my aim to their home. They welcomed the idea and gave me to go ahead with my assessment.

My first observations were to see some children who exposed themselves despite the cold weather condition, personal hygiene was another area of concern, the compound including some of their room I saw were tidy and clean however, behind the building was quite bushy and well littered with rubbish because there was no any dug-out pit as refuse dump. The house is a mud house of bricks and roofed with Aluminum roofing sheet. It is composed of four room which accommodates over ten people including all their belongings and hence that they have a little bit of problem with accommodation. However, their water source was a borehole and where it is stored was also clean.

The health educations I gave them was primarily on the need to protect themselves as well as the children especially during cold weather. They were also told to observe good personal hygiene and environmental hygiene, was of disposing of refuse given in pit. I encouraged them to maintain proper ventilation in their rooms. They were also told to prepare a well-balanced diet from the locally food staff available to strengthen their immunity and remain healthy with good food hygiene.

I encouraged them to seek early medical treatment and avoid self-medications whenever they fall sick. I ended the conversation by thanking them for their cooperation and reassured them of my patient is responding quickly to the treatment and will be with them soon at home and I also told them of my second coming.

4.3.2 Second Visit (29th November, 2021)

My second visit to my patient home was on 29th November,2021 which in actual fact was unannounced. This visit was to observe the home environment, their life style after the educations given and follow up to assess my patient coping ability at home and his general condition.

I was very much impressed when I got to the house. I saw that the compound was very neat including the surrounding which was littered and bushy was all looking so attractive and clean. The general observations were that, there was much improvement based on the previous health educations given.

I spent sometimes with my patient and family. The assessment and examination I made on my patient shows she was fit and fine and no complaint given. They were reminded to stick to the health educations given comprising the causes predisposing factors and manifestation of the disease condition including other relevant points that were touched on. My interaction with my

patient ended up after spending not less than two hours with them. I expressed gratitude to the family for their cooperation and support given to me during our interactions.

I asked for permission to leave and reminded patient/family about the review date on 1st December, 2021. Patient, and her mother escorted me to the road side where I bordered a taxi and left at 3:35pm.

4.3.3 Review (1st December, 2021)

On 1st December, 2021, at 7:50am, patient and her mother came to the hospital for review. I escorted them to the Out-Patient Department. Her vital signs were checked and recorded as;

Temperature	-	36.4°C
Pulse	-	76 beats per minute
Respiration	-	20 cycles per minute
BP	-	120/80mmHg

They were then asked to go to consulting room five, so I led them to the consulting room. On examination and assessment by the medical officer he confirmed the condition had improved. I observed that her condition had really improved. He then ordered for a chest x-ray to be taken. The x-ray showed that the lungs were in good shape. Patient and daughter were educated by the medical officer about the importance of eating a well balance diet and fruits. I encouraged her to continue with the treatment, reassured them on the need to report to the hospital whenever patient and any member of the family falls sick. I once again informed patient, my intention to terminate my nursing care and the need to hand over care to nearby community nurse when I embark on my 3rd home visit. I accompanied them to the hospital entrance and bade them a good bye.

4.3.4 Third Home Visit (7th December, 2021)

I made my third home visit on Tuesday, 7th December, 2021. The purpose of the visit was to find out how patient was doing and to terminate care which was discussed on my previous visit. I got to patient's house around 2:20pm to finalize my care rendered to Madam F.P. and to hand her over to a competent health worker to continue with her care. I was welcomed and offered a seat. I explained to them again on the need to terminate the care and hand her over to another health personnel to continue with her care.

On patient's preference and on assessment, I decided to hand over Madam F.P. to her parents to take over the care and to ensure continuity of Madam F. P's care. Patient looked cheerful, active and healthy. Patient's condition had improved and no complaints were presented. A quick general assessment and observation on the patient revealed that she was in good state of health. Since that was my last visit, I stressed on the importance of good nutrition, the need to eat more fruits and the need to ensure proper personal and environmental cleanliness. I also reinforced the education on the importance of reporting to the Health Centre early whenever they are sick. I encouraged them to ask questions. I reemphasized on health educations that had been given to them already. They were grateful and promised to adhere to the education. Since it happened to be my last day of therapeutic relationship with patient/family, I terminated the care by officially handing over patient to patient's parents (Mr. K.F and Mrs. A.K) I thanked them for their co-operation which made the study a success. Again, patient/family expressed their gratitude by showing how grateful they were to me for the support and care given to them. I sought permission to leave and bade them the final farewell. I boarded a taxi and left at 5:00pm.

CHAPTER FIVE

EVALUATION OF CARE

5.0 Introduction

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Cheever & Hinkle, 2014). This chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient/family.

5.1 Statement of Evaluation

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

5.1.1 Patient was relieved of breathing difficulty within 24 hours.

On 23rd November, 2021, the day of admission, at 12:20pm, patient had difficulty breathing. A nursing diagnosis of "Impaired gas exchange related to pulmonary congestions." was made. An objective to regain normal breathing pattern within 24 hours was set. Nursing interventions carried out included; patient was propped up in bed at angle of 45^0 to aid breathing, tight clothes around neck and chest were removed and light clothes were put on, nearby windows were opened and proper ventilation was ensured, patient nostrils were checked and secretions were cleared to maintain patent airway. On 24th November, 2021, at 12:20pm, the objectives that were set on 23rd November, 2021, to relieve patient of breathing difficulty was evaluated. Goal was fully met as patient reported that dyspnea has subsided and nurse observing patient having a normal breathing pattern.

5.1.2 Patient's normal body temperature was restored within 24 hours.

On 23rd November, 2021, day of admission at 12:20pm, Patient had high body temperature. A nursing diagnosis of "High body temperature (fever) related to infection." was made. An objective to help patient restore a normal body temperature within 24 hours was set. The nursing interventions rendered to patient to achieve our objective included; patient and family were reassured on reducing the temperature to normal again by the health team, nearby windows were opened to ensure fresh air, patient's vital signs were checked and recorded every 15minutes and reported and tepid sponging was done when temperature was high using 6 towels for body areas, aseptic techniques were also ensured to prevent infections,cold drinks were also given to reduce patient's body temperature. On the 24th November, 2021, at 12:20pm, the objective set to restore patient's body temperature to normal within 24 hours was evaluated and goals fully met as; patient verbalized reduction in feeling of warmth and nurse recorded a normal axillary temperature of 36.8 ^{O}C.

5.1.3 Patient's Body Comfort was Restored Within 24hours.

On 23rd November, 2021, day of admission, at 3:05pm, Patient complained of chest pains. A nursing diagnosis of "Altered body comfort related to chest pains" was made. An objective to regain patient's normal body comfort within 24hours was set. Nursing interventions carried out included; Patient was reassured that measures such as rest and administration of drugs would be put in place to relieve her of chest pains, patient's level of pain was assessed and patient rated 6 on the numerical pain rating scale, patient was placed in a fowler's position to ensure rest, external stimulation was reduced by restricting visitors to reduce noise, patient was educated on chest pain management and on assessment, patient correctly verbalized rational and measures of chest pain, prescribed analgesic, 1g of IV paracetamol was administered.

On 24^{h} November, at 3:05pm, the objective that was set on 23rd November, 2021, to regain normal body comfort within 24hours was evaluated. Goal fully met as patient no longer expresses pain and no longer cough.

5.1.4. Patient's Sleep Pattern was Restored to Normal within 48hours.

On 24th November, 2021, a day after admission at 8:05am, patient was not able to sleep well. A nursing diagnosis of "Altered sleep pattern (insomnia) related to persistent cough" was made. An objective was set to help patient regain normal sleep pattern within 48hours. The following interventions were carried out on the patient to achieve the set objective; comfortable bed was provided free from creases and crumbs, bed was elevated at head end at an angle of 45^{0}C to facilitate easy breathing, quiet and calm environment was provided for patient, patient was assisted to have warm bath and warm beverages were served at bed time to induce sleep, visitors were restricted at sleep time, nursing activities were organized in such a way that they did not interrupt with patient's rest and sleep. On 26th November, 2021 at 8:05am, the objective that was set on 24th November, 2021, to restore patient sleep pattern within 48hours was evaluated. Goal fully met as patient verbalized, she had a sound sleep.

5.1.5. Patient's Nutritional Pattern Was Restored Within 24 Hours.

On 24th November, 2021, a day after admission at 8:30am, patient had poor appetite. A nursing diagnosis of "Imbalanced nutrition (less than body requirement) related to inadequate dietary intake." was made. An objective was set to help restore patient's nutritional pattern throughout her period of hospitalization. The following interventions were carried out on the patient to achieve the set objective; patient was reassured that with time her eating pattern will improve, patient was encouraged to practice mouth care daily and rinse mouth after meals to boost her appetite for food, vitamins and carbohydrate with high protein diet were served, menu

was planned with patient and was served at frequent intervals, patient meal was served at the appropriate time as well, fruits such as oranges were served after each meal.

On 25th November, 2021 at 8:30am, the objective that was set on 24th November, 2021, to restore patient's nutritional pattern within 24 hours was evaluated and achieved as patient verbalized that she has eaten more than half of a meal served**.**

5.1.6. Patient and Her Family were Relieved of Anxiety Within 24hours

On 24th November, 2021, a day after admission at 9:30am, patient and relatives were anxious. A nursing diagnosis of "Anxiety related to unknown outcome and diagnosis of bronchopneumonia." was made. An objective was set to reduce patient's/family's within 24hours. The following interventions were carried out on the patient to achieve the set objective; patient and family were reassured that the healthcare team is competent, patient was made aware of the effective medical and nursing interventions that will ensure her speedy recovery, patient and family were introduced to other patients who were recovering from the same condition and all nursing procedures were explained to patient/family.

On 25th November, 2021 at 9:30am, the objective that was set on 24th November, 2021, to reduce patient/family's anxiety within 24 hours was evaluated and achieved as patient and family verbalized, they are no more anxious.

5.2 Amendment of Nursing Care

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

5.3 Termination of Care

The recovery of my patient gave rise to the termination of the holistic care. The termination started on the day of admission which was on 23rd November, 2021. I made my patient and family to understand that, the care I am rendering to them would end with time. My last interactions with my patient and family were my third visit which was on 7th December, 2021.

Health education was stressed on and I encouraged them to attend hospitals for medical care any time ill health sets in. I discouraged them from buying drugs over the counter. I further acknowledged the family for their support and cooperation given me during my interactions with them.

The family in turn thanked me and the health staff for the care rendered to their daughter during hospitalization. There and then on that faithfully day, our interaction and care got terminated. I however requested that the physician assistant should continue to visit them at their house.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This is the last chapter for the patient/family care study and it entails the summation and conclusion of all care to patient/family throughout the period of hospitalization.

6.1 Summary

My patient, Miss. F. P was admitted into the medical ward on the 23rd November, 2021 at 12:00pm with the complaint of fever, dry cough, difficulty in breathing (insomnia), chest pain, poor appetite general body weakness for five days at St. Theresa's Hospital, Nkoranza. She was seen by a medical doctor, Dr. E.A. and diagnosed as suffering from bronchopneumonia. Vital signs on admission were as follows; temperature – 38.2^0C, pulse - 80 bpm, respiration - 21 cpm, BP-120/80mmHg, weight - 51kg.

The following laboratory specimens were requested;

1. Chest x-ray
2. Blood sample for full blood count, urgent Hb.
3. Urine R/E
4. Blood film for malaria parasites.

Nursing diagnosis, orders and interventions were instituted and evaluated as such. Series of health educations were given in diverse ways in addition to medical treatment given to ensure speedy recovery of my patient and to prevent admissions into hospital. Treatments given to patient during her period of hospitalization included; IV fluid ringers lactate 2L for 24hours, IV dextrose normal saline 2L in 24hours, IV ceftriaxone 2g daily in 72hours, IV paracetamol 1g 8hourly in 24hours.

Continuity of care was ensured with three home visits. My first home visit was on 25th November, 2021, second home visit was on 29th November, 202, a follow up/review made in the hospital on 1st December, 2021 and the third home visit was on 7th December, 2021. Patient became well and was discharged on 27th November, 2021 without any complications. Patient came for review on the 1st December, 2021. Education was given on the importance of good nutrition, the need to eat more fruits and the need to ensure proper personal and environmental cleanliness.

6.2 Conclusion

The study has equipped me with knowledge on how to care for a patient as an individual. Through this study, I have been able to put into practice actual and holistic nursing care as it has been learnt theoretically and to manage a complication that resulted from the condition. The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (and family) relationship as well as broadened my knowledge on pneumonia, its management and prevention.

It is my recommendation that all students are given the opportunity to embark on the patient/family care study to implement the nursing process in order to render individualized comprehensive care to patients/families. In brief, I really enjoyed every bit of writing this script despite the challenges encountered.

APPENDIX

Table 7: Vital Signs of Madam F.P.

Date	Time	Temperature (°C)	Pulse (bpm)	Respiration (cpm)	Blood Pressure (mmHg)
23/11/2021	12:00pm	38.2	80	21	120/80
	2:00pm	37.5	91	15	120/80
	6:00pm	37.5	90	19	120/80
	10:00pm	37.0	86	17	120/80
24/11/2021	6:00am	37.1	89	19	110/70
	10:00am	36.8	97	22	120/80
	2:00pm	36.9	91	19	120/90
	6:00pm	36.8	93	20	120/80
	10:00pm	36.7	102	23	110/70

Date	Time	Temperature (°C)	Pulse (bpm)	Respiration (cpm)	Blood Pressure (mmHg)
25/11/2021	6:00am	36.6	100	20	120/80
	10:00am	36.9	104	23	120/80
	2:00pm	37.0	98	21	120/80
	6:00pm	36.8	101	20	120/80
	10:00pm	36.5	90	20	120/80
26/11/2021	6:00am	36.4	101	25	120/80
	10:00am	37.1	94	20	120/70
	2:00pm	36.8	99	23	120/80
	6:00pm	36.4	101	25	120/80
	10:00pm	36.5	87	20	120/80
27/11/2021	6:00am	36.2	76	20	110/70

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Others

Patient's folder number: *11254/17*

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