HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A PATIENT/ FAMILY CARE STUDY ON SEVERE ANAEMIA

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

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PREFACE

In the past nursing care was concerned with bathing, wound dressing and feeding of the patient informally requiring no training. Nursing became a profession towards the 19th century when Florence Nightingale provided and established a pattern which has become the basis nursing study today. The nursing profession has undergone series of transformation with much knowledge in technology in recent years. Nursing is now a science and uses the nursing process approach. The nursing process is the deliberate problem-solving tool that nurse employ to resolve actual and prevent potential patient/family health problem. Its components are; assessment, analysis, planning, implementation and evaluation. The patient/family care study is a detailed written report of nursing care rendered to a patient/family within a specific period of time.it explores nursing care rendered from the time of encounter to termination of nurse-patient relationship. It gives an in-depth description and explanation of how a patient's response to a specified disease. It gives the student nurse opportunity to combine knowledge acquired in the classroom and the clinical flied into practice and also a chance to interact and coordinate with members of the healthcare team. The study serves as an evaluation tool by the Nursing and Midwifery Council of Ghana as partial fulfilment towards the award of license to practice as a Registered General Nurse. The confidentiality of the patient/family was ensured by the use patient/family initials in place of their full names.

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I thank the gracious and almighty lord for a successful study.

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I am grateful to all the authors of books from which relevant information were picked for the study.

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I would like to extend my appreciation to my class, diploma 23.

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INTRODUCTION

Patient and family care study uses the nursing process approach, which is defined as a systematic method of taking an independent action, allowing application of knowledge and skills in an organized goal-oriented manner, effectively about the patient's condition with the health team. The patient/family case study was carried on a thirty-three-year-old man who for the purpose of confidentiality will be referred to as G.A in the study. he was admitted on the 7th December 2022 at the emergency ward, and later transferred to the males' ward at the Holy Family Hospital Berekum with the diagnoses of Severe Anemia with hemoglobin level of 4.3g/dl. A cordial and therapeutic relationship was established with patient and family. he spent eight days at the ward and with effective medical and nursing care, patient was discharged home on the 16th December, 2022. On the day of admission, master G.A presented with general feeling of unwell which started with dizziness and general body weakness, difficulty in breathing and chest pains afterwards. His vital signs were checked and recorded as Blood Pressure-130/90mmHg, Pulse-84bpm, Respiration-12Cpm, Temperature-36.2°C, Weight-65kg, SPO2-98%. I introduced myself to him as a final year student nurse of the Holy Family Nursing and Midwifery Training College, Berekum and will like to use his condition for writing of a patient/family care study. he agreed and was very co-operative. Three consecutive home visits were also paid to patient's house to assess the home environment upon which health education was given. The first home visit was done while patient was still on admission 10th December, 2022, the second home visit was on the 18th December, 2022 and third home visit was on the 31st December, 2022. he was rescheduled to come for review on 27th December, 2022. It also aimed at determining whether the patient had improved on his condition and conforming to the drug regimen.

The following drugs were used in the treatment of the condition:

1. IVF Dextrose in Normal Saline 1L Overnight
2. Hydroxide Polymaltose complex 20mg BID x 30days
3. IVF Normal saline 500mls Stat
4. Oral tothema 1 vial BD x 14 days
5. IV paracetamol 500mls -1G stat.

Laboratory investigations that were requested for patient include;

1. Blood for grouping and cross matching
2. Hemoglobin level estimation
3. Full blood count
4. Blood film test for malaria parasite

The study has been arranged in six chapters in line with the generally accepted steps that is assessment, diagnosis, planning, intervention and evaluation.

1. Chapter one: Assessment of Patient/Family.
2. Chapter two: Analysis of data collected
3. Chapter three: Nursing Care Plan for Patient/Family.
4. Chapters four: Implementation of Patient and family care plan.
5. Chapter five: Evaluation of care rendered to patient and family.
6. Chapter six: Summary and conclusion of care rendered.

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CHAPTER ONE

ASSESSMENT OF PATIENT AND FAMILY

1.0 Introduction

According to Toney-Butler (2020), assessment involves the systematic and continuous collection of data about a patient's psychological, physiological, sociological, and spiritual status; sorting, analyzing, and organizing the data and the documentation and communication of the data. It includes the patient's medical, personal, social and environmental status. It forms the first part of the nursing process upon which nursing diagnosis is established. It also helps to render the exact nursing care to the patient and family. Information is gathered from patient and family through interviewing, observation, and reference to past medical records. It involves patient's particulars, family medical history and socioeconomic history. Assessment provides information that forms the patient's database. The patient is the primary source of data but other sources such as patient's folder, results and patient relatives are also vital in obtaining information about patient.

1.1 Patient's Particulars

According to Harper (2020), particulars of a patient are the facts or details about patient, which are written down and kept as a record. It is the biographical data of a client which includes areas such as client's name, date of birth, sex, marital status, nationality, next of kin, address, occupation, hometown, denomination and others that is written down and kept as record. Mr. G. A is a 33years old, born on 30th June, 1989. He is fair in complexion and a Ghanaian by nationality. Mr. G.A. is a native of Berekum in the Bono Region of Ghana. Mr.G.A. stays in a compound house closer to The God Is Love Storey Building in Berekum with house number F74. He is an Akan by tribe and speaks Twi only. Mr. G.A. is 170cm tall and weighs 65kg. He was

born to Mr. F.A. and Mrs. J.Q. He is the second born among five children. His siblings are in good health except the first born who died from natural cause. Mr. G.A. is a Christian and attends The Church of Pentecost Ghana at Berekum. He dropped out of school at the senior high level (S.H.S.-2) due to financial problems. Patient has no physical impairment on assessment. Mr. G. A. is not married but has one child with Miss K.F. The next of kin is his Brother Mr. B.A., the fourth born, who stays at Nsoatre .

1.2 Family's Medical History

According to Mr. G.A. there is no known history of hereditary diseases such as hypertension, diabetes, epilepsy, gout, sickle cell disease or any form of mental disorders or congenital abnormalities. The mother of Mr. G.A. also testified that such diseases aren't spotted in their lineage. The parents of Mr. G. A. are both alive and in a healthy state as well as his siblings. His father is a farmer and the mother as well. Mr. G.A. however indicated that the family members occasionally get diseases like malaria, headache and common cold which are treated using over the counter (OTC) medication and sometimes local herbal preparation. Patient mother claims there are no known history of allergies in the family. There is no history of hospitalization and the family main source of healthcare is the use of traditional medicines and over the counter medication.

1.3 Family's Socio-Economic History

Hellmich (2015), states that socio-economic history relates to a combination of an individual's income occupation, and social background. Mr. G. A. is from the middle socio-economic class family so they are able to meet most of their daily expenses though they sometimes face some difficulties in purchasing goods and equipment's for farming. The family members have a cordial relationship and thus give the necessary help to each other when the need arises. Mr. G.A. stated that it

is taboo in the community to go to farm on Wednesday and as Christian drinking alcohol and telling lies are prohibited. Mr. G.A. and his family upholds Christian values and cultural practice dearly. Also, they attend funerals, weddings, and other social activities organized in the community including communal labor.

Mr. G. A. dropped from S H.S and could not continue his education due to some financial constrains they suffered on the part of the parents of Mr. G.A. at that time. Mr. G.A. is self employed, an electrician with three apprentices. The family source of healthcare is the use of traditional medicines and Over the Counter Medications (OTC). The parents of Mr. G.A. are not employed but are farmers. The Patient's mother indicated that occupational hazards they are at risk to include injuries afflicted by animals, theft, vehicle accident, amputation and exposure to toxic chemicals but by the grace of God, none has occurred.

1.4 Client's Developmental History

Growth is the progressive development of a living thing, especially the process by which the body reaches its point of complete physical development (Weller, 2017). According to Mr. G. A., his mother informed him that, she gave birth to him through vaginal delivery with the aid of a registered midwife at the Holy Family Hospital Berekum without any complication on 30th June, 1989. Mr. G.A., was circumcised a week after discharge at the Holy Family Hospital Berekum. According to the mother he was exclusively breastfeed for 24 weeks.

He could cry and move his limbs actively at the 8th week. Mr. G.A. was very aware of his environment, he could raise his head and arms from a surface and his eyes could follow movement of objects at the 12th week. On the 22nd week Mr. G.A, developed his first milk teeth. Also in a conversation with the mother, patient sat on the 36th week and started crawling on the 40th week and took his first step in the 52nd week and could say "mama" when he was a year old.

He has never suffered from any of the vaccine preventable diseases. The Bacillus Calmette-Guérin (BCG) mark is clearly seen on his right upper deltoid muscle. He did not suffer from any congenital abnormalities when growing. At the age of 3years, he started schooling at the Demonstration B school at Berekum and completed Demonstration B Junior High School (JHS) in 2007. He started Senior High School at the age of 17 at the Presbyterian Senior High School Berekum and ended at S.H.S 2 due to financial constraints on the part of the parents.

The parents of Mr. G A, could not afford tertiary institution due to financial constraints.

Mr. G. A. started growing pubic hair in the axilla and other genital areas when he was 13years old. During his adolescence he used to associate himself with his peer group who were into the making of smaller cars from used cans and used slippers. Mr. G. A. always wanted to be in the army from childhood to adolescence. He was an average student and his favorite subject was mathematics. Although growing up was not all that juicy, he cultivated a land from his parents which served as a form of revenue growing up.

According to Erickson's theory of psychosocial development (1959), there are eight stages with possible result, thus either success or failure personality.

Mr. G. A. falls within the sixth stage; Intimacy verses isolation (19 years to 40) years. According to Erickson, intimacy is loving relationship of any sort. It requires sharing yourself with other. They explore personal relationships because they want to fit in the society. Erikson believed it is vital that people develop close, committed relationships with other people. Those who are successful at this stage will have the ability to love and have a committed and secured relationship.

Some people seek deep intimacy and satisfying relationship, but if unsuccessful isolation occurs.

Mr. G.A has achieved the intimacy stage because he has develop close, committed relationships with other people. According to Mr. G.A, he is in a mature relationship leading to marriage preparations

1.5 Client's Lifestyle and Hobbies

Mr. G. A. goes to bed at 8:30-9:00pm and wakes up at 5:30-6:00am. Mr. G.A. bathes and perform oral hygiene two times daily. He does not have a specific time for breakfast because, it is either taken in the house or at his workplace where he works as an electrician. He then proceeds to his workplace at 7:00am and closes at 5:30-6:00pm. He is an electrical engineer who works at the Namasua car station to meet his demands. According to him he takes his bath upon returning from work and get himself some food to eat around 6:30pm-7:00pm. He is able to tolerate all meals served but prefers "Banku" with "Okro stew".

Also Mr. G.A, said he a was footballer in school and has stopped playing because he sustained a knee injury but still has the interest for football and support Accra Hearts of Oak and likes listening to sports commentary on the radio. He stated clearly that he does not smoke but has been abusing alcohol but ceased taking alcohol 4 months ago due to counselling from pastors and advice from elders. According to Mr. G.A., he uses his leisure time to do his household activities which is mostly on weekends. He visits the farm on Saturdays early morning and returns in the afternoon to rest and goes to play "Oware" and "Dame" with his friends. He attends church on Sundays and days when the church schedules a program. He attends funerals, weddings, naming ceremonies and engage himself in most social activities, when the need arises. Mr. G. A. stated that he is allergic to plantain and beans stew and also pomade with pungent smells. He uses both verbal and nonverbal communication styles when he speaks such as gestures and eye movement to speak to children to desist from doing certain things. Mr. G. A. is an extrovert and from the

observation made, he is cheerful, loving and a kind hearted person. Mr. G. A. also said he dislikes talking too much and likes to help others in need.

1.6 Client's Past Medical History

Patient past medical history is a record of a past medical problem and treatment that a person has had in the past (Merriam-Webster, 2022). Among such information are childhood illness, allergies, accident and injury, mental check-ups.

Through interaction with Mr. G. A., he admitted that he had taken all immunizations against the vaccine-preventable disease. He has no physical disability has never been admitted to the hospital.

He never suffered from any childhood illness like measles, whooping cough, diphtheria, and so on. However, he occasionally experiences minor illnesses like coughing, headache, and weakness usually after the hard day's work of which they are relieved using over -the -counter drugs such as Paracetamol, cough syrup, liver salt, that is bought from nearby pharmaceutical shop. Patient is not allergic to any drug, animal or insect. Patient has never been hospitalized and never sustained any injuries or accidents. He does not possess any physical disability.

1.7 Client's Present Medical History

According to Mr. G. A. he was well until 7th of December 2022, when he experienced general feeling of unwell which started with dizziness and general body weakness, difficulty in breathing and chest pains afterwards. He went to Zongo health Centre when he was referred to Holy Family hospital Berekum. The signs and symptoms started in the morning around 7:00 AM and had a sudden onset. Mr. G.A. stated it was the first time he experienced those signs and symptoms.

He reported to Holy Family Hospital, Berekum at 10:20am where he was attended to by Dr. O.A. He was looking pale and complained of dizziness, general body weakness, difficulty in breathing and chest pains. Patient blood sample was taking to the laboratory and results confirmed low hemoglobin level and with the above signs and symptoms, the doctor made a diagnosis of severe anaemia. The doctor admitted him to the Accident and Emergency ward.

1.8 Admission of the Patient

Mr. G.A. was admitted to the Male's ward on the 8th of December 2022 through the Accident and Emergency Unit accompanied by a staff nurse and her sister in a conscious and alert state. Patient was ambulant. They were warmly welcomed and introduced to the staff on duty and a prepared admission bed, free from creases and cramps was given to make the patient comfortable because he was feeling dizzy. The patient and relatives were introduced to staff on duty. Tight clothes were removed from the patient. They were reassured that the patient was in competent hands and everything possible will be done to ensure his recovery. The patient's particulars such as name, date of admission, time, age, and next of kin among others were taken and recorded in the ward state, admission and discharge book. The patient`s relatives were informed about the ward policy on visiting hours, ward rules, items and clothing that were needed during the hospitalization.

A quick assessment of the patient's general appearance was made and vital signs were checked recorded as follows;

- Temperature …….. 36.2 ^{0}C
- Pulse……. 84bpm
- Respiration ……. 12cpm
- Blood pressure …… 130/90mmHg

- Weight ……. 73kg
- SPO2……. 98%

Patient was introduced to other patient on the ward. The relatives of the patient were orientated to the ward and it annexes. The patient was in a conscious state and was reassured of competent staff available and good nursing interventions to be carried out on him to ensure his speedy recovery. Physical examination of patient revealed pallor of the conjunctiva, ankle edema, and complained of chest pains when breathing out.

Patient treatment plan are as follows;

5. IVF Dextrose in Normal Saline 1L Overnight
6. Hydroxide Polymaltose complex 20mg BID x 30days
7. IVF Normal saline 500mls Stat
8. Oral tothema 1 vial BD x 14 days
9. IV paracetamol 500mls -1G stat.
10. Blood for grouping and cross matching
11. Hemoglobin level estimation
12. Full blood count
13. Blood film test for malaria parasite

His blood sample was taken for grouping and cross matching at the laboratory. The result revealed that he is “O positive” and his hemoglobin level was 4.3g/dl. The need for blood transfusion was explained to him and he was convinced to sign the consent form. Four units of whole blood was ordered for the patient and one unit was retrieved from the blood bank. Patient was educated on the need for blood transfusion and pre-transfusion vital signs was done and

recorded as Blood Pressure 120/90mmHg, Temperature-36.2^{0}C, Pulse-89bpm, Respiration-13cpm and oxygen saturation 95%. Teachings was done prior to transfusion about the possible reaction that may occur during the transfusion process such as rashes, chills, itching and fever and documented accordingly. Afterwards blood was set up at 12:45pm and completed successfully at 3:10pm. Upon interaction with the patient and observation and assessment made during the transfusion process there was no post transfusion reaction. Intravenous paracetamol 500mls in 1g was administered accordingly to alleviate chest pains and the side effects monitored.

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

1.9 Clients Concept about His Illness

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

1.10 Literature Review on Anaemia

This section deals with documented information about the condition Mr. G.A. was diagnosed with, that is anaemia

Definition of Anaemia

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

Incidence of Anaemia

According to World Health Organization (W.H.O) the incidence of anaemia is extremely high particularly in developing countries where nutrition is poor. It is a serious global public health problem that particularly affect young children and pregnant women. WHO estimates that 42% of

children less than 5 years and 40% of pregnant women worldwide are anaemic. It is also high in the tropical regions where hookworm and malaria is endemic. Women of the reproductive age especially pregnant women and children are the most vulnerable. Elderly people are not left out in this and it is the most common hematological condition that affects the elderly (Smeltzer, Bare, Hinkle & Cheever, 2016).

Types of Anaemia

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

1. Nutritional Anaemia

- Aplastic Anaemia
- Iron Deficiency Anaemia (Ida)
- Pernicious Anaemia

2. Hemolytic Anaemia

- Sickle Cell Anaemia.
- Glucose-6- Phosphate Dehydrogenase Deficiency
- Thalassaemia
- Auto-Immune Anaemia

3. Hyperchromic Macrocytic Anaemia

4. Hypochronic Microcytic Anaemia

5. Normochromic Normocytic Anaemia

Nutritional Deficiency Anaemia

A. Aplastic anaemia

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

B. Iron Deficiency Anaemia (IDA)

Iron deficiency anaemia develops when there is inadequate iron for haemoglobin synthesis. The causes are: blood loss, increased demands, e.g. growth and pregnancy, decreased absorption (e.g. post-gastrectomy), poor intake. Most iron deficiency is due to blood loss, usually from the uterus or gastrointestinal tract. Premenopausal women are in a state of precarious iron balance owing to menstruation. A common cause of iron deficiency worldwide is blood loss from the gastrointestinal tract resulting from parasites such as hookworm infestation. The poor quality of the diet, predominantly containing vegetables, also contributes to the high prevalence of iron deficiency in low income countries. Even in developed countries, iron deficiency is not uncommon in infancy, when iron intake is insufficient for the demands of growth. It is more

prevalent in infants born prematurely or where the introduction of mixed feeding is delayed. (Kumar & Clark, 2021).

C. Pernicious Anaemia

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

2. Haemolytic Anaemias

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

A. Sickle Cell Anaemia

SCD can cause a severe hemolytic anemia that results from inheritance of the sickle hemoglobin (HbS) gene, which causes the hemoglobin molecule to be defective. HbS acquires a crystal-like formation when exposed to low oxygen tension. The oxygen level in venous blood can be low enough to cause this change; consequently, the erythrocyte containing HbS loses its round, pliable, biconcave disc shape and becomes dehydrated, rigid, and sickle shaped. These long, rigid erythrocytes can adhere to the endothelium of small vessels; when they adhere to each other, blood flow to a region or an organ may be reduced. If ischemia or infarction results, the patient may have pain, swelling, and fever. The sickling process takes time; if the erythrocyte is again exposed to adequate amounts of oxygen before the membrane becomes too rigid (e.g., when it travels through the pulmonary circulation), it can revert to a normal shape. For this reason, the "sickling crises" are intermittent. Cold can aggravate the sickling process, because

vasoconstriction slows the blood flow. Oxygen delivery can also be impaired by an increased blood viscosity, with or without occlusion due to adhesion of sickled cells; in this situation, the effects are seen in larger vessels, such as arterioles. (Hinkle & Cheever, 2018).

B. Glucose-6- Phosphate Dehydrogenase Deficiency

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

B. Thalassaemia

The thalassaemias affect people throughout the world, and at least 60000 severely affected individuals are born every year. Normally, there is balanced (1:1) production of α and β chains.

The defective synthesis of globin chains in thalassaemia leads to 'imbalanced' globin chain production, causing precipitation of the excess globin chains within the red cell precursors and resulting in ineffective erythropoiesis. Precipitation of globin chains in mature red cells leads to haemolysis. This concept of globin chain imbalance is critical in understanding the relationship between a patient's genotype and phenotype (the greater the imbalance, the worse the phenotype), as well as understanding how novel therapies are being used to ameliorate the disease. (Kumar & Clark, 2021)

C. Auto-Immune Anaemia

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

Classification of Anaemia According To The Morphology Of The Cells And Haemoglobin Concentration.

3. Hyperchromic Macrocytic Anaemia

In this type of anaemia, the red blood cells are fewer but larger than normal (macrocytic) with increased haemoglobin content (hyperchromic). It is caused by lack of vitamin B 12 or folic acid (Kumar & Clark, 2021).

4. Hypochromic Microcytic Anaemia

Microcytic anaemia most commonly results from iron deficiency, the most common cause of anaemia globally, affecting 30% of the world's population. This is because of the body's limited ability to absorb iron and the frequent loss of iron owing to bleeding. Although

iron is abundant, most is in the insoluble ferric (Fe3+) form, which has poor bioavailability. Ferrous (Fe2+) iron is more readily absorbed. (Kumar & Clark, 2021).

5. Normochromic Normocytic Anaemia

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

Aetiology Of Anaemia

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

1. Disease condition e.g. malaria, cancers, hookworm infestation
2. Nutritional deficiencies such as vitamin B12, folic acid, ascorbic acid and protein deficiencies
3. Haemorrhage (excessive blood loss)
4. Haemorrhoids causes iron deficiency anaemia due to rectal bleeding which results in large amount of blood being lost from the body
5. Haemolysis (excessive destruction of erythrocytes)
6. Chemicals or drug (cytotoxic drugs) with the potential to suppress bone marrow activities
7. Morphological abnormalities (structure, shape and size)

Pathophysiology of Anaemia

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

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

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

General Clinical Features of Anaemia

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

- Breathlessness
- Fatigue
- Headaches
- Palpitations
- Faintness
- Pallor
- Tachycardia
- Systemic flow murmur
- Cardiac failure
- Jaundice
- Bone deformities

- Leg ulcers
- Brittle nails
- Angular stomatitis
- Brittle hair
- Spoon-shaped nails

Diagnostic Investigations

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

1. Physical examination
2. Blood film for malaria parasite
3. Sickling solubility test
4. Red bone marrow examination
5. Haemoglobin level estimation
6. Haematocrit
7. Computed tomography for cancers
8. Erythrocyte sedimentation rate
9. A test for vitamin B 12 absorption (schilling test)
10. Blood smear reveals variation in size, shape and number of cells
11. Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination

Medical Treatment of Anaemia

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

A. Treating the underlying cause of anaemia and restoration of hemoglobin level to normal i.e.

14-18g/dl in males and 12-16g/dl in females.

B. Replenishing iron store after correction of anaemia in iron deficiency.

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

1. Blood transfusion in severe cases
2. Iron preparations like ferrous sulphate orally. Adults: 200mg tid x 30 days
3. Give antimalarial drug if anaemia is due to malaria.
4. Administer antihaemorrhoidal drugs like Himalaya Pilex 1 TDS x 14 days and phlebodia 600mg BID x 14 days when anaemia is as a results of haemorrhoids
5. In the case of sickle cell anaemia, hydroxyuria which is effective in increasing haemoglobin level and decrease the formation of sickle cell can be given
6. Folic acid can be given and the dosage depends on the condition but it can be given prophylactically. The dosage is as follow adult 5mg daily x 30 days, children 2.5mg daily x 30 days
7. If anaemia is due to worm infestation, tabs albendazole can be given adult 400mg bd x 3 days, children 200mg daily x 3 days.
8. Tabs vitamin C 200mg tid x 7 days
9. Analgesics like tabs tramadol, Paracetamol to relief pain
10. Haematenics. Eg. Hydroxide Polymaltose complex and Oral Tothema
11. Antibiotics may be given to control and treat infections. Some of the antibiotics that can be given include; ciprofloxacin, amoxicillin, and metronidazole.

Surgical Treatment Option

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

- Bone marrow transplantation can be done if anaemia is due to bone marrow depression
- Splenectomy is done if anaemia is caused by hypersplenism
- Stripping and ligation can be done if blood vessels are damaged due to trauma

NURSING MANAGEMENT OF ANAEMIA

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

DIET

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

- The nurse must ensure that the client is served with a well-balanced diet as much as possible. The diet should be rich in iron, protein, vitamin etc. some of the food advisable for the patient includes egg, milk, vegetables, meat, fruits like banana, orange and so on
- Give iron and folic acid supplements daily.
- Diet must be served in bits to enhance appetite
- Pass NG tube if necessary

REST AND SLEEP

Rest and sleep should be observed since this can promote fast recovery. The follow points are noted to ensuring rest and sleep:

- Dress the bed to be free from creases and cramps
- Restrict visitors
- Minimize noise and improve ventilation by opening windows and funs
- Plan activities in such a way that they don't interfere with the patient's time of rest and sleep
- Give warm bath and serve beverages at bed time
- Assess patient's sleeping pattern
- Administer prescribed analgesics and sedatives.

Personal Hygiene

- The relevance of personal hygiene must be explained to the client
- The patient has to be educated on the need to bath at least twice daily and if the client is bed ridden, bed bathing should be given.
- Assist the client to trim his/her nails and also care for hair of the patient
- Ensure oral hygiene twice daily
- Advice the patient on washing the hands after visiting toilet

Chemotherapy

- Administer prescribed antianemic drugs and chart them.
- Observe for any side effects and report appropriately.
- Educate patient on the side effects of the drugs.
- Educate patient on the contraindication of the drug.

Observation

- General physical appearance of the client should be observed and examined including the colour of the skin and mucus membrane, nature of hair and nails.
- Check and record vital signs four hourly or as directed.
- Observe for bed sore and treat if any.
- Observe and estimate the level of anxiety in client and family.
- Look for signs of shock including tremors, hypotension, and clummy skin.
- If the patient is on transfusion, monitor for reaction example; sweating, restlessness, rashes, flushing.
- Check out for any reaction or side effects of drugs and report if any
- Observe and record intake and output of the client

Psychological Care

- Reassure patient and family of competent care.
- Introduce the patient to other patients especially those recovering from similar sickness.
- Encourage client to ask questions about his condition and express his feeling and take time to address those questions.
- Explain every procedure to be carried on the patient and family.
- Establish an effective interpersonal relationship between yourself and the client and family.

Health Education and Prevention

- The nurse should educate the client and family on the causes, signs and symptoms, treatment and prevention of anaemia.
- The patient should be advised against self-medication.

- Educate the patient to take a well-balanced diet.
- Inform the client to report any abnormality to the hospital after discharge.

Complications of Anaemia

According to (Kumar & Clark, 2021), the complications of anaemia include:

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

1.11 Validation of Data

Validation is also the process where a valid assessment of data is made to render quality nursing care to patients and families to prevent errors in the care plan and to aid speedy recovery (New Concise Medical Dictionary, 2016). It is the act of measuring or indicating the quality of a data collected as far as it can be judged. This is to ensure that, data compiled on patient and relatives are free from biases. The information given by Mr. G.A. and relatives were compared with those in the patient's folder. Visits to the patient house also confirmed most of the information given by

Mr. G. A. The data collected from patient, health workers (medical team and nurses), patient's folder, laboratory investigation and physical assessment were compared with literature review to ensure that information collected was free from errors, bias and misinterpretations. The collected data on Mr. G. A. were valid and reliable for the study since no difference was seen in the entire sources.

CHAPTER TWO

ANALYSIS OF DATA COLLECTED

2.0 Introduction

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

The chapter comprises;

- Comparison of data with standards
- Patient and family strength
- Patient health problems
- Nursing diagnosis

2.1 Comparison of Data with Standards

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

A. Diagnostic investigations
B. Causes
C. Clinical features
D. Treatment
E. Complication

A. Diagnostic Investigation/ Test

Diagnostic investigation is a study conducted on a patient to confirm the condition he/she is suffering from and to find the causes of a disease to guide treatment plan.

To help in the diagnosis and treatment of Mr. G.A., the following investigations were carried out on Mr. G.A. during his period of hospitalization;

1. Blood for grouping and cross matching
2. Hemoglobin level estimation
3. Full blood count
4. Blood film test for malaria parasite

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

Table 1: Comparing the Laboratory investigations carried out on Mr. G. A. with those stated in the literature review

Laboratory Investigations stated in the literature review	**Laboratory investigations carried out on the patient**
Hemoglobin level estimation	Hemoglobin level estimation was done
Sickling test	Sickling test was not done
Blood film for malaria parasite	Blood film for malaria parasite was done
Haematocrit	Haematocrit was not done
Computed tomography for cancers	Computed tomography for cancers was not done
Erythrocyte sedimentation rate	Erythrocyte sedimentation rate was not done
A test for vitamin B 12 absorption (schilling test)	A test for vitamin B 12 absorption (schilling test) was not done

Blood smear reveals variation in size, shape and number of cells	Blood smear reveals was not done.
Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination	Glucose-6-phosphate dehydrogenate deficiency (G-6-PD) examination was not done.
Full blood count	Full blood count was done
Physical examination	Physical examination was done.

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

Table 2: Diagnostic Investigations /Tests Carried Out On Mr. G. A.

DATE	SPECIMEN	INVESTIGATIONS	RESULTS	NORMAL VALUE	INTERPRETATION	REMARKS
08/12/22	Blood	Haemoglobin level estimation	4.3g/dl	Male 12- 18g/dl Female 11-16g/dl	Patient was very anemic since his haemoglobin level was below normal	Whole blood transfusion and Haematenics like hydroxide polymaltose complex were administered.
08/12/22	Blood	Red blood cell count	2.46 10^6/UL	4.50-5.50K/UL	Patient red blood cell was below normal range indicating the present of anaemia	Whole blood transfusion and Haematenics like hydroxide polymaltose complex 20mg given twice daily.
08/12/22	Blood	White blood cell count	6.83 10^3/UL	2.6-8.50K/UL	Patient white blood cell count was within normal range	No treatment was given
08/12/22	Blood	Blood film for malaria parasite	Negative	No malaria parasite	No malaria parasite present	No treatment given

08/12/22	Blood	Grouping and cross matching	Blood group O positive	A (+ or -) AB(+ or -) B (+ or-) O (+ or -)	Client belonged to blood group O with Rhesus Positive, (O+).	Client was transfused with O positive blood with batch number FR 52
13/12/22	Blood	Haemoglobin level	6.1g/dl	Male 12-18g/dl Female 1116g/dl	Haemoglobin level was below normal indicating the presence of anaemia	Whole blood transfusion was done with batch number FR 92

B. CAUSE OF PATIENT'S ILLNESS

With reference to the general causes of anaemia in the literature review and compared with the laboratory results, Mr. G. A. suffered anaemia as a result of poor nutrition.

CLINICAL FEATURES

Table 3: Comparison of Patient's Clinical Features to Clinical Features in the literature

TEXTBOOK CLINICAL FEATURES	PATIENT'S CLINICAL FEATURES
1. Loss of appetite	1. Loss of appetite was not observed in patient
2. Dizziness	2. Dizziness was present
3. Headache	3. Headache not present
4. Tachycardia	4. Tachycardia was not present
5. Oedema of the ankle	5. Ankle oedema was manifested
6. Vomiting	6. Vomiting was not present
7. Palpitation	7. Palpitation not present
8. Increased sensitivity to cold	8. Increased sensitivity was not indicated
9. Impaired thought process	9. Impaired thought was not manifested.
10. Weight loss	10. Weight loss was not present
11. Constipation	11. Constipation was not present
12. Increased pulse rate	12. Client increase pulse rate was normal
13. Pallor	13. Pallor was observed in patient
14. Nocturia	14. Nocturia was not presented
15. Abdominal pain	15. Abdominal pain was not present

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

C. TREATMENT GIVEN TO THE PATIENT

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

1. IV Dextrose in Normal Saline 1L Overnight
2. IVF Normal saline 500mls Stat
3. Hydroxide Polymaltose Complex (Iron III capsules) 20mg BID x 30days
4. Oral Tothema 1 vial BD x14 days
5. Iv paracetamol 500mls in 1G Stat
6. Blood transfusion (4 Pints)

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

Table 4: Comparison of Drugs given to Patient and those in Literature Review

Drugs Outlined in The Literature Review	**Drugs given to my patient**
1. Analgesics	1. Analgesics (IV paracetamol) was given
2.Tab vitamins	2. Tab vitamins was not given
3. IV Fluids	4. IVF Normal Saline and IVF DNS were given
5. Diuretics	5. IV Furosemide was not given
6. Albendazole	6. Albendazole was not given
7. Blood transfusion	7. Blood transfusion was done

8. Antimalarial	8. Antimalarial was not given
9. Folic acid	9. Folic acid was not given
10. Hemateins	10. Hydroxide Polymaltose Complex was given
11. Hydroxyurea	11. Hydroxyurea was not given
12. Antihaemorrhoidal	12. Antihemorrhoidal was not given

Table four shows the drugs that were used for the patient. Some of the drugs which were present in the literature review such as Hydroxide Polymaltose Complex, IV DNS, IV paracetamol and IV Normal Saline were given which confirmed that the patient had the right treatment which led to his recovery.

Table 5: Pharmacology of Drugs Administered to Mr. G. A.

DATE	DRUGS	DOSAGE/ ROUTE OF ADMINISTRATION IN LITERATURE REVIEW	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO CLIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECTS AND REMARKS
08/12/22	IV Dextrose in Normal Saline	Dose: Amount to be given depends on the patient's condition Route- Intravenously	Dosage: 1L Route- Intravenous	Isotonic intravenous infusion	Hydration and electrolyte replacement	Dehydration was prevented.	Circulatory overload, extravasation, Infection at the injection site. These were not observed.
08/12/22	Hydroxide Polymaltose complex	Dose: Adult 1 Tab once daily Route- oral	Dosage: 1 Tab BID x 30 Route- Oral	Hematinic	Increase red blood cell formation as it combines with porphyrin globin chains to form haemoglobin.	Hemoglobin level of client improved.	Nausea, diarrhea constipation. These were not observed.

Table 5: Pharmacology of Drugs Administered to Mr. G. A, Cont'd

DATE	DRUGS	DOSAGE/ ROUTE OF ADMINISTRATION IN LITERATURE REVIEW	DOSAGE/ ROUTE OF ADMINISTRATION GIVEN TO CLIENT	CLASSIFICATION	DESIRED EFFECT	ACTUAL ACTION OBSERVED	SIDE EFFECTS AND REMARKS
08/12/22	IV paracetamol	Dose:500mg -1g every 4 6hours x5days	Dosage: 500mls-1g Stat Route- intravenous	Analgesic	It exhibits analgesic action by peripheral nerve blockage, probably by inhibiting prostaglandin synthesis in the central nervous system.	Pain was alleviated.	Skin rash, dizziness, nausea, vomiting. These were not observed.
09/12/22	IV Normal Saline	Dose: Amount to be given depends on the patient's condition Route- Intravenously	Dosage: 500mls st Route- Intravenous	Isotonic intravenous infusion	Hydration and electrolyte replacement.	Dehydration was prevented.	Circulatory overload, extravasation, Infection at the injection site. These were not observed.

10/12/22	Oral tothema	Dose: Adult 1 Vial twice daily Route- Oral	Dosage: 1 Vial BD x 14 days Route- Oral	Hematinic	Improves hematologic and biochemical index, completely supplies iron and cooper deficiency.	Haemoglobin level of client improved.	Gastric burning nausea vomiting diarrhea. These were not observed.

D. COMPLICATIONS

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

2.2 Patient/Family Strengths.

Adams and Kroshinsky (2016), explained strength as a resource and ability that an individual has which can help her cope with the stress of her condition. Patient and family strength include healthy physiological functioning, emotional health, cognitive abilities, coping skills, and interpersonal strength. These strengths of the patient and family will assist the nurse to be able to plan effective nursing care for the patient.

The following strength were observed on Mr. G. A. and his family.

1. Patient can perform activities of daily living when assisted. (08/12/2022)
2. Patient pain subsides when he assumes a semi-fowler's position. (08/12/2022)
3. Patient is able to eat well when served with preferred food. (08/12/2022)
4. Patient is able to identify factors that aggravate and relieves extreme tiredness. (09/12/2022)
5. Patient can relax when he listens to hymnals. (09/12/2022)
6. Patient is in good condition both physically and mentally to learn about the causes, management and treatment of his condition. (09/12/2022)

2.3 Patient/ Family Health Problems

1. Patient complained of dizziness. (08/12/2022)
2. Patient complained of chest pain. (08/12/2022)

3. Patient was observed to have less interest in taking food. (08/12/2022)
4. Patient complained of extreme tiredness. (09/12/2022)
5. Patient complained of uncertainty about possible outcome of condition. (09/12/2022)
6. Patient was observed to have no insight to his condition. (09/12/2022)

2.4 Nursing Diagnoses

A nursing diagnosis according to NANDA International (2016) is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group or community. It is a clear and definite statement of the patient's health status that can be influenced by nursing interventions.

1. Activity intolerance related to decrease tissue oxygen perfusion.
2. Acute pain (chest) related to increased cardiac work load.
3. Imbalanced nutrition; less than body requirements, related to inadequate intake of essential nutrients
4. Fatigue related to poor exercise.
5. Anxiety related to unknown outcome of disease condition.
6. Deficient knowledge related to new health diagnosis.

CHAPTER THREE

PLANNING FOR PATIENT/FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2016). This phase deals with designing of nursing strategies and interventions required to prevent, reduce or eliminate those problems of the client/family identified during the analysis phase. The objectives are set and the necessary interventions made to solve patient's health problems.

3.1 Patient/Family Care Objective

Based on Mr. G.A health problems identified, the following objectives were set for him and his family during his hospitalization.

1. Patient will be able to perform activity unaided within 24 hours as evidenced by;
    a. Patient verbalizing absence of dizziness.
    b. Nurse observing patient performing self-care activities without assistance.
2. Patient will be relieved of pain within 6 hours as evidenced by;
    a. Patient verbalizing absence of pain.
    b. Nurse observing that patient have a stable vital sign.
3. Patient will regain adequate nutrition throughout the period of hospitalization as evidenced by;
    a. Patient eating enough food served.
    b. Nurse observing that patient show adequate interest towards food intake.

4. Client will regain ability to perform her activities of daily living independently throughout the period of hospitalization as evidenced by;
    a. Patient verbalizing that he has increased energy and improved wellbeing.
    b. Nurse observing patient perform activity of daily living independently.
5. Patient will be relieved of anxiety within 24 hours as evidenced by;
    a. Patient acknowledging and discussing fears and concerns.
    b. Nurse observing that patient maintains regular daily routine throughout hospitalization
6. Patient will verbalize accurate information about condition and treatment by the end of hospitalization as evidenced by;
    a. Patient verbalizing, he understands the new situation and treatment.
    b. Nurse observing that patient has made adjustment in her eating habit.

Table 40: Patient/Family Nursing Care Plan for Mr. G.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
08/12/2022 At 9:20am	Activity intolerance related to decrease tissue oxygen perfusion	Patient will be able to perform activity unaided within 24 hours as evidenced by; evidenced by; a. Patient verbalizing absence of dizziness. b. Nurse observing patient performing self-care activities without assistance	1. Nurse patient on a low bed and raise the side rails. 2. Group specific task together so that patient can rest. 3. Put personal items within reach. 4. Encourage adequate bed rest 5. Monitor vital signs and oxygen saturation regularly. 6. Assist patient in activities of daily living	1. Patient was nursed on a low simple bed and side rails raised to prevent falls. 2. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. 3. Item for oral care, bath and water for drinking were kept patient bed side lockers. 4. Relatives and visitors were restrict to encourage bed rest. 5. Vital signs and oxygen saturation were monitored 4 hourly. 6. Patient was assisted to perform activities of daily living like oral care and bath.	09/12/2022 At 9:20 am	Goal fully met as; a. Patient verbalized absence of dizziness. b. Nurse observed patient performing self-care activities without assistance	A. B

Table 41: Patient/Family Nursing Care Plan for Mr. G.A continued

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
08/12/2022 At 9:20am	Acute pain (chest) related to increased cardiac work load.	Patient will be relieved of pain within 6 hours as evidenced by; a. Patient verbalizing absence of pain. b. Nurse observing that patient have a stable vital sign.	1. Assess for pain using the pain rating scale (0-10) 2. Put patient in a comfortable position to help patient pain subside. 3. Engage the patient in diversioanl therapy. Encourage patient to have enough bed rest. 4. Monitor vital signs regularly 5. Administer prescribed analgesic.	1. Patient rated pain was 4 on assessment to help determine the best treatment. 2. Patient was placed in a semi-fowler's position to help patient pain subside. 3. Patient was engaged in listening to hymnals to make her relaxed. 4. Patient vital signs was monitored 4 hourly and alterations were managed. 5. IV Paracetamol 1g was served 3 times daily to relieve pain.	08/12/2022 At 3:20 pm	Goal fully met as; a. Patient verbalized absence of pain. b. Nurse observed that patient had stable vital signs	A.B

Table 8: Patient/Family Nursing Care Plan for Mr. G.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
08/12/2022 At 9:20am	Imbalanced nutrition; less than body requirements, related to inadequate intake of essential nutrients.	Patient will regain adequate nutrition throughout the period of hospitalization as evidenced by; a. Patient eating enough food served. b. Nurse observing that patient show adequate interest towards food intake.	1. Educate patient on the importance nutritious diet 2. Plan meal with patient that promotes optimal nutrition 3. Serve meal regularly and attractively. 4. Advice the patient on the interference of alcohol and essential nutrient utilization.	1. Patient was educated on intake of protein foods, iron and its benefits. 2. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. 3. Meals were served three times a day with garnished vegetables. 4. Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12.	16/12/2022 At 9:20 am	Goal fully met as; a. Patient eats enough food served. b. Nurse observed that patient showed adequate interest towards food intake.	A.B

Table 9: Patient/Family Nursing Care Plan for Mr. G.A

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
09/12/2022 At 9:20am	Fatigue related to poor exercise.	patient will regain ability to perform his activities of daily living independently throughout the period of hospitalization as evidenced by; a. Patient verbalizing that he has increased energy and improved wellbeing. b. Nurse observing patient perform activity of daily living independently.	1. Assess specific cause of fatigue and current level of activity. 2. Educate client on energy conservation. 3. Assess client ability to perform activities of daily living. 4. Prioritize activities of the patient. 5. Establish a balance between activity and rest that is acceptable to the patient. 6. Monitor vital signs.	1. Physical inactivity was assessed to be the cause of fatigue. 2. Patient was educated to pace work and rest breaks throughout the day 3. Patient ability to perform activities of daily living was assessed to show increased tolerance to activity. 4. Urgent activities like oral care and medication were done before less urgent activities like receiving of visitors. 5. Patient rest for 1 hour after every 2 hours of performing of activity like walking around the ward. 6. Vital signs were monitored 4 hourly to determine any deviation in condition	16/12/2022 At 9:20 am	Goal fully met as; a. Patient verbalized that has gained energy and wellbeing improved. b. Nurse observed that patient performed activities of daily living independently.	A.B

Table 10: Patient/Family Nursing Care Plan for Mr. G.A continued

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
09/12/2022 At 8:35am	Anxiety related to unknown outcome of disease condition	Patient will be relieved of anxiety within 24 hours as evidenced by; a. Patient acknowledging and discussing fears and concerns. b. Nurse observing patient that patient maintains regular daily routine throughout hospitalization.	1. Identify anxiety triggering factors. 2. Maintain a calm reassuring environment 3. Utilizes existing cooperating strategies. 4. Encourage support system presence and participation 5. Monitor vital signs 6. Orient patient to relieve anxiety	1. Complication of anemia (enlarged liver) was identified as triggering factor of anxiety. 2. Patient was nursed in a noise free environment and privacy and confidentiality assured. 3. Respect for patient opinions and allowing her to speak up during interaction were utilized. 4. Patient relatives were engaged in her care. 5. Vital signs were monitored 4 hourly. 6. Patient was introduced to patient who have recovered from the same condition and nurses on the ward.	10/12/2022 At 8:35am	Goal fully meet as; a. Patient acknowledged and discussed fears and concerns. b. Nurse observed that patient maintains a regular daily routine throughout hospitalization.	A.B

Table 11: **Patient/Family Nursing Care Plan for Mr. G.A continued**

DATE/ TIME	NURSING DIAGNO SIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN.
09/12/2022 At 12:50 pm	Knowledge deficit related to new health diagnosis (severre aneamia).	Patient will verbalize accurate information about condition and treatment by the end of hospitalization as evidenced by; a. Patient verbalizing, she understands the new situation and treatment. b. Nurse observing that patient has made adjustment in his eating habit.	1. Assess patient and family level of knowledge about the new diagnosis 2. Observe for possible barriers that might make learning more difficult. 3. Create a friendly learning environment 4. Explain standard terms used in describing the disease process 5. Encourage them to ask questions for clarification. 6. Provide informational resources of learning materials.	1. Patient and relative's knowledge were assessed. 2. Superstition was observed as a barrier to the learning process. 3. Introduction of staff and addressing of patient by the correct title was done to create a friendly environment. 4. Key words were explained in clear simple terms 5. Patient was given time ask questions in between discussion and was answered appropriately. 6. Diagrams and leaflets were provided to ease teaching and learning.	16/12/2022 At 12:50 pm	Goal fully met as; a. Patient verbalized she has understood the new situation and treatment. b. Nurse observed patient make adjustment in her eating habit.	O.A.C.

CHAPTER FOUR

IMPLEMENTATION OF PATIENT AND FAMILY CARE

4.0 Introduction

According to Mish (2016), implementation is making something that has been officially decided start to happen or be used. Implementation is the fourth nursing process. It refers to carrying out of proposed plan of care. The nurse takes responsibility including the family and other health team members. While implementing care, the nurse should assess the patient's response to the nursing care and make alteration when necessary.

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

4.1 Summary of the actual Nursing care Rendered to Patient/Family

Day on Admission (08/12/2022)

Patient was admitted to the male's ward via the emergency unit accompanied by a staff nurse and her sister in a conscious and alert state with the diagnosis of Severe Anemia. Patient and her sister were given seats at the nurses' station. Patient's LHIMS (Light Hospital Information Management System) card was collected from her sister. His name was mentioned to confirm the right patient and he responded. An introduction of self and staff on duty were done to the patient and relative. Patient particulars such as name, date of admission, age, and occupation were taken and recorded in the admission and discharged book. The patient was then admitted into a well-prepared simple unoccupied bed free from cramps and creases because he was feeling dizzy.

Tight clothes were removed from the patient. Patient and relatives were reassured that the patient was in competent hands and everything possible will be done to ensure his recovery.

A quick assessment of the patient's general appearance was made and vital signs were checked recorded as follows;

Temperature ……... 36.2 ^{0}C

Pulse……. 84bpm

Respiration ……. 12cpm

Blood pressure …… 130/90mmHg

Oxygen saturation…… 98%

Weight ……. 73kg

Physical examination revealed that patient was pale. The patient and relatives were informed about the hospital policy concerning the payment of bills since the patient was non-insured on the National Health Insurance Scheme (NHIS), visiting hours, ward rules, items and clothing that were needed during the hospitalization. The relatives of the patient were orientated to the ward and it annexes such as nursing station, washroom, bath room, where to switch on the fan, the light and where to fetch water. Items needed for the patient's stay in the hospital were given to the relatives to be brought to the ward. The preparation for discharge started from the day of admission and they were also informed that admission to the hospital was temporal and would be discharged home as soon as the condition subsides.

His prescribed drugs were collected at the pharmacy and treatment started as follows;

1. IVF DNS 1L Overnight
2. Hydroxide Polymaltose complex 1 BID x 30days
3. IVF Normal saline 500mls Stat
4. Oral to'thema 1 vial BD x 14 days
5. IV paracetamol 500mls in 1G stat.

Drugs were collected from the dispensary, administered and recorded accordingly.

At 9:20am, patient complained of dizziness. Therefore, a nursing diagnosis of Activity intolerance related to decrease tissue oxygen perfusion was made. An objective was set to help patient perform activity unaided within 24 hours. Nursing interventions implemented are as follows: Patient was nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept by patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4 hourly. Patient was assisted to perform activities of daily living like oral care and bath.

During the interaction with the patient at 9:20am, he also complained of chest pains. A nursing diagnosis of acute pain (chest) related to increased cardiac work load was established and an objective was set to help patient be relieved of pain within 6 hours. Nursing interventions implemented are as follows: Patient rated pain as 4 on assessment to help determine the best treatment. Patient was placed in a semi-fowler's position to help patient pain subside. Patient was engaged in listening to hymnals to make him relaxed. Patient vital signs was monitored 4

hourly and alterations were managed. IV Paracetamol 1g was served 3 times daily to relieve pain.

On assessment Mr. G. A. was observed to have less interest in taking food. Therefore at 9:30am, a nursing diagnosis of Imbalanced nutrition; less than body requirements, related to inadequate intake of essential nutrients was made and an objective to help patient regain adequate nutrition throughout the period of hospitalization was commenced. The following interventions were carried out; Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables. Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12.

Also during an interaction with Mr. G. A. he complained of complained of extreme tiredness at 9:20am. A diagnosis of fatigue related to sedentariness was made and an objective was set to help regain ability to perform his activities of daily living independently throughout the period of hospitalization. Nursing interventions implemented included; Physical inactivity was assessed to be the cause of fatigue. Patient was educated to space work and rest breaks throughout the day.

Patient ability to perform activities of daily living was assessed to show increased tolerance to activity. Urgent activities like oral care and medication were done before less urgent activities like receiving of visitors. Patient rest for 1 hour after every 2 hours of performing of activity like walking around the ward. Vital signs were monitored 4 hourly to determine any deviation in condition. Banku" and "Okro stew" were served for lunch at 12:30 pm, of which he had no interest in taking the meal served. The following interventions were done; Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with

regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables

Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12. Prescribed drugs IV fluid; hydroxide polymaltose complex and IV normal saline, were administered and side effects observed. Mr. G.A. had an afternoon rest 30minutes after his launch. Patient was transfused with blood group 'O' positive and a batch number FR-52 at 12:45pm and completed successfully at about 3:00pm with no transfusion reaction such as itching, rash, chills and fever. Prescribed drugs were administered and the side effects monitored.

At 3:20 pm the objective set to relieve patient pain within 6 hours was evaluated and goal was fully met as patient verbalized absence of pain and Nurse observed patient having as stable vital signs. At 4:15pm blood was successfully transfused with no transfusion reaction. Mr. G.A., took fufu and palm nut soup for super. Vital signs were checked and recorded at 6:00pm. At 6:30pm patient was assisted in performing some activities like bathing, and grooming, patient was restricted from unnecessary movement.

Prescribed drugs were administered and the side effects monitored. Patient vital signs was monitored at 10:00pm. Patient slept at 10:50pm.

First Day on Admission (09/12/2022).

Patient woke up at 5:20am, brushed his teeth and took his bath himself. Morning vital signs were checked and recorded at 6:00am

All due medications were served and documented at 6:00am.

Patient took porridge with bread in the morning as breakfast at 8:00am of which he was seen eating the food served. Patient was educated on intake of protein foods, iron and its benefits.

Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables

Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12. On ward rounds at 8:10am, the Doctor ordered for blood sample for Full Blood Count for posttransfusion hemoglobin level.

At 8:35am patient complained of uncertainty about possible outcome of condition. A diagnosis of Anxiety related to unknown outcome of disease condition was made and objective was set to resolved patient anxiety within 24 hours. Nursing intervention implemented included; Complication of anemia (enlarged liver) was identified as triggering factor of anxiety. Patient was nursed in a noise free environment and privacy and confidentiality assured. Respect for patient opinions and allowing him to speak up during interaction were utilized. Patient relatives were engaged in his care. Vital signs were monitored 4 hourly. Patient was introduced to other patients who have recovered from the same condition and nurses on the ward.

Also, at 9:20am the objective that was set the previous day to help patient perform activity on unaided was evaluated and goal fully met as Patient verbalized absence of dizziness and Nurse observed that patient performed self-care activities without assistance.

At 9:20am the objective that was set on 8th December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was reviewed and intervention continued.

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

Patient took “rice and Kontomire stew” with an egg at 12:00pm in the afternoon. Mr. G.A showed great interest in taking food because of the education given to the patient on diet.

At 12:50pm, it was also observed that patient and relatives had no insight on how to manage his condition. Therefore, a nursing diagnosis of deficient knowledge related to new health diagnosis was made. An objective was set to enable patient verbalize accurate information about condition and treatment by the end of hospitalization. The following interventions were carried out, Patient and relative's previous knowledge were assessed. Superstition observed as a barrier to the learning process. Introducing staff and addressing of patient by the correct title was done to create a friendly environment. Key words explained in clear simple terms. Patient given time ask questions in between discussion and was answered appropriately. Diagrams and leaflets provided to ease teaching and learning.

At 2:00pm patient vital signs were checked and recorded with no abnormal values. At 5:45pm patient took "Fufu and garden eggs soup" as supper. Patient was able to eat half of food served. He was then served with two oranges 30 minutes after super. Patient bathed without assistance at 6:30pm. Patient vital signs were checked and recorded at 10:00pm. Patient went to bed around 10:45pm.

Second Day on Admission (10/12/2022)

Patient woke up at 5:30am, he took his bath and brushed his teeth unaided.

According to night staff, patient had a sound sleep during the night. At 6:00am, due medications were administered and vital signs were checked and recorded.

He ate wheat porridge with bread as breakfast at 7:30am.

On ward rounds at 8:00am the investigation that was ordered Full Blood Count on 9th December 2022 was ready to be revealed and results of hemoglobin level was 6.1g/dl.

At 8:35am the objective set on the previous day to help resolve patient anxiety within 24 hours was evaluated and goal fully met as patient acknowledged and discussed fears and concerns and nurse observed patient maintains a regular daily routine throughout hospitalization.

At 8:30am, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization was continued with the following intervention; Superstition observed as a barrier to the learning process. Introducing staff and addressing of patient by the correct title was done to create a friendly environment. Key words explained in clear simple terms. Patient given time ask questions in between discussion and was answered appropriately. Diagrams and leaflets provided to ease teaching and learning continued.

At 9:20am the objective that was set on the 08th of December, 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization was continued with the following interventions; Patient nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4hourly. Patient was assisted to perform activities of daily living like oral care and bath continued.

At 9:20am, the objective that was set on the 08th of December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was continued.

At 10:00am patient vital signs were checked and recorded with no abnormal values. At 12:15pm patient was served with cooked yam and garden eggs stew with an egg for lunch and in 30 minutes time he was served with banana. Patient was educated on intake of protein foods, iron

and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables

Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12. Vital signs checked and recorded at 2:00pm. Patient took nap and at 4:30pm he was awake.

He was served with "banku and okro" stew with meat for super at 5:20pm.

At 6pm noon patient vital signs were checked and recorded and medications served and documented. Patient took his bath at 6:30pm with no assistance. Vital signs were checked recorded at 10:00pm. Patient went to bed around 10:50pm.

Third Day on Admission (11/12/2022)

Patient woke up at 5:30am, he took his bath and brushed his teeth.

According to night staff, patient had a sound sleep during the night. At 6:00am, due medications were administered and vital signs were checked and recorded.

He took milo with bread as breakfast at 7:40am. On this day patient made no new complains.

At 8:30am, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization was continued with following interventions; Patient and relatives previous knowledge assessed.

Superstition observed as a barrier to the learning process. Introduction of staff and addressing of patient by the correct title was done to create a friendly environment. Key words explained in clear simple terms. Patient given time to ask questions in between discussion and was answered appropriately. Diagrams and leaflets provided to ease teaching and learning continued.

At 9:20am, the objective that was set on the 08th of December, 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization

was continued with the following interventions; Patient nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking kept patient bed side lockers. Relatives and visitors restrict to encourage bed rest. Vital signs and oxygen saturation monitored 4 hourly. Patient was assisted to perform activities of daily living like oral care and bath continued. Also the objective that was set on the 08th of December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was continued.

At 10:00am patient vital signs were checked and recorded. At 12:30pm patient took "banku and groundnut soup" with fish for lunch and in 30minutes was served with three slides oranges. He took a nap and woke up around 4:15pm. In the evening at 5:00pm patient was served with rice and tomato stew. At 6:00am medications were served and documented and vital signs checked and recorded. At 6:40pm patient took his bath without assistance. Patient and relatives were engaged in a conversation. Patient vital signs at 10:00pm was checked and recorded. Soon after vital signs was checked the patient went to bed.

Fourth Day on Admission (12/12/2022)

Patient woke up at 5:30am, he took his bath and brushed his teeth.

According to night staff, patient had a sound sleep during the night. At 6:00am, due medications were administered and vital signs were checked and recorded.

He ate porridge with bread as breakfast at 7:50am. On this day patient made no new complains.

On ward rounds patient was assessed and patient made no new complains, no new treatment was given. Patient was being managed on the old treatment plan. Also, during the ward rounds the doctor ordered for blood sample for Full Blood count with hemoglobin level estimation

At 9:20am, the objective that was set on the 08th of December, 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization was reviewed and following interventions; Patient was nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4hourly. Patient was assisted to perform activities of daily living like oral care and bath continued.

Also, the objective that was set on the 08th of December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was reviewed and intervention continued. At 10:00am the patient vital signs were checked and recorded.

At 12:50pm, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization was reviewed and the following intervention; Patient and relatives' previous knowledge were assessed.

Superstition was observed as a barrier to the learning process. Introduction of staff and addressing of patient by the correct title was done to create a friendly environment. Key words were explained in clear simple terms. Patient was given time ask questions in between discussion and was answered appropriately. Diagrams and leaflets were provided to ease teaching and learning continued.

Patient was served with cooked yam and "kontomire" stew with an egg for lunch at 12:20pm.

Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables

Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12. At 2:00pm the patient vital signs were checked and recorded. Patient took a nap after lunch and woke up at 4:30pm. Patient took rice and tomato stew with meat for super at 5:15pm. Patient medication was served and documented and also vital signs was checked and recorded at 6:00pm. At 6:30pm patient took his bath. Patient was seen in a conversation with other patient on the ward and at 10:00pm patient vital signs was checked and recorded. Patient went to bed soon after vital signs was checked and recorded.

Fifth Day of Admission (13/12/2022)

Patient woke up at 5:40am, he took his bath and brushed his teeth.

As early as 6:50am patient took his breakfast. Patient was served with milo and bread.

During taking over from the night staff, patient had a sound sleep during the night. At 6:00am, due medications were administered documented and vital signs were checked and recorded.

During ward rounds at 8:00am, patient made no new complains and the investigation that was ordered on 12th December 2022, results were ready and the hemoglobin level was reviewed as 5.9g/dl. The doctor established a new treatment plan as follows; transfuse with 3 units of blood, hold oral tothema and hydroxide polymaltose complex.

At 9:20am, the objective that was set on the 08th of December, 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization was also reviewed and following interventions; Patient was nursed on a low simple bed and side

rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4hourly. Patient was assisted to perform activities of daily living like oral care and bath continued. Also, the objective that was set on the 08th of December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was reviewed and intervention continued.

At 10:00am patient vital signs were checked recorded. At 12:30pm patient was served with "banku with okro" stew with meat for lunch. Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables

Patient took a nap and woke up at 3:45pm. Blood to be transfused was not ready and they had to wait for the donor before the transfusion could begin.

At 12:50pm, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization was reviewed and the following intervention; Patient and relatives previous knowledge were assessed.

Superstition was observed as a barrier to the learning process. Introduction of staff and addressing of patient by the correct title was done to create a friendly environment. Key words were explained in clear simple terms. Patient was given time to ask questions in between discussion and was answered appropriately. Diagrams and leaflets were provided to ease teaching and learning continued.

At 5:15pm patient was served with "fufu and groundnut soup" with meat for super.

At 6:30pm patient second unit of O-positive blood with batch number FR-92 was set up with pre-transfusion vital signs checked and recorded as follows;

Temperature…… 36.3ºC

Blood pressure……. 120/90mmHg

Pulse …… 82bpm

Respiration …….. 20cpm

Oxygen saturation……96%.

Patient was educated on hemotransfusion reaction and he was told to alert any nurse when he sees reaction such as rash and chills. He was reassured and was kept under close monitoring.

At 8:45pm, transfusion was successfully completed with no transfusion reaction. Post transfusion vital signs was checked and recorded as follows;

Temperature.....…… 36.8^0C

Blood pressure ……..….. 120/80mmHg

Respiration ……. 21cpm

Pulse…… 91bpm

Oxygen saturation…….. 97%

Patient was reassured and made comfortable in bed. At 10:00pm patient vital signs was checked and recorded. Patient went to bed around 10:30pm.

Sixth Day of Admission (14/12/2022)

Patient woke up at 5:40am, he took his bath and brushed his teeth.

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

At 8:15am patient took his breakfast. He was served with wheat with bread. At 9:20am, the objective that was set on the 08th of December, 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization was also reviewed and following interventions; Patient was nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4hourly. Patient was assisted to perform activities of daily living like oral care and bath continued. Also, the objective that was set on the 08th of December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was reviewed and intervention continued.

At 9:35am patient third unit of O-positive blood with batch number FR-93 was set up and pretransfusion vital signs was checked and recorded as follows;

Temperature.....…… 36.5^{0}C

Blood pressure ……..….. 120/70mmHg

Respiration ……. 21cpm

Pulse…… 94bpm

Oxygen saturation…….98%

Patient was educated on hemo-transfusion reaction and he was told to alert any nurse when he sees reaction such as rash and chills. He was reassured and was kept under close monitoring.

At 11:30pm, transfusion was successfully completed with no transfusion reaction. Post transfusion vital signs was checked and recorded as follows;

Temperature……. 36.4ºC

Blood pressure…… 120/90mmHg

Pulse …….. 90bpm

Respiration …… 20cpm

Oxygen saturation ……. 97%.

Patient was reassured and made comfortable in bed.

At 12:50am, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization was reviewed and the following intervention; Patient and relatives' previous knowledge were assessed.

Superstition was observed as a barrier to the learning process. Introduction of staff and addressing of patient by the correct title was done to create a friendly environment. Key words were explained in clear simple terms. Patient was given time ask questions in between discussion and was answered appropriately. Diagrams and leaflets were provided to ease teaching and learning continued.

At 12:50pm patient took his lunch he was served with cooked yam with “kontomire” stew with fish. He ate three slides of oranges 30 minutes after lunch. Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables. Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12. At 2:00 pm patient vital signs were checked and recorded.

He took a nap and was up around 4:30pm. He was seen having a fun time with the relative and patient looked cheerful and happy. At 5:20pm patient took “fufu and garden eggs” soup with fish and meat. Patient vital signs was checked and recorded at 6:00pm. At 6:45pm patient took his bath and was prepared for bed. Patient was seen watching television. At 10:00pm patient vital signs were checked and recorded. Patient went to bed soon after vital signs was checked.

Seventh Day of Admission (15/12/2022)

Patient woke up at 5:40am, he took his bath and brushed his teeth.

According to night staff, patient had a sound sleep during the night. At 6:00am, vital signs were checked and recorded

At 8:15am patient took his breakfast for which he was served with milo and bread.

At 9:20am, the objective that was set on the 08th of December, 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization was continued with following interventions; Patient was nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and water for drinking were kept patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital

signs and oxygen saturation were monitored 4 hourly. Patient was assisted to perform activities of daily living like oral care and bath continued. Also. the objective that was set on the 08th of December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was continued.

At 9:45am the last unit of O-positive blood with batch number FR-96 was set up and pretransfusion vital signs checked and recorded as follow;

Temperature ……... 36.2^0C

Pulse……. 85bpm

Respiration ……. 20cpm

Blood pressure …… 120/80mmHg Oxygen

saturation…….. 99%.

Patient was educated on hemotransfusion reaction and he was told to alert any nurse when he sees reaction such as rash and chills. He was reassured and was kept under close monitoring.

At 11:25pm, transfusion was successfully completed with no transfusion reaction. Post transfusion vital signs was checked and recorded as follows;

Temperature……. 36.7ºC

Blood pressure…… 110/70mmHg

Pulse …….. 79bpm

Respiration …… 20cpm Oxygen

saturation ……. 97%.

Patient was reassured and made comfortable in bed and still under continuous monitoring for post hemotransfusion reaction. At 12:40pm patient was served with fufu and palm nut soup with fish for lunch. Soon after his lunch he ate two slides of apple.

At 12:50am, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization were continued such as; Patient given time ask questions in between discussion and was answered appropriately.
Diagrams and leaflets provided to ease teaching and learning continued.

At 2:00pm patient vital signs were checked and recorded. Patient took a nap after lunch and was awake from sleep at 4:00pm. At 5:30pm patient took his super for which he was served with cooked yam and "kontomire" stew with an egg. Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing protein, iron and vitamins. Meals were served three times a day with garnished vegetables. Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12.

At 6:00pm patient vital signs were checked and recorded. Patient took his bath at 6:40pm and he was prepared for. In an interaction with the he looked cheerful and happy and told he was fine and wanted to go home. At 10:00pm patient vital signs were checked and recorded. At 10:30pm patient went to bed.

Eight Day on Admission (Day of Discharge-16/12/2022)

This day happened to be day of discharge of Mr. G.A. He woke up as early as 5:30am to perform his personal hygiene. He looked cheerful and calm.

The report from the night nurse indicated that the patient had a sound sleep at night. Patient took milo drink with bread as breakfast.

At 6:00am vital signs were checked and recorded

During ward rounds at 8:00am, laboratory investigations indicated that the patient's post transfusion hemoglobin level had increased from 6.4g/dl to 11.6 g/dl. Patient was discharged home by Dr. F.A after thorough and careful assessment and to come for review on 27/12/22.

Mr. G.A.'s sister was informed and the bills were assessed to be paid in private cash. Patient was educated on the important to eat food containing the entire essential nutrient like protein, vitamins and carbohydrate and also maintenance of good personal hygiene. The date for review 27/12/2022 and the need to continue with medications were stressed on. He was advised to report any symptoms before the said date for review.

At 9:20am the objective that was set on 08th December 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization was evaluated and goal was fully met as Patient verbalized that has gained energy and well-being improved and nurse observed patient performs activities of daily living independently. Also. the objective that was set on the 08th of December, 2022 to help patient regain adequate nutrition

throughout the period of hospitalization was evaluated and goal fully met as Patient eats enough food served and nurse observed patient showing adequate interest towards food intake.

At 12:50am, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization was evaluated and goal fully met as Patient verbalized, he has understood the new situation and treatment and nurse observed patient make adjustment in his eating habit.

At 2:30pm, patient and relatives were ready to go home after helping them pack their belongings. Patient expressed gratitude to the nursing and medical staff for their immense care rendered to him and bid farewell to other patients. Patient's particulars were then signed off in the admission and discharge book and also in the daily ward state. They left the ward at 3:00pm. Patient and relatives were accompanied to the hospital entrance to an awaiting taxi. Bed linen was taken off, disinfected with 0.5% bleach solution, cleaned and left to dry and was prepared for the next admission.

4.2 Preparation of Patient/Family for Discharge and Rehabilitation

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

a) Drugs

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

b) Diet

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

encouraged.

c) Personal and Environmental Hygiene

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

4.3 Follow Up/Home Visits/Continuity of Care

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

First Home Visit (10/12/2022)

The first home visit was made when patient was on admission. Patient was informed about my intension to visit his house; he agreed and gave me directions to his house. Patient was visited on 10th December,2022 at 11am. The aim of the visit was to find out the factor that could contribute to patient health. Patient stays at Berekum near The Namasua Station. It was a 20munites drive

to the town. I was welcomed by Miss. C.A who happens to be his niece, she took me to the house gave me a seat and offered me some water. I was welcomed by the Mrs. J.Q the mother of Mr. G.A. Communication was not a problem since we all speak Twi.

An introduction of self to Mrs. J.Q the mother of Mr. G.A. as a student of Holy Family Nursing and Midwifery Training College Berekum who was rendering care to Mr. G.A as a fulfillment of my care study project and she was glad to see me. Various observations were made on the compound during the visit. Mr. G.A. and relatives live in a compound house which is made up seven (7) bed rooms, with one bathroom. They use the public toilet. The house is plastered, painted and roofed with aluminum sheet. The windows were made of wood with net in the windows. They obtain their water from a pipe and have a poly tank reservoir and they dump their refuse at the public refuse dump which is frequently emptied by the Zoom lion company. An education on the need for them to clear waste products around the house to prevent mosquitoes from breeding and also sleep under Treated mosquito net was given.

During interaction with the patient mother, patient dietary habits was asked and the mother stated Mr. G.A. buys most of his food outside and does also do cook occasionally. She stated that his diets are mostly carbohydrate. She clearly stated that Mr. G.A. mostly buys “banku” with “okro” stew and that is what he takes for super. Mrs. J.Q. was much grateful and thanked me. I also thanked her and applauded her for cooperation. At 12:30pm, permission was sought to leave. I promised her of another visit to their house after discharge of Mr. G.A.

Second Home visit (18/12/2022)

My second visit to Mr. G.A home after his discharge that was on the 18th December, 2022 at 2:30pm. This visit was aimed at assessing the patient’s health status and also to find out whether he is taking his medications as ordered and also remind him of his review date. I went there with

Mrs. Elizabeth a community health nurse for her to know the family of the patient she will be taking care of after his discharge. I introduced her to the relatives of the patient and her inclusiveness towards the patients care. Every member of the family was happy to see me. I was very pleased to know that he was feeling much better without any complaints and was taking his medications as directed. The rest of the family was healthy. I reminded them of the review as scheduled or earlier if they detect any abnormality and promised to meet them at the outpatient department on that day. I emphasized on eating a well-balanced/nutritious diet, maintaining good personal and environmental hygiene and avoidance of use of over-the-counter medications. I sought permission to leave around 3:30pm.

Day of Review (27/12/2022)

Mr. G.A. reported to the out-patient department of the Holy Family Hospital Berekum on the 27/12/2022 at 7:30am. His vital signs were checked and recorded as follows;

Temperature ……... 36.4 ^{0}C

Pulse……. 80bpm

Respiration ……. 19cpm

Blood pressure …… 120/70mmHg

He was attended to Dr. M.A who upon assessment indicated the absence of weakness, pallor and dizziness. Mr. G.A. had no complain. The doctor did not prescribe any other medication for Mr. G. A. but told him to continue with his medication regimen.

Emphasis was made on the need for good nutrition, personal and environmental hygiene and most especially the need to seek for medical attention when he gets sick. I congratulated him for

paying heed to the treatment plan. Mr. G.A. was accompanied to the entrance where I asked him to extend my greetings to his family bid him goodbye.

Third home visit (31/12/2022)

The third home visit was on the 31st of December, 2022 after patient's review. The purpose of the visit was to terminate care and hand over patient and family to the community health nurse at Zongo Health Center. I was warmly welcomed by patient and his family. They offered me a comfortable seat and gave me the best hospitality. I was very happy on seeing Mr. G.A. as observation showed that patient and family had really adhered to the pieces of advice given to them during the first and second home visit. Patient's conditions had improved and no complaints were made. Education given to the patient and relatives on anaemia and the need to observe personal hygiene and maintain a good nutrition was reinforced. They also promised to visit the hospital whenever ailments befall them as they are now aware of the adverse effect of over-the counter drugs on the body. Patient was advised again on his diet and the need to have enough rest. Mr. G.A. was handed over to the community health nurse Mrs. Elizabeth, who gladly accepted and promised to visit them whenever possible. I thanked them and they accompanied me to the car station to board okada to my hometown and we exchanged goodbyes.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT/FAMILY

5.0 Introduction

Evaluation is the determination of the patient's responses to the nursing interventions and the extent to which the outcomes have been achieved (McIntosh, 2013). Evaluation, as part of the nursing process, is the last stage. Evaluation in nursing care seeks to measure the effectiveness of assessment, diagnoses, and implementation. Patient's health status is compared to the goals of health to determine goals achieved. It involves the members of the health team, patient, and family. Unachieved goals of nursing care plan are amended and care is terminated afterward.

5.1 STATEMENT OF EVALUATION

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

1. **Patient was able to perform activity unaided within 24 hours. (09/12/2022).**

On the 08th December, 2022 at 9:20am, patient complained of dizziness. Therefore, a nursing diagnosis of Activity intolerance related to decrease tissue oxygen perfusion was made. An objective was set to help patient to Patient will be able to help patient perform activity unaided within 24 hours. Nursing interventions implemented included; Patient was nursed on a low simple bed and side rails raised to prevent falls. Specific task like vital, medications and ward rounds were grouped together to increase patient ability to rest. Item for oral care, bath and

water for drinking were kept patient bed side lockers. Relatives and visitors were restricted to encourage bed rest. Vital signs and oxygen saturation were monitored 4 hourly. Patient was assisted to perform activities of daily living like oral care and bath.

On 16th December, 2022 at 7:30am an evaluation was made on the objective and goal was fully met as evidenced by patient verbalized absence of dizziness and nurse observed patient performing self-care activities without assistance.

2. Patient was relieved of pain within 6 hours (08/12/2022).

On the 08th December at 9:20am, patient complained of chest pain. A nursing diagnosis of acute pain (chest) related to increased cardiac work load was established and an objective was set to help patient be relieved of pain within 6 hours. Nursing interventions implemented included; Patient rated pain as 4 on assessment to help determine the best treatment. Patient was placed in a semi-fowler's position to help patient pain subside. Patient was engaged in listening to hymnals to make him relaxed. Patient vital signs was monitored 4 hourly and alterations were managed. IV Paracetamol 1G was served 3 times daily to relieve pain. On 8th December, 2022 at 3:20 pm the objective set to relieve patient pain within 6 hours was evaluated and goal fully met as patient verbalized absence of pain and Nurse observed patient having as stable vital signs.

3. Patient regained adequate nutrition throughout the period of hospitalization (16/12/2022).

On the 08th December, 2022 upon assessment Mr. G. A. was observed to have less interest in taking food. Therefore at 9:30am, a nursing diagnosis of Imbalanced nutrition; less than body requirements, related to inadequate intake of essential nutrients was made and an objective to help patient regain adequate nutrition throughout the period of hospitalization was commenced. The following intervention were carried out; Patient was educated on intake of protein foods, iron and its benefits. Patient was involved in planning meal with regards to food containing

protein, iron and vitamins. Meals were served three times a day with garnished vegetables Patient was advice to limit the intake of alcohol since it interferes with absorption vitamin B12.

On 16th December, 2022 the objective that was set on the 09th of December, 2022 to help patient regain adequate nutrition throughout the period of hospitalization was evaluated and goal fully met as Patient eats enough food served and nurse observed patient showing adequate interest towards food intake.

4. **Patient regained his ability to perform his activities of daily living independently throughout the period of hospitalization (16/12/2022).**

On the 08th December at 9:20am, patient of complained of tiredness. A diagnosis of fatigue related to poor exercise was made and an objective was set to help regain ability to perform his activities of daily living independently throughout the period of hospitalization. Nursing interventions implemented included: Physical inactivity was assessed to be the cause of fatigue. Patient was educated to pace work and rest breaks throughout the day

Patient ability to perform activities of daily living was assessed to show increased tolerance to activity. Urgent activities like oral care and medication were done before less urgent activities like receiving of visitors. Patient rest for 1 hour after every 2 hours of performing of activity like walking around the ward. Vital signs were monitored 4 hourly to determine any deviation in condition

On December 16th 2022, at 7:30am the objective that was set on 08th December 2022 to help patient regain ability to perform his activities of daily living independently throughout the period of hospitalization was evaluated and goal fully met as Patient verbalized that has gained energy and well-being improved and nurse observed patient performs activities of daily living independently.

5. Patient anxiety was relieved within 24 hours (09/12/2022).

On the 09th December at 9:20am, patient of complained of complained of uncertainty about possible outcome of condition. A diagnosis of Anxiety related to unknown outcome of disease condition was made and objective was set to resolved patient anxiety within 24 hours. Nursing intervention implemented included; Complication of anemia (enlarged liver) was identified as triggering factor of anxiety. Patient was nursed in a noise free environment and privacy and confidentiality assured. Respect for patient opinions and allowing him to speak up during interaction were utilized. Patient relatives were engaged in his care. Vital signs were monitored 4 hourly. Patient was introduced to patient who have recovered from the same condition and nurses on the ward.

On 10th December 2022, at 10:30am the objective set on the previous day to help resolve patient anxiety within 24 hours was evaluated and goal fully met as patient acknowledged and discussed fears and concerns and nurse observed patient maintains a regular daily routine throughout hospitalization. Banku" and "Okro stew" were served for lunch at 12:30 PM, Prescribed drugs IV fluid; hydroxide polymaltose complex and IV normal saline, were administered and side effects observed. Mr. G.A. had an afternoon rest 30minutes after his launch. Patient was transfused with blood group 'O' positive and a batch number FR-52 at 12:45pm and completed successfully at about 3:00pm with no transfusion reaction such as itching, rash, chills and fever. Prescribed drugs were administered and the side effects monitored.

6. **Patient verbalized accurate information about condition and treatment by the end of hospitalization (16/12/2022).**

On 9th December, 2022 at 12:50pm, it was also observed that patient and relatives had no insight on how to manage his condition. Therefore, a nursing diagnosis of deficient knowledge related to new health diagnosis was made. An objective was set to enable patient verbalize accurate information about condition and treatment by the end of hospitalization. The following interventions were carried out, Patient was educated on his condition. Pain and anxiety as a barrier to the learning process was resolved. A noise free environment was created to enhance patient teaching. Measurable and achievable short- and long-range goals were made to help describe the disease process. Patient was carefully listened to and no interruption made when patient was answering questions. Books and leaflets were provided to ease teaching and learning.

On 16th December, 2022 at 7:30am, the objectives set on 09th of December, 2022 to help patient verbalize accurate information about condition and treatment by the end of hospitalization was evaluated and goal fully met as Patient verbalized he has understood the new situation and treatment and nurse observed patient make adjustment in his eating habit.

5.2 Amendment of Nursing Care Plan for Partially Met or Unmet Outcome

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

5.3 Termination of Care

Termination of care is the ending of care and the relationship between the patient, relatives and the nurse. Since separation can sometimes bring about anxiety and depression due to its accompanied psychological pain, Mr. G.A. family members whom he lives with and was always

at the patient's side was given a gradual psychological preparation from the day of admission to the day of discharge. They were told that hospitalization was just a temporal measure to improve their relative's condition and that he would be discharged and handed over to a community health nurse to continue with the care.

Interactions with Mr. G.A and family started on the day of admission, 08th December, 2022 through to the discharge date, 16th December, 2022. His condition had improved as a result of good nursing care and medical care rendered. Three home visits were embarked on before rendered care was terminated. The first home visit was on the 10th December, 2022. This was done when my client was still on admission. The purpose of the visit was to assess the patient's home environment for factors that contributed to the illness and also to educate his family members. The family members of Mr. G.A were educated on the importance of good nutrition. The second home visit was carried out on the 18th of December, 2022. An assessment and evaluation of the patient's health status was done and to comprehend whether patient and relatives were adhering to the education given to them. This home visit was embarked with Mrs. Elizabeth a community health nurse for her to know the family of the patient she will be taking care of after his discharge. Mrs. Elizabeth was introduced to the patient and relatives of the patient and her inclusiveness towards the patients care. Patient and relatives were adhering to the education given to them which was exciting to hear. Mr. G.A was reminded on the review date. Finally, the care of the patient and family was terminated on the third home visit (31/12/2022) when the patient and family were finally handed over to the community health nurse Mrs. Elizabeth who had already being introduced to them during the second home visit. I thanked them and promised to call anytime I had the chance. They were grateful and happy.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

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

6.1 Summary

Summary according to Papandrea (2018) is a comprehensive and usually brief abstract, recapitulation or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with
the situation.

Mr. G.A. is a 33 years old Ghanaian and an electrical engineer who lives in Berekum in the Bono Region. He was admitted on the 08th December, 2022 into the accident and emergency ward of the Holy Family Hospital, Berekum with the diagnosis of Severe Anaemia by Dr. O.A. On admission, he complained of dizziness and chest pains and on assessment had paleness of the conjunctiva. The patient was managed on the following treatment plan throughout his hospitalization

1. IVF DNS 1L Overnight
2. Hydroxide Polymaltose complex 20mg BID x 30days
3. IVF Normal saline 500mls Stat
4. Oral tothema 1 vial BD x 14days
5. IV paracetamol 500mls stat.

6. Blood transfusion 4 pints.

The following laboratory investigations were requested:

1. Blood for grouping and cross matching.
2. Hemoglobin level estimation.
3. Full blood count.
4. Blood film test for malaria parasite.

The following problems were identified within the period of hospitalization; dizziness, chest pain, tiredness, uncertainty about possible outcome of condition, patient observed to have less interest in taking food, and observed to have no insight on how to manage the condition. Based on the problems identified, nursing diagnosis were made and continue his medication and report to the hospital for review all aimed towards a successful recovery. Three home visits were carried out during the care. The first home visit was done when he was still on admission on the 10th December, 2022, aimed at assessing the patient's home environment. The second visit was made on the 18th of December, 2022, to enquire about the health status of the patient whilst the last home visit was on the 31st December, 2022 to terminate care and hand over client to the community health nurse. The care was successfully terminated when the patient and family were handed over to a community health nurse.

6.2 Conclusion

McIntosh (2013) defines conclusion as the final decision, reached by reasoning. Generally, the study on Mr. G.A has been a successful one because he recovered and regained strength in the end and resumed his normal daily activities. This write up has enabled to put into practice the nursing process learned during the three-year study. It has broadened the knowledge on anaemia especially the causes, clinical manifestations, complications and the management of client with

anaemia. The study has helped to boost confidence and improved communication skills. It has also helped to understand comprehensive nursing care rendered to the client and family as well as developing a cordial relationship with client and family to provide effective care. This study has also helped to provide a holistic nursing care to client and to be a useful member of the health team. The study has benefit client and family to meet their health needs.

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

APPENDIX Table 12: Vital signs chat for Mr. G.A throughout hospitalization;

Date	Time	Temperature(^{0}C)	Pulse(bpm)	Respiration(cpm)	Blood Pressure(mmHg)	Oxygen saturation (%)
08/12/2022	7:30am	36.2^{0}C	84bpm	12cpm	130/90mmHg	98%
	10:00am	36.7^{0}C	90bpm	15cpm	120/90mmHg	97%
	2:00pm	36.8^{0}C	89bpm	15cpm	120/80mmHg	98%
	6:00pm	36.5^{0}C	85bpm	16cpm	120/80mmHg	99%
	10:00pm	36.3^{0}C	90bpm	16cpm	120/80mmHg	99%
09/12/2022	6:00am	36.8^{0}C	88bpm	16cpm	120/80mmHg	98%
	10:00am	36.5^{0}C	85bpm	16cpm	110/80mmHg	97%
	2:00pm	36.7C	89bpm	15cpm	120/80mmHg	98%
	6:00pm	36.4^{0}C	84bpm	15cpm	110/90mmHg	99%
	10:00pm	36.5^{0}C	89bpm	17cpm	120/80mmHg	99%
10/12/2022	6:00am	36.1^{0}C	87bpm	19cpm	110/80mmHg	98%
	10:00am	36.5^{0}C	83bpm	18cpm	110/90mmHg	99%
	2:00pm	37.0C	85bpm	19cpm	120/70mmHg	99%
	6:00pm	36.4^{0}C	90bpm	17cpm	120/80mmHg	98%
	10:00pm	36.9^{0}C	87bpm	19cpm	120/80mmHg	97%
11/12/2022	6:00am	36.4^{0}C	90bpm	20cpm	120/80mmHg	99%
	10:00am	37.0^{0}C	92bpm	19cpm	110/80mmHg	99%
	2:00pm	38.8C	89bpm	17cpm	120/80mmHg	98%
	6:00pm	36.7^{0}C	85bpm	20cpm	120/70mmHg	99%
	10:00pm	37.0^{0}C	90bpm	19cpm	110/70mmHg	97%

Vital signs chat for Mr. G.A throughout hospitalization; cont'd

Date	Time	Temperature(^{0}C)	Pulse(bpm)	Respiration(cpm)	Blood Pressure(mmHg)	Oxygen saturation (%)
12/122022	6:00am	36.0^{0}C	86bpm	20cpm	120/80mmHg	99%
	10:00am	36.1^{0}C	89bpm	20cpm	120/70mmHg	99%
	2:00pm	36.7C	92bpm	21cpm	120/80mmHg	97%
	6:00pm	37.1^{0}C	87bpm	19cpm	120/80mmHg	98%
	10:00pm	36.9^{0}C	90bpm	20cpm	110/80mmHg	98%
13/12/2022	6:00am	36.5^{0}C	89bpm	19cpm	110/80mmHg	98%
	10:00am	36.2^{0}C	90bpm	17cpm	110/70mmHg	98%
	2:00pm	37.0C	92bpm	18cpm	110/70mmHg	99%
	6:00pm	36.8^{0}C	89bpm	20cpm	120/70mmHg	97%
	10:00pm	37.0^{0}C	86bpm	19cpm	120/90mmHg	99%
14/12/2022	6:00am	36.4^{0}C	87bpm	18cpm	120/80mmHg	99%
	2:00pm	36.5C	89bpm	19cpm	110/80mmHg	97%
	6:00pm	36.9^{0}C	84bpm	20cpm	120/90mmHg	98%
	10:00pm	36.7^{0}C	90bpm	19cpm	110/90mmHg	97%
15/12/2022	6:00am	36.9^{0}C	80bpm	20cpm	120/70mmHg	98%
	10:00am	36.8^{0}C	84bpm	19cpm	120/80mmHg	99%
	2:00pm	37.0C	89bpm	20cpm	110/80mmHg	99%
	6:00pm	36.5^{0}C	85bpm	18cpm	120/70mmHg	98%
	10:00pm	36.9^{0}C	84bpm	17cpm	120/70mmHg	99%
16/12/2022	6:00am	36.2^{0}C	80bpm	20cpm	120/70mmHg	98%
	7:00am	36.4^{0}C	85bpm	19cpm	110/80mmHg	99%

Biography

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