HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

PATIENT/FAMILY CARE STUDY ON BRONCHO PNEUMONIA

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A PATIENT/FAMILY CENTERED CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTICAL FULFILMENT TOWARDS THE AWARD OF LICENSE AS A PROFESSIONAL NURSE

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PREFACE

The patient and family care involves an interaction between client, his family, community and the health team. The interaction starts from the day of admission to the day of discharge and arrangement for follow-up visit is attained and maintained to give the highest level of physical, social, psychological and spiritual needs of the client and family. The patient and family care study is part of the final assessment of the student nurse by the Nursing and Midwifery Council of Ghana for the award of the Registered General Nursing Certificate.

Patient and family care helps the student nurse get an in-depth knowledge on the causes, incidence, pathophysiology, signs and symptoms, diagnostic investigation, complications, prevention and treatment of disease condition.

This further prepares the student nurse to put into practice the theoretical knowledge achieved in the clinical area. Again the study provides a serene environment to provide a focused and holistic health care to patient, to involve and educate family in maintaining a healthy living. Master N.M.N.Y.O, a 5 years old boy with Broncho pneumonia disease was therefore chosen for this study. This is to enable me to study the disease condition and offer holistic nursing care and health education to patient, family and the community to attain the wellbeing of the patient. To ensure that confidentiality of the patient is attained, patient/family names were stated in initials rather than using their names in full.

ACKNOWLEDGEMENT

I wish to express my immense gratitude to the Almighty God who by his Grace gave me the knowledge, strength and direction to bring this work to success.

My special thanks go to the patient N.M.N.Y.O. and his family for their cooperation and necessary information they gave me both at the hospital and during my home visit.

Also many thanks go to the senior nursing officer in charge of paediatrics ward and the entire nursing staff of the paediatric ward at Holy Family Hospital, Techiman through their cooperation and assistance, this study became a greatly. Furthermore, I am particularity grateful to my parents and to the final year students of Holy Family Nursing and Midwifery Training College, berekum for their contribution and support towards this work.

Moreover I express my sincere gratitude to Mr Dramani F. Ayamba, Alhassan Ibrahim my supervisors who has gone beyond all odds to make this study a success and to all tutors of Holy Family Nursing and Midwifery Training College, Berekum for their patience, guidance and commitment in reading through and making the necessary corrections in the script.

Lastly, I am very grateful to the various authors and publishers from whose books valuable information was extracted to bring this care study to a successful conclusion.

May God bless us all.

INTRODUCTION

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

The care study was carried out on Master N.M.N.Y.O five (5) years old boy. He come from Techiman in the Bono east region, Master N.M.N.Y.O. was admitted to the paediatric ward on the 28th November, 2021 at the Holy Family Hospital Techiman, with a diagnosis of bronchopneumonia. On admission the mother complained of vomiting, sleeping difficulty fever and breathing difficulties with cough. He was admitted for five (5) days and six (6) problems were identified on him and the mother. Objectives were set and the necessary interventions were given.

During his admission, he was treated with the following drugs;

1. IV Cefuroxime 600mg TDS x 5 days.
2. Syrup Simple Linctus 7.5mls TDS x 7days.
3. IV Gentamycin 100mg OD x 48hours
4. IV Hydrocortisone 50mg TID x a day

The following laboratory investigations were ordered to confirm the diagnosis;

1. Blood film for malaria parasites (MP's) to rule out the presence of malaria parasite.

2. White blood cell count (WBC) to know if there is any infection and Red blood cell count (RBC) done to know if there is any haemolysis.

3. Chest radiology.

He was finally discharged on the 2st December, 2021. They were asked to come for review on the 9th December, 2021. Three home visits were made to the patient and family to know the situation of their environment, to validate information given to me by patient and family and to identify the presences of any health facility in their area. Health education was given on the problems identified in the house. The care of N.M.N.Y.O. and his family was terminated on 17th December, 2021 during my last home visit when I handed him over to a community health nurse. But his mother as nurse said she is going take good care of him with the support of the community health nurse.

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CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 Introduction

According to Weller (2010), assessment is the critical analysis and judgment of the status or quality of a particular condition, situation or other subject of appraisal. In the nursing process, it involves the gathering of information about the health status of a particular patient, analysis and synthesis of data, and the making of clinical judgment. The outcome of the nursing assessment is to identify the nursing problems of the patient and the appropriate intervention. Assessment of patient involves collection of data from the patient, her family members, the community within which they live and the health personnel. This is done through observations, interviews, physical examination and laboratory investigations. These help the nurse to determine the health status of the patient and his family in order to plan an effective nursing care towards recovery.

1.1 Patient's Particulars

According to Lutcher (2016), particulars are detailed information about a person or an event, especially when officially recorded. It includes patients, name, address, house number, date of birth, etc.

Patient's name is N.M.N.Y.O. he is five (5) years of age and was born on the 27th of September, 2016, at the Holy Family Hospital, Techiman. He is a native of Techiman in the Bon East Region. He is born to Mr. O.F. and Madam N.V. According to the mother, his father is still alive. He is dark in complexion and weighs 20kg with a height of 3.3 centimetres, He is Bono by tribe as said by the mother. They speak Twi, Dagaari and English. According to patient's mother, patient has one siblings with patient inclusive of which they are all males and he is the last-born. He is a

Christian attending Roman Catholic Church with his parents at Techiman, sansama. Master N.M.N.Y.O attends school at Adventist preparatory school at Techiman and is in KG two (2) and depends on both his father and mother Mr O. F and madam N. V for his livelihood. Patient Master N.M.N.Y.O live with his parent's at Techiman sansama in the house number TS/155. His senior brother, is his next of king

1.2 Patient / Family Medical history and surgical history

Medical history is a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health whiles surgical history is a history of surgical procedures that a particular person has had (Lutcher, 2016).

According to N.M.N.Y. O's mother, she revealed that there are no known hereditary diseases such as diabetes, hypertension, down syndrome, sickle cell anaemia, turner syndrome and the like in the family. It is only the grandmother who is dead and the cause of death was asthma. There is no known mental disorder in the family but they do experience fever and headache frequently, which is often treated by resorting to medical treatment from the hospital. There are no communicable diseases such as measles and tuberculosis in the family. The mother said that, her son was allergic to dust, cab webs and strong air. His mother also said patient has not undergone any surgical procedure before.

1.3 Patient /Family Socio-Economic History

According to Webster (2020) it is the position of an individual on socio-economic scale that measures such factors as education, income and occupation. According to patient's mother, there are no social cohesions in the family. The family are very friendly and supports each other well. Their family are neither rich nor poor but they classify themselves in the middle class income earners. They are able to take care of their education and hospital bills and meet their needs.

Their family is very united to the extent that they support each other whenever any member of the family is in need of something. Their source of financing medical care is the national health insurance scheme which all the family members have registered. The mother confirmed that she is a nurse who works at Holy Family Hospital Techiman OBGY(obstetrics-gynaecology) and had some occupational hazards like; waist pain, splash of medication on her uniform, needle prices, slips and falls, patient vomiting on her etc.

1.4 Patient's Developmental History

Growth and development are two major factors that are of great importance as far as children are concern. Growth is the gradual increase in the size of the body and its organs whereas development is the biological and psychological changes that occur in human beings between birth and the end of adolescence as the individual progresses from dependency to increasing autonomy (Webster, 2020).

Patient Master. N.M.N.Y.O was delivered at the Holy Family Hospital, Techiman by a qualified midwife on the 27th September, 2016. According to N.M.N.Y. O's mother, she had a normal spontaneous vaginal delivery with no complications. The child was immunized against the vaccine preventable disease; this was evidenced by the scar at the right shoulder. According to the mother, the child was fed exclusively for six (6) month after which she started introducing additional feeds like 'wean mix' and "koko". Master N.M.N.Y.O Patient began to make sounds at the 5th month, started Eruption of teeth at the 6TH month, crawling by the 7th month then at 1 year and a week he started walking. At the 18th month, he could say simple words like ''mama, dada and can form multi-word sentences. Child started schooling at age three (3 years) in a day care in their vicinity. According to Eric Erikson's psychosocial theory of development, the 5-year-old Master N.M.N.Y.O falls under the growth theory of initiative verses guilt. People under this stage are

within their pre-school years and they begin to assert their power and control over the world through directing play and other social interactions. Children who are successful in this stage feel capable and able to lead others. They also begin to discover the differences between their sexes. On the other hand, the unsuccessful once are left with a sense of guilt, self-doubt and lack initiatives as well. Based on the theory, this patient is known to exhibiting initiative other than guilt. Patient at this age can gather milk and milo tins in the form of preparing car as most boys used to do in their previous years respectively.

1.5 Patient's Lifestyle and Hobbies

Life style is defined as the habits, attitudes, moral standards, economic level etc. that together constitute the mode of living of an individual or group whiles hobby is an activity or interest pursued for pleasure or relaxation and not as a main occupation (Webster, 2020).

Madam N.V, client's mother said, he is calm when he is with strangers but noisy when he is at home with his fellow age mates playing. Patient sleeps at 8:00pm and wakes up at 6:00am on his own as said by the mother. He takes his bath, brushes his teeth and prepare for school at 7:00am and returns home at 5:00 pm.

Patient's mother said, he normally takes tea or "koko" as her breakfast and Banku and Okuro stew which is his favourite as lunch and at times supper, he also likes taking indomine and Kalypso. He empties his bowels whenever he has the urge but normally does it twice daily. On Saturdays, he is always at home. On Sundays, patient/family attends church and does not perform any activity at the church. Patient has no allergies to food or drugs. His hobbies are playing football and temple run games.

1.6 Patient's Past Medical/Surgical History

Past medical and surgical history talks about the patients past experiences with illnesses, operations, injuries and treatment. Also past medical history is a narrative or record of past events and circumstances that are relevant to patient's current state of health, (Merriams-Wester 2020).

According to his mother, he had no childhood illness like diphtheria, whooping cough, and measles since he was immunised against all the six childhood killer diseases, which are tetanus, diphtheria, polio, whooping cough, measles and tuberculosis. She also admitted that, her child has not had any surgical procedure done on him before. He has no known allergies to food, drugs, or inserts and has not involved in any accident before.

1.7 Patient's Present Medical History

The history of the present health concern or illness is the single most important in helping the health care team arrive at a diagnosis or determine the patient's needs. The physical examination is helpful but often validates the information obtained from the history (Cheever & Hinkle, 2014). Also history of present illness is a complete, clear and chronologic account of the problems prompting the patient to seek care (Bickley &SZilagyi, 2009)

Patient's mother said on the 27th November, 2021, he started vomiting with fever and became weak which subsided in the night. On the next day, he had insomnia, breathing difficulty with cough, fever, anorexia and vomiting of which she tepid sponged the child. The mother said when she saw that her son's condition was not getting any better, Master. N.M.N.Y.O was brought to the Emergency Unit of Techiman Holy Family hospital to seek for further treatment and he was detained at the Emergency Unit of the hospital on the 27th November 2021. He was examined and

it was observed that, he has no wheezing sounds and crackles. The following lab investigations were ordered at the ER;

1. Full blood count
2. Blood film for malaria parasites (MPs)
3. Chest x-ray/radiology

The provisional diagnosis was pneumonia and was later confirmed by chest x-ray

At 6:30pm. On the next day, 28 November 2021 he was admitted to the paediatric ward.

1.8 Admission of patient

According to McGraw Hill, (2022), admission involves staying at a hospital for at least one night or more. It usually refers to inpatient care. It is change of environment to the patient and relatives. On the 28th November, 2021 at 8:30am, Master N.M.N.Y.O was brought to the paediatric ward accompanied by his mother and staff nurse from the Emergency Unit of Holy Family Hospital, Techiman. They were warmly welcomed and offered a seat by myself and introductions were made. I collected the folder from the mother and mentioned the child's name to verify if it's his folder and if he is the right patient. Patient was admitted into an already prepared admission bed and relatives offered seats at the nurse's station. I reassured them that, all the necessary nursing and medical intervention would be carried out to restore him to normal health. His particulars such as name, age, address, religion, allergies, and next of kin were taken and recorded in the admission and discharge book, as well as the ward state after confirming with patient. All necessary sheets like medications; laboratory and temperature sheets were filled accordingly. His vital signs were checked and recorded as follows;

Temperature - 38.8^{o}C

Pulse - 101bpm

Respiration - 40cpm

His weight was recorded as 20kg.

Patient was tepid sponged due to the high body temperature. After the vital signs were checked and recorded, I asked patient's mother about what was wrong with her son and she complained of vomiting, sleeping difficulty, high body temperature and difficulty breathing with cough. Patient's information was entered into the admission and discharge book and the daily census. The medication sheet, vital signs sheet and the nurses note.

Client was placed on the following drugs:

1. IV Cefuroxime 600mg TID x 5 days.
2. Syrup Simple Linctus 7.5mls TID x 7days.
3. IV Gentamycin 100mg OD x 48hours
4. IV Hydrocortisone 50mg TID x 1day.

I introduced other staffs on duty and other patients admitted to the word already to patient and patient's mother. N.M.N.Y. O's mother was informed about the time for medication and other routine works at the ward. Patient/family was oriented to the ward especially the dining area, washroom, and playground for the children, nurse's station and etc. I made patient and his mother aware of time for visiting which starts from 4:30am to 5:00am in the morning and 4:30pm to 5:30pm in the evening. Since patient had National Health Insurance, no deposit was paid but I made mother aware that some medications are non-insured and must be paid when discharged. The discharge planning of patient started on the day of admission. It included patient, the family and the health team in whom the patient's care was entrusted to. I later expressed interest in using Master N.M.N.Y.O for my care study in partial fulfilment of the Award of licence from the Nursing and Midwifery Council and introduced myself to the mother again as a final year student of Holy

Family Nursing and Midwifery Training College, Berekum. I told patient's mother about my intention to use them for my care study and explained further that it would not involve the patient only but the family also. The reason was that I have learnt the theoretical aspect of the condition (pneumonia) and so I want to use this opportunity to do the practical aspect of it. I made her aware that there will be the need for me to render a complete and individualized nursing care to the patient/family until discharge and follow up visit after discharge until he recovers fully. After the admission procedure, objectives and nursing care were planned with the patient's mother in order to achieve a speedy recovery.

1.9 Patient's Concept of his Illness

Patient concept of illness deals with what the family pursue to have caused the child's condition and their beliefs about it. (Weller, 2010).

Master N.M.N.Y.O mother said the illness was not due to any spiritual force but thought the cause might be the cold water he always uses to bath even in the cold weather and believed that with the treatment at the hospital and the assurance given to them her child's condition will be better.

1.10 The Literature Review on pneumonia

Definition of Pneumonia

According to Smeltzer, Suzanne, Branda and Bare (2010), Pneumonia is an infection of lung tissue and is mostly classified according to the causative organism which may be bacteria or viral and even protozoan. However, it can further be classified according to the area of lung that is involved, that is bronchopneumonia or lobar pneumonia.

Brief Anatomy and physiology of the lungs

The lungs are paired cone shaped organs in the thoracic cavity. They are separated from each other by the heart and other structures of the mediastinum, which divides the thoracic cavity into two anatomically distinct chambers. As a result, if trauma causes one lung to collapse, the other may remain expanded (Smeltzer, et al., 2010). Each lung is enclosed and protected by a double layered serous membrane called the pleural membrane. The superficial layer, the parietal pleura, lines the wall of the thoracic cavity, the deep layer the visceral pleura, covers the lungs themselves. Between the parietal and visceral pleural cavity, is a small space, the pleural cavity, which contains a small amount of lubricating fluid secreted by the membranes (Smeltzer, et al., 2010).

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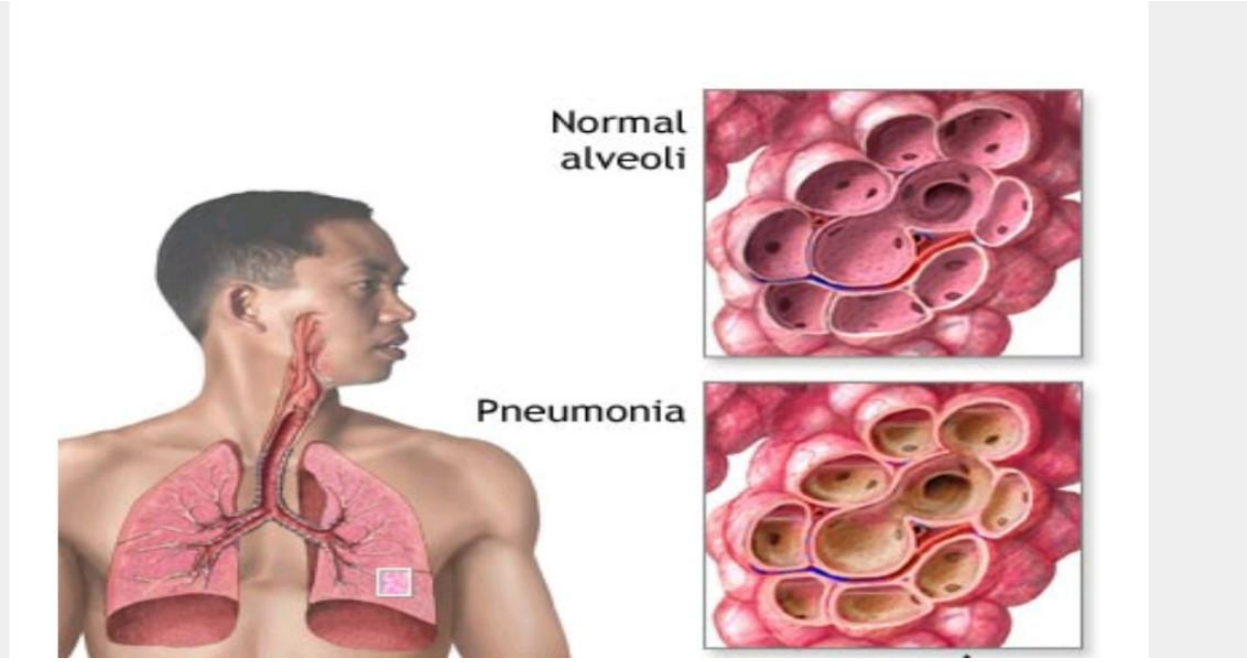

Incidence of Pneumonia

According to Smeltzer, Suzanne, Branda and Bare (2010), pneumonia can occur in the following instances:

- It is common in people who have had chest disease before. Example of these chest disease are: Chronic bronchitis.
- It's common in over-crowded places.
- It affects both sexes.
- It occurs in 4% of children under the age of 4years.
- It is also common among people living in poor environmental areas.
- It also affects the elderly mostly because of lowered resistance to infection.

Causes of Pneumonia

The causes of the disease may either be virus, bacteria or protozoan. Virus such as influenza and common cold virus causes pneumonia especially in children.

Bacteria such as staphylococcus aureus and mycobacterium tuberculosis also cause pneumonia after infecting the lungs. It mostly occurs in older children and adults.

A protozoan called pneumocystis carinii causes a form of pneumonia in people with weakened immune system. E.g. AIDS (Smeltzer, et al, 2010).

Predisposing Factors

According to Smeltzer, Suzanne, Branda and Bare (2010), some of the predisposing factors of pneumonia include:

- Alcoholism and smoking predisposing people to chest infection.
- Overcrowding or congestion in a room.
- Any chest disease presents such as chronic bronchitis and chest cancer.
- Exposure to cold environments.

- In babies and small children, infections such as whooping cough and measles can lead to pneumonia.

Types of Pneumonia

According to Kumar and Clark (2020), pneumonia has got four (4) types namely;

- Pneumocystis carinii pneumonia.
- Lobar pneumonia.
- Aspiration pneumonia.
- Bronchopneumonia (which my patient is suffering from).

Bronchopneumonia

This is characterized mainly by patchy areas of consolidated lung tissues. Causative organisms may be bacterial and fungal and include staphylococci, pneumococcal, streptococci, haemophilus influenza and Candida. It usually occurs in individuals with low immunity and often in the very old, very young, unconscious patients and as a result of a pre-existing disease, such as chronic bronchitis, atelectasis or carcinoma in adults (Kumar and Clark, 2020).

Mode of transmission of pneumonia

- Inhalation of poisonous gases or through carbon droplets.
- Aspiration of food and fluids.
- Infections spreading to the lungs through the blood stream.

Pathophysiology of Pneumonia

As it has been discussed in Hinkle and Cheever (2014); Williams and Hoper (2015),

Upper airway characteristics normally prevent potentially infectious particles from reaching the sterile lower respiratory tract. Pneumonia arises from normal flora present in patient whose resistance has been altered or from aspiration of flora present in oropharynx, patient often have an acute or chronic underline disease that impairs those defence. Pneumonia may also result from blood born organism that enters the pulmonary circulation and are trapped in the pulmonary capillary bed becoming a potential source of pneumonia.

Pneumonia often affects both ventilation and diffusion. An inflammatory reaction can occur in the alveoli, producing exudates that interfere with the diffusion of oxygen and carbon dioxide. White blood cells, mostly neutrophils, also migrate into the alveoli and fill the normally air-containing spaces. Areas of the lung are not adequately ventilated because of secretions and mucosal oedema that cause partial occlusion of the bronchi or alveoli, with a resultant decrease in alveolar oxygen tension. Bronchospasm may also occur in patients with reactive airway disease. Because of hypoventilation, a ventilation-perfusion mismatch occurs in the affected area of the lung. Venous blood entering the pulmonary circulation passes through the under ventilated area and exit to the left side of the heart poorly oxygenated. The mixing of oxygenated and deoxygenated or poorly oxygenated blood eventually results in arterial hypoxemia.

If a substantial portion of one or more lobe is involved, the disease is referred to as

Lobar Pneumonia. The term bronchopneumonia is used to describe pneumonia that is distributed in a patchy fashion, having originated in one or more localized areas within the bronchi and extending to the adjacent surrounding lung parenchyma. Bronchopneumonia is more common than Lobar Pneumonia. (Smeltzer ET Tal 2010).

Clinical Features of Pneumonia

According to Bare, Suzanne, Branda and Smeltzer (2010), clinical features are the assessments and diagnostic findings of a condition: clinical features of pneumonia may include:

- Fever develops with temperature of about 38.0^{o}C.
- Chest pains
- Crackles and wheezing sound on auscultation.
- There is breathlessness.
- Cough
- Nausea, vomiting and anorexia are present.
- Respiration becomes rapid and distressed.
- There is tachycardia.
- Dyspnoea is present.
- There is cyanosis.

Diagnosis of Pneumonia

According to Weller (2010), diagnosis is the determination of the nature of a disease OR it is an art or act of identifying a disease from its signs and symptoms.

- Signs and symptoms presented by the patient (physical examination).
- Bronchoscopy done to collect specimen.
- Blood culture to detect the presence of bacteria in the blood.
- Sputum for culture and sensitivity to isolate organism.
- Chest radiography often shows opacity and consolidation of affected lung.
- White Blood Cell count indicates leucocytes in bacterial pneumonia and a normal or low count in viral pneumonia.

- Blood MPs to detect the presences of malaria parasites in the blood.

Medical treatment of Pneumonia

Treatment is the application of medications, surgery, psychotherapy, etc. to a patient or to a disease or symptoms**.** (Kumar and Clark 2020).The following classes of drugs may be used in the management of pneumonia

- Antipyretics are given for pyrexia.
- Antibiotics are the first drug of choice.
- Oral or intravenous fluids may be given.
- Oxygen therapy to treat hypoxemia.
- Cough mixtures are given to relief cough.

Surgical treatment

- Thoracentesis (chest aspiration) is done if there is dyspnoea resulting from fluid accumulation in the pleural cavity.
- Lobectomy is usually done in cases of tumour.

(Kumar and Clark, 2020).

Nursing management

With reference to Kumar and Clark (2020), the nursing management of bronchopneumonia can be carried out under the following headings:

A. Observation

- Vital signs (temperature, pulse and respiration) are checked and recorded.

- Intake and output of fluids are checked and recorded.
- Patient's respiratory pattern is observed.
- Observe sputum for any abnormalities such as colour and amount and then record and report.
- Patient is observed for improvement of condition**.**

B. Position

The patient is put in an upright position on a comfortable bed to ensure good breathing pattern. The position is changed every two (2) hours to semi recumbent till patient's breathing pattern is normal.

C. Rest and Sleep

- Patient is nursed in a well-ventilated room and quiet environment.
- Temperature is controlled by tepid sponging to provide comfort.
- Client is encouraged to lie on the affected side to help splint the chest, especially the affected side to reduce pleural rubbing.
- Plan and carry out care in such a way that the client's resting time will not be interrupted.

D. Diet and Nutrition

- Encourage enough fruits and roughages to avoid constipation.
- Adequate intake of fluid to avoid dehydration (about 3-4litres daily should be given).
- If client experiences dyspnoea, liquid diet is more preferable to avoid chocking.
- A pleasant environment should be provided during meal time.

- More protein, vitamins, mineral salt and carbohydrate meal are served to help in fighting infection and enhancing worn-out tissue repair.

E. Personal Hygiene

- Bed linen and clothing's should be changed as soon as it is soiled.
- Client should be given water to rinse mouth after coughing out sputum due to unpleasant taste of the sputum.
- Patient should be bath twice daily to maintain personal hygiene and to induce sleep.
- Mouth care should be given regularly to combat dryness or cracking of the lips and infections in the mouth.

F. Medicine

- Serve prescribed drugs at the correct time and ensure client takes them.
- Observe for therapeutic effect of the drug, record and report for early detection.
- Observe for signs of adverse reaction of the drug served, record and report immediately.

G. Maintenance of Airway

Change the patient position every two hours to prevent pooling of secretions. If possible, encourage patient to do deep breathing exercise. If child is unable to cough sputum, oropharyngeal suction is done to clear the airway. This is done with care in order not to introduce foreign substance into the pleural cavity.

H. Psychotherapy

- Explain the procedure carried out on the patient and the condition to the patient and family so that their anxiety will be allayed.
- Client and relatives should be encouraged to ask questions and answers provided tactfully to allay all fears.

I. Health Education

- Educate the patient and family on the disease condition so that they can prevent any complication.
- Educate on the need for follow-up and treatment regimen of antibiotics.
- The patient should be taught coughing and breathing exercise.
- Educate on the need to avoid sleeping directly under fans but rather should open windows for ventilation.
- Educate patient on the avoidance of alcohol, smoking and fatigued exercise.
- Educate patient to avoid dust and cold environment because this can predispose one to getting pneumonia.

Complications of pneumonia

According to Bare, Suzanne, Branda and Smeltzer (2010) and Kumar and Clark (2020), complication is a secondary disease that aggravating an already existing one. There may be complications such as;

- Cardiac failure
- Respiratory failure
- Pleural effusion
- Lung abscess

Prevention of pneumonia

According to Bare and Smeltzer (2010), pneumonia can be prevented in the following ways;

1. Educate on proper environmental and personal hygiene.
2. Sudden change of body temperature should be reported.

3. Avoid excessive intake of alcohol, dusty or smoky environment.
4. The patient should sleep in a well-ventilated room.
5. Disease of the Upper Respiratory Tract should be treated quickly to avoid organism descending into the Lower Respiratory Tract.

1.11 Validation of data

Validation is defined as the process of establishing the truth or logical cogency of something (American psychological Association, 2020). Also Validation is the extent to which measure, indications or a method of data collection possesses the quality of being sound or true as far as it can be judged (Weller, 2010).

N.M.N.Y. O's folder was a great source of information and the staff in the ward especially the nurse in-change, the doctors and the laboratory technician helped in obtaining validation for data collection. The patient's mother also helped in obtaining information which were all found out to be true and helpful since I kept on asking patient's mother the same questions but there was no difference in answers given.

The patient's condition compared to the literature review, confirmed my patient was suffering from bronchopneumonia.

CHAPTER TWO

ANALYSIS OF THE DATA COLLECTED

2.0 Introduction to Chapter

According Hornby (2021), Analysis is the detailed study or examination of something in order to understand more about it. This chapter forms the second phase of the nursing process, which deals with the critical examination and interpretation of data collected during the assessment of the patient. It also talks about analysing the information gathered from the patient, family and other health team members as well as the literature review. It also deals with the result of investigations, medical treatment, patient and family's strength and possible problem identified which requires nursing diagnosis and intervention.

2.1 Comparison of Data with Standard Diagnostic Investigation/Test

According to Weller, (2010), diagnosis is the determination of the nature of a disease and Test is defined as an examination or trial. Investigation refers to the procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatments, also diagnosis is the process of identifying and determine the nature of the disease or the disorder by it signs and symptoms, through the use of assessment techniques (American psychological Association) To help in the diagnosis and treatment of N.M.N.Y.O., the following investigations were carried out on him during his period of hospitalization.

1. Full blood count
2. Blood film for malaria parasites (MPs)
3. Chest x-ray/radiology

Table 1: Comparison of diagnostic measures of master N.M.N.Y.O to the literature review

Diagnostic Measures in the Literature Review	**Diagnostic Measures conducted on master N.M.N.Y.O**
Blood analysis FBC	Conducted on patient.
Chest radiology	Conducted on patient.
Physical examination	Conducted on patient.
Sputum specimen test	Not conducted on patient.
Erythrocyte segmentation rate	Not conducted on patient
Bronchoscopy	Not conducted on patient
Blood MPs	Conducted on patient

The above table, are some diagnoses investigations carried out to help health care givers of the patient to give appropriate diagnosis to patient presenting signs and symptoms.

Table 2: Diagnostic Investigations/Test

Date	Specimen	Investigation	Results	Normal Value	Interpretation	Remarks
27/11/2021	Blood	Haemoglobin level estimation. WBC level. RBC level.	12.0g/Dl. 11K/UI. 5.04M/UI	Children: 8-17g/Dl. 3.0-8.50K/UI. 4.00-5.50M/Ul	Within normal range. Out of normal range. Within normal range.	No treatment was given. IV Gentamycin 100mg was given. No treatment was given.
27/11/2021	Chest	Chest radiography	Consolidation of right lower lobe of the right lung	Lung tissue firm and darkened	Inflammation of the lung parenchyma(been filled with fluids) indicating bronchopneumonia	IV Cefuroxime was ordered and administered
27/11/21	Blood	Malaria parasite	Negative	No malarial parasites should be present.	Negative means absence of malaria parasite.	No treatment giv en

Causes of patient's condition

Patient's mother believed that the child's condition was caused by the cold water she always used to bath her. With respect to the literature review (predisposing factors), N.M.N Y. O's condition might have been caused by the cold weather being one of the predisposing factors in the literature review.

Table 3: Signs and Symptoms Exhibited by Patient as compared to Text Book Presentation (Literature Review).

According to Weller, (2010). Signs is an objective evidence of a disease or dysfunction. Symptoms are any indication of disease perceived by the patient**.**

Text Book Presentation	**Patient's Presentation**
1. Fever develops with temperature of 38.0 °C.	1. Patient presented with temperature of 38.8°C.
2. Chest pains.	2. Patient did not presented with chest pains
3. Dyspnoea.	3.dyspnoea was Present
4. Nausea, vomiting and anorexia.	4. Vomiting was present.
5. Tachycardia.	5. Absent of tachycardia
6. Crackles and wheezing sound on auscultation.	6. Crackles and wheezing sound was not Present.
7. Child may experience rapid and distress respiration.	7. Rapid and distressed respiration was present.
8. The onset must be gradual with nasal congestion and sneezing.	8. Nasal congestion and sneezing were not present
9. cyanosis	9. cyanosis was absence
10.Cough	9.Cough was present

From the above comparison, it is clearly seen that, Master N.M.N.Y.O suffered the condition since he exhibited most of the signs and symptoms of the condition.

Treatment given to patient

According to Weller, (2010). Treatment refers to the mode of dealing with a patient or disease. Pneumonia may be treated base on the clinical manifestations presented by Master N.M.N.Y.O. And the laboratory investigations conducted, he was treated and managed on the following.

i. IV Cefuroxime 600mg TDS X 5 days.
ii. Syrup Simple Linctus 7.5mls TDS X 7days.
iii. IV Gentamycin 100mg OD X 48hours.
iv. IV Hydrocortisone 50mg TID X a day
v. IV paracetamol 200MG TID X 7days.
vi. Suspension cefuroxime 600mg TDS X 5 days.
vii. Syrup paracetamol 200MG TID X 7 day

Table: 4 table fore: comparisons of patients medical treatment with literature review

TREATMENT ACCORDING TO LITRETURE REVIEW	**TTREATMENT GIVEN TO PATIENT**
Antibiotics; ceftriaxone, erythromycin, co-Amoxiclav, cefuroxime, doxycycline, ciprofloxacin, metronidazole, clindamycin, and Azithromycin, gentamicin.	Iv and suspension Cefuroxime, gentamicin was prescribed
Analgesic; aspirin, paracetamol, ibuprofen and phnylbutazone.	Iv and syrup paracetamol was prescribed.
Haematinics; folic acid, vitamin B12, and iron supplements	Not prescribed
Expectorants/mucolytic	Syrup simple linctus was given
Intravascular fluids ; normal saline, ringers lactate and dextrose saline	Not prescribed
Anti-inflammatory (corticosteroid)	Hydrocortisone was prescribed
Oxygen therapy to treat hypoxemia	Not prescribed

From the table above almost all of the drugs that were prescribed for the patient are in the literature review.

Table 5: Pharmacology of drugs administered to master N.M.N.Y.O

Date	Drug	Standard dosage And Route Of Administration According To Literature	Dosage And Route Of Administration To Patient	Classification	Desirable Effect	Actual Effect	Side Effect/ Remedies
27/11/21 And 02/12/21	IV Cefuroxime Cefuroxime suspension	**Child:** 30-50MG/KG **Route:** Oral, Intravenous.	**27/11/2021** **DOSE;** 600MG TDS 48hours intravenously **Dose;** 600mg TDS 7days oral	Cephalosporin Antibiotic	Cefuroxime is bactericidal agent that act by inhibiting bacterial cell wall synthesis	Symptoms of pneumonia subsided and breathing was restored to normal indicating improvement in the lung parenchyma.	Headache, nausea, vomiting, diarrhoea, abdominal pains and allergic reaction. None was observed with patient.

27/11/2021	Syrup Simple Linctus	125MG to 5ML **Route:** Orally	7.5ml TDS for 7days. Orally	Antitussive	Simple linctus contain citric acid monohydrate, it coats the throat and relieves the symptoms of cough.	Cough was relieve	Headache, nausea, vomiting, diarrhoea. None was observed with patient.

Pharmacology of drugs administered to Master N.M.N.Y.O Cont'd

Date	Drug	Standard Dosage and Route of Administration According to Literature	Dosage And Route Of Administration To Patient	Classification	Desirable Effect	Actual Effect	Side Effect/ Remedies
28/11/2021	IV Gentamycin	**Child:** 5mg/KG **Route:** intravenous ,intramuscular	**Dose:** 100mg OD X 48 hours **Route:** Intravenously	Broad spectrum penicillin.	It inhibits bacterial protein synthesis by binding to 30S ribosomes.	Help to control infection.	Lethargy, Vertigo nausea, vomiting. None was observed with patient. None was observed with patient.

28/11/2021	Hydrocortisone	**Dose:** 1to5 years is 50mg and 6 above is 100mg **Route:** Intravenously, oral and topical	**Dose:** 50mg TID a days **Route:** Intravenously.	Glucocorticoids	It enters target cells and binds with cytoplasm receptors leading to downstream effects like inhibiting of phospholipase A2.	Helps to control allergic reactions	Vertigo, headache, petechial, ecchymosis, insomnia, convulsions, psychosis. None was observed with patient.
29/11/2021 And 02/12/2021	Paracetamol Paracetamol Syrup	**Dose:**15mg/kg **Route:** oral, rectal, IV	**29/11/2021** 200mg was given intravenously for TDS 7days. **02/12/2021** 200mg was given orally TDS 7days	Antipyretic and analgesic	It inhibit cyclooxygenase mediated production of prostaglandins which help relieve fever	It help to relieve fever	Tightness in the chest, skin rash, liver problem, unusual tired, unexplained bleeding.

Complications

According to the literature review, patients with this condition suffer from cardiac failure, respiratory failure, pleural effusion and lung abscess but my client suffered none of them.

2.2 Patient/Family Strengths

Patient and family strengths are the resources and abilities that can help him/her to cope with the disease condition and management given. (Weller, 2010).

The strength could be social, economic, physical or psychological. Examples are minimal or absence reaction to medications, showing or absence of anxiety during medical and nursing procedures and being able to fund the cost of hospitalization.

The following strengths were identified in my client and her family;

1. Patients can tolerate tepid sponging when there is fever.
2. Patient can sleep for about 2-3 hours at night.
3. Patient can tolerate some amount of fluid after vomiting.
4. Patient could assume semi fowler's position.
5. Patient can eat some amount of food when served in bits.
6. Patient's mother could ask questions on the disease condition.

2.3 Patient/Family Problems

A health problem is any physical, psychological or social limitation or stress on a patient that can cause overt or covert reaction to his health

N.M.N.Y.O and his family had the following problem;

1. Patient had pyrexia (38.8 ^{0}C). 28/11/2021.
2. Patient presented with vomiting/nausea**.** 28/11/2021
3. Patient has difficulty in breathing 28/11/2021.

4. Patient has insomnia 29/11/2021.
5. Patient was unable to eat well 29/11/2021.
6. Patient mother has less knowledge about condition 29/11/2021.

2.4 Nursing Diagnosis

This is the phase of the nursing care plan where the identified health problems are developed into prioritized diagnoses. The nurse through his education and experience is able to identify and treat patient and family health problems.

After assessing N.M.N.Y.O and the family, the following nursing diagnoses were formulated

1. Pyrexia (38.8℃) related to bacterial presences causing infection in the lungs 28/11/21.
2. Risk for fluid volume deficits (potential) related to frequent vomiting 28/11/2021.
3. Dyspnoea related to ineffective airway clearance 28/11/ 2021.
4. Insomnia related to frequent attack of cough 29/11/2021
5. Imbalance nutrition (less than body requirement) related to anorexia 29/11/2021.
6. Knowledge deficit related to inadequate information on causes, treatment and preventions of bronchi pneumonia 29/11/2021.

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 problems in daily life and produce an individual care plan **(**Weller, 2010). This chapter is the third phase of the nursing process and deals with planning the nursing care for the patient and family.

It comprises the process of formulating nursing strategies required to prevent, reduce or eradicate the client and the family's health problems which were identified at the analysis stage.

Planning is achieved by setting of clear objectives or outcome criteria and the stating of specific nursing measures.

This helps the patient and family to meet their health needs.

3.1 Objective/Outcome Criteria for Patient/ Family Care

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

1. Patient's high body temperature would be reduced from 38.8°C to normal range (36.2°C - 37.2°C) within 24 hours as evidence by:
    I. Nurse observing that patient's temperature has reduced to normal with the aid of a thermometer.
    II. Patient's mother verbalizing that patient is less warm and comfortable in bed.
2. Patient would maintain his normal fluid volume throughout the period of hospitalization as evidence by:

I. The nurse and patient's mother observing and verbalizing cessation of vomiting.

II. The nurse visualizing the absence of signs and symptoms of dehydration. Example sunken eyes and moist mucous membranes.

3. Patient would regain his normal breathing pattern (20 to 25 cpm) within 24hours as evidence by:
    I. Nurse observing a stable respiration cycle between 20-25c/m.
    II. Patient's mother verbalizing that child has regain his normal breathing pattern.
4. N.M.N.Y.O would regain his normal sleeping pattern (6-9) within 48 hours as evidence by:
    I. Patient's mother verbalizing that child had his normal sleeping hours.
    II. The night nurse observing that child slept throughout the night without interruption.
5. Patient would maintain his normal nutritional status throughout the period of hospitalization as evidence by:
    I. Patient ate all the three square meals served.
    II. Patient gaining optimum weight.
6. Mother would have enough knowledge on pneumonia within 24hours as evidence by:
    I. Their ability to verbalize the causes, management and prevention of the condition.
    II. Mother's cooperation in the management of child.

Table 6: Patient/Family Care plan for Master N.M.N.Y.O

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Signature
28/11/2021 08:40am	Pyrexia (38.8℃) related to bacterial presences causing infection in the lungs.	patient's high body temperature would be reduced from 38.8°C to normal range (36.2°C - 37.2°C) within 24 hours as evidence by: 1. Nurse observing that patient's temperature has reduced to normal with the aid of a thermometer. 2. Patient's mother verbalizing that client is	1. Reassure patient and mother that patient will regain his normal body temperature. 2. Tepid sponge patient for 15 to 20 minute 3.Remove tight clothes and ware patient light clothes. 4. Monitor and record vital signs particularly temperature 4hourly. 5. Save cold drinks.	1. Patient and relative were reassured of reduction of body temperature to normal. 2. Patients was tepid sponged for 15 minutes. 3. Tight clothing's were loosened and light ones worn. 4. Vital signs were Checked and recorded.	29/11/2021 08:35am	Goal fully met as client had a normal body temperature of 37.2ºC	

		less warm and comfortable in bed.	6. Administer prescribed antipyretics and antibiotics.	5. Cold drinks were given. 6. Iv paracetamol, iv gentamicin was served and recorded.			

Patient/Family Care plan for Master N.M.N.Y.O

Date/ Time	**Nursing Diagnosis**	**Objective/Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Signature**
28/11/2021 at 9:00am	Risk for fluid volume deficit (potential) related to frequent vomiting.	Patient would maintain his normal fluid volume throughout the period of hospitalization as evidence by: 1. The nurse and patient's mother	1. Reassure patient and relatives that vomiting will stop. 2. Clean patient's mouth after vomiting. 3. Encourage the intake of copious fluids.	1. Patient and relatives were reassured that vomiting will stop. 2. Patients mouth was cleaned after vomiting. 3. Oral fluids 500ML were served as tolerated.	02/12/2021 At 9:00am	Goal fully met. Child's vomiting stopped and was able to retain some amount of fluid.	

		observing and verbalizing cessation of vomiting. 2. The nurse visualizing the absence of signs and symptoms of dehydration. Example sunken eyes and moist mucous. Membranes.	4. Assess the patient for signs and symptoms of dehydration. 5. Assess the nature of the vomitus. 6. Monitor patient intake and output.	4. Signs and symptoms of dehydration were absent on assessment. 5. Patient was assessed and Vomitus was clear, non-offensive. 6. Patient fluid balanced maintain as patient passed 600ml of urine.			

Patient/Family Care plan for Master N.M.N.Y.O

Date/ Time	**Nursing Diagnosis**	**Objective/Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Signature**
29/011/2021 At 8:45am	Dyspnoea related to ineffective airway clearance	4.Patient would regain his normal breathing pattern (20 to 25 cpm) within 24hours as evidence by: 1. Nurse observing a stable respiration	1. Reassure patient and mother that normal breathing pattern will be restored. 2. Nurse patient in an upright position. 3. Monitor vital signs especially respiration every	1. Patient and mother were reassured. 2. Patient was nursed in an upright position. 3. Vital signs were monitored especially respiration.	30/11/21 At 8:45am	Goal fully met. Child's breathing pattern was normal (20-25 c/m).	

		cycle between 20-25c/m. 2. Patient's mother verbalizing that child has less chest discomfort.	30 minutes and record until it becomes stable and record. 4. Assess patient for chest pain. 5. Teach and encourage deep breathing exercises 2 hourly during the day. 6. Serve prescribed drugs as ordered.	4. Patient was assessed for chest pains. 5. Deep breathing exercises were taught and encouraged. 6. Drugs were served as prescribed.			

Patient/Family Care plan for Master N.M.N.Y.O

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Signature

29/11/2021 7:00pm.	Insomnia related to frequent attack of cough.	N.M.N.Y.O would regain his normal sleeping pattern (6-9) within 48 hours as evidence by: 1. Patient's mother verbalizing that child had his normal sleeping hours. 2. The night nurse observing that child slept throughout the night without interruption.	1. Assess patient sleeping pattern. 2. Ensure noise- free and calm environment. 3. Encourage patient to urinate before going to bed. 4. Group and carry out nursing activities at a go to promote sleep.	1. Patient sleeping pattern was assessed and his usual sleep duration is 6hours during night and an hour in the day. 2. Radio and televisions volume was reduced. 3. Patient pass urine before going to bed. 4. Due medications were administered and vital signs assessed at the same time.	31/11/2021, 7:00pm	Goal fully met. Client was able to have his normal sleeping hours.	

			5. Prepare a comfortable bed for patient. 6. Administer cough medications.	5. A bed free of creases and crumps was prepared for patient to lie on. 6. Patient cough medications was served.			

Patient/Family Care plan for Master N.M.N.Y.O

Date/ Time	**Nursing Diagnosis**	**Objective/Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Signature**
29/11/2021 At 5:15pm	Imbalance nutrition (less than body requirement) related to anorexia.	Patient would maintain his normal nutritional status throughout the period of hospitalization as evidence by:	1. Reassure patient and relatives on maintenance of body weight. 2. Assess nutritional history of patient.	1. Patient was reassured on body weight maintenance 2. Patient nutritional history was take using the 24houres food recall.	02/12/2021 At 10:00am	Goal was fully met as patient ate all the three square meals served.	

		I. Patient ate all the three square meals served. ii. Patient gaining optimum weight.	3. Give patient mouth care. 4. Plan diet with patient and mother. 5. Save foods in bit but at frequent interval. 6. Weigh the patient and document.	3. Patient mouth was care for to stimulate appetite. 4. Patient was involved in planning menu. 5. Patient was provided with small but frequent and nutritious diet. 6.patient body weight assessed was done			

Patient/Family Care plan for Master N.M.N.Y.O

Date/ Time	**Nursing Diagnosis**	**Objective/Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Signature**
29/11/2021 At 7:30am	Knowledge deficit (parent) related to lack of information on Broncho-Pneumonia.	Mother would have enough knowledge on pneumonia within 24hours as evidence by: I. Their ability to verbalize the causes,	1. Assess patient and parents level of understanding to condition. 2. Assess patient and parent's willingness and motivation to learn about the condition.	1. Patient understanding on condition was assessed. 2. Patient and parent willingness and motivation to lar was assessed.	29/11/2021 At 3:30pm	Goal fully met. Mother was able to mention some causes and preventive	

		management and prevention of the condition. II. Mother's cooperation in the management of the child.	3. Educate mother on the causes, signs and symptoms, prevention and management of the condition. 4. Allow mother and patient to ask questions and clarify her doubts and misconceptions. 5. Ask her questions for feedback.	3. Patient and mother was given information on the prevention of spread and the preventions of bronchi pneumonia. 4. Patient and mother was allowed to ask questions for clarification and tactfully answered were given.		measures of pneumonia.	

				5. Feedback to questions tell the understanding of patient condition.			

CHAPTER FOUR

IMPLEMENTING OF PATIENT / FAMILY CARE PLAN

4.0 Introduction

According to Smeltzer, Branda Suzanne, and Bare (2010), implementation is the actualization of the plan of care through nursing intervention. Implementation is the fourth step in the nursing process. This chapter summarizes the actual nursing care rendered to patient and family throughout the period of interaction on admission until termination of care, rehabilitation as well as follow-ups home visit and continuity of care.

This include the performing stage of the nursing care plan derived during the planning phase of the nursing process. Implementation is directed towards fulfilling the client's needs that result in health promotion, illness management and health restoration in different setting such as a health facility, home and work place. It also involves the delegation of task to care-givers and assistive personnel and documentation of the specific activities and procedures executed by the nurse and the client's response to these activities and procedures.

4.1 Summary of Actual Nursing Care rendered to Patient/Family

The nursing care rendered to N.M.N.Y.O started from the day of admission which was 28th November, 2021 and continued till he was discharged on 2ed December, 2021. The nursing care was aimed at ensuring comfort of the patient and to promote his recovery with no complications.

First Day of Admission 28/11/2021

On the 28th November, 2021 at 8:30am, Master N.M.N.Y.O was brought to the paediatric ward accompanied by his mother and staff nurse from the Emergency Unit of Holy Family Hospital, Techiman. They were warmly welcomed and offered a seat by myself and introductions were

made. I collected the folder from the mother and mentioned the child's name to verify if it's his folder and if he is the right patient. Patient was admitted into an already prepared admission bed and relatives offered seats at the nurse's station. I reassured them that, all the necessary nursing and medical intervention would be carried out to restore him to normal health. His particulars such as name, age, address, religion, allergies, and next of kin were taken and recorded in the admission and discharge book, as well as the ward state after confirming with patient. All necessary sheets like medications; laboratory and temperature sheets were filled accordingly. His vital signs were checked and recorded as follows;

Temperature - 38.8^{o}C

Pulse - 101bpm

Respiration - 40cpm

His weight was recorded as 20kg.

Patient was tepid sponged due to the high temperature. After the vital signs, I asked patient's mother about what was wrong with her son and she complained of pyrexia, sleeping difficulty, vomiting, and breathing difficulties with cough which were recorded in the nurses' continuation sheet. Patient's information was entered into the admission and discharge book and the daily census. The medication sheet, vital signs sheet and the nurses' continuation sheet were kept at the bedside.

Patient was placed on the following drugs:

1. Syrup Simple Linctus 7.5mls TID x 7days.
2. IV Gentamycin 100mg OD x 48hours
3. IV Hydrocortisone 50mg TID x 1day.
4. IV Cefuroxime 600mg TID x 5 days.

I introduced other staffs on duty and other patients admitted to the word already to patient and patient's mother. N.M.N.Y. O's mother was informed about the time for medication and other routine works at the ward. Patient/family was oriented to the ward especially the dining area, washroom, and playground for the children, nurse's station and etc. I made patient and his mother aware of time for visiting which starts from 4:30am to 5:00am in the morning and 4:30pm to 5:30pm in the evening. Since patient had National Health Insurance, no deposit was paid but I made mother aware that some medications are non-insured and must be paid when discharged. The discharge planning of patient started on the day of admission. It included patient, the family and the health team in whom the patient's care was entrusted to. I later expressed interest in using Master N.M.N.Y.O for my care study in partial fulfilment of the Award of licence from the Nursing and Midwifery Council and introduced myself to the mother again as a final year student of Holy Family Nursing and Midwifery Training College, Berekum. I told patient's mother about my intention to use them for my care study and explained further that it would not involve the patient only but the family also. The reason was that I have learnt the theoretical aspect of the condition (pneumonia) and so I want to use this opportunity to do the practical aspect of it. I made her aware that there will be the need for me to render a complete and individualized nursing care to the patient/family until discharge and follow up visit after discharge until he recovers fully. After the admission procedure, objectives and nursing care were planned with the client's mother in order to achieve a speedy recovery.

On 28th November 2021at 8:40am patient had high body temperature, hence a nursing diagnosis was made on pyrexia (38.8℃) related to bacterial presences causing infection in the lungs. An objective was set to restore a normal body temperature within 24hours therefore the following nursing intervention were made; patient and relative were reassured of reduction of body temperature to normal, patients was tepid sponged for 15 minutes, tight clothing's were loosened and light ones worn, vital signs were checked and recorded as stated in the appendix, cold drinks were given and Syrup paracetamol was served and recorded. 29th November 2021 at 8:35am an evaluation was done, the goal was fully met as patient body temperature reduced to normal range (37.2°C).

On 28th November, 2021 at 8:45am, nursing assessment was made and patient had difficulty breathing hence a nursing diagnoses was set as dyspnoea related to ineffective airway clearance an objective was made to maintain a normal sleeping pattern within 24hours; patient and mother were reassured, patient was nursed in an upright position, vital signs were monitored especially respiration, patient was assessed for chest pains, deep breathing exercises were taught and encouraged and drugs were served as prescribed.

On 29th November 2021 at 8:45 am goal was fully met as child's breathing pattern returned to normal (20-25 c/m). On that same day. Mrs N.V was asked to provide good clothing and ensure N.M.N.Y.O was having adequate ventilated environment. His mother was also educated on how to change N.M.N.Y.O's position in the bed. Windows were opened to ensure adequate ventilation

On 28th November 2021 at 9:00am patient had vomiting, there for a nursing diagnosis was made on Risk for fluid volume deficit (potential) related to frequent vomiting. An objective was made to restore normal fluid volume throughout the period of hospitalization and the following nursing

intervention was given; Patient and relatives were reassured that vomiting will stop, patients mouth was cleaned after vomiting, oral fluids 500ML were served as tolerated, signs and symptoms of dehydration were absent on assessment, was assessed and was Vomitus clear, non-offensive, patient fluid balanced maintain as patient passed 600ml of urine. On the 02 of December 2021 at 9: 05 am on the evaluations goal was fully met as child stopped vomiting and was able to retain some amount of fluids.

At **12:30am** patient was served with about 125mls of fruit drink and biscuit as he requested and he drunk more than half of the drink served. No medication was served in the afternoon as patient was not on any afternoon prescription.

Patient 2: 00pm vital signs were checked and recorded as follows;

Temperature – 38.5^0 C

Pulse – 127 beats per minute

Respiration – 39 cycles per minute

SPO2-- 100%

Patient mother was assisted to tepid sponge him with tepid water, patients cloths were removed and funs were turned on to bring adequate ventilation.

At **2:00pm**, with assistance of mother patient was also tepid sponged down with tepid water to reduce temperature. The temperature dropped from 38.8^{o}C to 36.8^{o}C. Mrs. N.V was educated on procedures were thoroughly explained to her before performing.

Second Day Admission 29/11/2021

According to the night nurses report, patient slept intermittently due to frequent assessment and woke up around 5:30am.The mother was assisted to maintain patient's personal hygiene. His bed linen was changed and he was groomed and made comfortable in bed. At 6:00am vital signs were checked and recorded as follows:

Temperature - 37.7^{o}C

Pulse - 106beats per minute.

Respiration - 26 cycle per minute

SPO2 - 99%

The mother was encouraged to feed the child on demand to help maintain the nutritional status. Patient was served "muole koko" and dough-nut at 7:30am but he ate about 300mls of the porridge served. Due 6am medications served and recorded included,

Intravenous Cefuroxime 1g 600mg X 5 daily.

Intravenous Hydrocortisone 50mg TID a daily.

Syrup Simple Linctus 7. 5mls TID X 7 days.

Gentamycin 100mg OD X 48hours.

At 8:15 am, the medical team came on ward rounds and the doctor was impressed with N.M.N.Y.O's health. The medical doctor ordered for IV paracetamol 200mg TDS for 7 days to be added.

Afternoon medication was served around 2:00 pm, which included Intravenous paracetamol 1g, 200mg TID and vital signs were checked and recorded as follows:

Temperature – 37.6 ^{o}C

Pulse - 110beats per minute.

Respiration - 26 cycle per minute

Mrs N.M complained that patient cannot feed well at 5:15pm on 29th November, 2021 it was assessed and a nursing diagnosis was made imbalance nutrition (less than body requirement) related to anorexia. An objective was made to restore normal nutritional status and nursing intervention was made as follows; patient was reassured on body weight maintenance, patient nutritional history was take using the 24hours food recall, patient mouth was care for to stimulate appetite, patient was involved in planning menu, patient was provided with small but frequent and nutritious diet and patient body weight assessed was done. Mother was taught how to serve food nicely and in bits to the child. Mrs N V was reassured and educated to feed N.M.N.Y.O with a well-balanced die. Patient was saved with banku and okra stew and he eat about 15 boles. These basic nursing measures were taken to improve the nutritional status of the patient and provide comfort.

On 02/12/2021 10:00am an evaluation was made, goal was fully met as patient ate all the three square meals served.

During visiting time, N.M.N.Y.O's aunty visited him. My intention of visiting their house was made known to them and the directions to their house was given by patient's mother but the actual day of visit was unknown to them. At 6:00 pm, patient's vital signs was checked and recorded as

Temperature - 36.8 ^{o}C

Pulse - 124bpm

Respiration - 28cpm

Spo2 - 100%

At **6:30 pm** Mrs N V was assisted to give N M N Y O a bath with lukewarm water. Mrs N.V served tom brown with milk and bread, made comfortable in bed. Patient was then handed over to the night nurses including all documents for continuity of care.

On 29th November 2021 at 7:00pm, patient had difficulty sleeping so a nursing diagnosed was set as Insomnia related to frequent attack of cough. An objective was set to maintain a normal sleeping pattern within 48hours therefore nursing intervention was made; patient sleeping pattern was assessed and his usual sleep duration is 6hours during night and an hour in the day, radio and televisions volume was reduced, patient pass urine before going to bed, due medications were administered and vital signs assessed at the same time, a bed free of creases and crumps was prepared for patient to lie on and patient cough medications was served.

On 30 December 2021 at 7:00pm, an assessment was done, goal was fully meet as patient regained his pattern.

On the 29/11/2021 at 7:30am nursing diagnosis of Knowledge deficit (parent) related to lack of information on Broncho- Pneumonia, objective was set for parent that she will have enough knowledge on her child's condition within 8 hours when it was known that patient and his mother have less knowledge on condition. Interventions included; reassuring mother that the health team will help her to know much about the condition, procedures carried out on patient was explained with it rationale, patient mother was allowed to ask questions bothering her mind, questions asked were answered tactfully. And on the 30/11/2021 at 3:30pm. Evaluation was made and goal was fully meet

At **10:00pm,** N.M.N.Y.O was served with intravenous paracetamol 1g, 200mg TID. Following his due medication scheduled and was recorded on the nurse note. N, M.N.Y.O was make comfortable on bed with a good night wish to him and his mother. He slept around 10:30pm.

THIRD DAY ON ADMISSION 30/11/2021.

At 6:40am, N.M.N.Y.O was heard crying while coughing and when attended to, it was realized that the crying was associated with chest pain.

N.M.N's mother was reassured that necessary measures will be put in place to relieve patient of chest pain. Patient was nursed in an upright position to facilitate breathing and relieve pain. He was also made to sleep on the unaffected side as well as supporting patient with pillow. Intravenous paracetamol 1g, 200mg TID as an analgesia to relieve N.M.N.Y.O of chest pain and Intravenous Cefuroxime 1g 600mg daily as part of patient morning medications. Patient was allowed to have adequate rest and sleep by straightening his bed to make it comfortable for him. Noise on the ward was reduced to provide a suitable atmosphere for the patient to sleep well.

Later during the day, N.M.N.Y.O's mother was educated on good oral hygiene, personal, environmental hygiene straightening of bed, nursing patient in upright position, and were all documented in the nurse's note whiles drugs administered were entered into the drug administration chart. N.M.N.Y.O was served with boiled yam and beans stew with fruit juice which he was able to consumed one-third of the food served and drunk the 120mls of drink. The mother was also encouraged to give any form of food complements that he request frequently on demand

FOUR DAY ON ADMISSION 31/11/2021

Night report indicated that, N.M.N.Y.O had a sound sleep, woke up around 5:30am. He was bathed with lukewarm water, his mouth was clean and served with oath with milk around 7:30am Family members who visited N.M.N.Y.O and mother were happy because of the tremendous

improvement of N.M.N.Y.O. Patient looked cheerful and active as he assumed running and playing games with his mother phone.

His personal hygiene was ensured and the vital signs such as temperature, pulse and respiration were checked and recorded in the appendix. During ward rounds around 8:15am, in the morning, N.M.N.Y.O was found to be fit by the doctor. But he was still place on monitoring to see further improvement.

The patient's mother was educated on the need for eating balance diet and vitamin supplements to boost patient's immune system and also the need to continue medication at home. The mother was also educated on personal and environmental hygiene.

N.M.N.Y.O'S mother was also reminded of the causes, signs and symptoms, and the prevention of the patient and the need to report to the hospital early when features manifest.

The dosage of the drugs were further explained.

On the 02 of December 2021 at 10:00 am the doctor came around to discharge N.M.N.O.Y, his parents were asked to go to the paediatric ward pharmacy for any additional medications and to settle all bills that the health insurance did not cover by NHIS. Patient cannula was removed and discard Assistance was given to the mother to pack their belongings. Parents were reminded on the need for continuity of medication, personal hygiene, they were seen off to the car park and promised to come on the review date. All care rendered were documented into the nurse's notes whiles the discharge was entered into the admission and discharge book and the daily ward state.

4.2 Preparation of Patient for Discharge and Rehabilitation

Preparation of patient and family towards discharge started on the day of admission till the day of discharge. Even though patient and relatives were anxious and worried about his hospitalization

and the prognosis of pneumonia, they were reassured that, his admission was a temporal measure to give proper medical and nursing care.

Prior to discharge the patient's family were given education on the disease condition and the need to give the patient discharge medication.

Patient's family were educated on the need for Follow-up visits and educated on the dosage, action and adverse effects of medication.

On the 2nd of December, 2021 during the general ward rounds, N.M.N.Y.O was discharged on the following drug:

- Syrup simple linctus 7.5mls TID X 7days.
- Syrup paracetamol 200mg TID X 7 days
- Suspension cefuroxime 600mg X 5days

His parents were educated on the dosages and the need to conform to the drug regimen and were told of the date of review which was on Thursday 9th December, 2021. The date and time of discharge were entered into the admission and discharge book and the daily ward state.

On the ward, they were assisted in packing their belongings. Patient's parents bid goodbye to the staff and other patients on the ward after settling their bills with the account department on uninsured drugs.

4.3 Follow Up/Home Visit/Continuity of Care

This is the visit made to patient's home before and after discharge. This helps the health provider to assess the home of the patient, ensuring continuity of care and rehabilitation of patient. During the period of visit, the nurse identifies problems affecting the patient and the family health and how to solve it. I embarked on three home visits to my patient's house

First home visit (Tuesday, 01/12/2021

The first home visit was made on 1st December, 2021 whilst patient and mother were still on admission was to help me know much about patients environment, to validate the information given by patent and the mother and to also identify any health facility around their vicinity. It was made around 3:55pm with patient aunty who came visiting in previous days to the first home visit. On entering the house, a quick observation was made on the environment and it was found to be clean. It was a compound house built with blocks and mud and roofed with aluminous roofing sheet. The house is subdivided into sections of which they owe two bed rooms self-contain. Their water supply is from a tap mounted in the middle of the compound. They have access to electricity supply. Their refuse is gathered into a big dust been with lid and emptied every time is full at the public refuse site. They were commended for their clean and healthy environment. N.M.N.Y.O'S brother had not yet returned from school.

Patient's aunt saw me off after answering the questions they asked me on N.M.N.Y.O condition.

Second home visit [on Tuesday] 07/ 12/ 2021

My second home visit was on the above offered date, six days after patient was discharged to find out the health status of Patient and to remind them of the review date then his aunt introduced me to other family members who were not around during my first home visit. Enquiry was made of any new complaint and general health of N.M.N.Y.O and the family. There were no complaints as he looked very active and cheerful playing with his brothers and friends. It was enquired if there was continuous administration of patient's drugs and positive answer was given. N.M.N.Y.O'S mother was also encouraged to continue with balance diet feeding and porridge (Tom brown).

They were reminded of the review date which was on 9th of December, 2021[Thursday]. After some conversation on N.M.N.Y.O condition, permission was sought to leave. Another visit was promised as they saw me off to board a taxi.

Review (Thursday, 9th December, 2021)

On 9th December, 2021, patient and Aunty were met at the Out Patient Department of Holy Family Hospital –Techiman. Patient and the Aunty looked well I helped them renew patients. Folder number. Vital signs were checked and recorded as

Temperature	-	36.8 ^{o}C
Pulse	-	124bpm
Respiration	-	28cpm
Spo2	-	100%

Patient's was seen by the doctor in the consulting room 4 and upon the doctor's examination, he was found to be healthy. The Aunty had no new complains. Mother was asked to provide patient with balanced diet, protect patient against cold weather, smoke, and dust particles. She was also informed to wash hands with soap and water when feeding N.M.N.Y.O. Patients parent were reminded of my third visit which will be my last visit and to terminate care. No new medications were ordered patient and Aunty were seen off at the taxi station to board a car.

Third home visit [Monday 17/ 12/ 2021]

On the offered date a visit was paid to patient's parent's house to find out how patient was faring after review and to hand over patient to public health nurse for continuity of care. Upon reception and exchange of greetings, enquiry was made about the general condition of the Patient. No new complains were made as patient's condition looked improved. Health education on the prevention

of pneumonia was emphasized and questions asked by the mother were answered precisely. The public health nurse was introduced to the family but patient mother who is a nurse also told me she was going to intervene in N.M.N.Y.O'S general health .Patient was handed over for continuity of care and follow-ups. The public health nurse and the mother who is a nurse promised to continue care and patient's family also expressed their willingness to cooperate with them.

I expressed my appreciation to Mrs N.V and her family for their co-operation and also assured them of occasional visit. After some few discussions permission was sought to leave as we bid each other fare well and goodbye.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO THE CLIENT/FAMILY

5.0 Introduction

This is the last phase of the patient/family care study. It is about the assessment of efficiency and effectiveness of the nursing intervention that were carried out on the patient and patient response towards them. Also the nurse analyses and finds out to what extent the set goals were met or unmet. It also covers the termination of care rendered to client/family.

5.1 Statement of Evaluation

Evaluation is the interpretation of the effectiveness of nursing care based on the expected outcome. It involves comparing client's health status with the goals and objectives of the planned care and determination of the client's progress.

It is the final phase of updating the plan of the patient's care. Depending on the outcome, unmet goals are re-examined, modified and re-prioritised after a proper assessment for an effective nursing care to be rendered.

Patient's body temperature reduced to normal value on 29/11/2021

On 28th of November 2021 at 8: 40am Master N.M.N.Y.O had pyrexia. An objective was set for patient's temperature to be within the normal range (36.2°C – 37.2°C). Nursing interventions done on patient include Patient and relative were reassured of reduction of body temperature to normal. Patients was tepid sponged for 15 minutes. Tight clothing's were loosened and light ones worn. Vital signs were Checked and recorded. Cold drinks were given.

On the 29th November 2021 at 8: 40am an evaluation was done, the goal was fully met as patient body temperature reduced to normal range (37.2°C).

29/11/2021 patient normal breathing pattern was regained

Master N.M.N.Y.O presented difficulty breathing on the 28th November, 2021at 8:00 am A nursing diagnoses breathing pattern disturbance related to ineffective airway clearance formulated. An objective was set that client will regain her normal breathing pattern within 24 hours. Interventions includes; Patient and mother were reassured. Patient was nursed in an upright position. Vital signs were monitored especially respiration. Patient was assessed for chest pains. Deep breathing exercises were taught and encouraged. Drugs were served as prescribed. On 29th November 2021 at 8: am goal was fully met as child's breathing pattern returned to normal (20-25 c/m).

Patient's risk for fluid volume deficit, was regained on 02/12/2021

On 28/11/2021 at 9am patient mother complained that her child has been vomiting. A nursing diagnose was formulated with an objective set that patient will maintain his normal fluid volume throughout the period of hospitalization. Nursing interventions implemented on patient to help regain her fluid volume1. Patient and relatives were reassured that vomiting will stop. Patient's mouth was cleaned after vomiting. Oral fluids 500ML were served as tolerated. Signs and symptoms of dehydration were absent on assessment. Vomitus was assessed and was clear, non-offensive. Patient fluid balanced maintain as patient passed 600ml of urine.

On 2nd of December 2021 on the evaluations goal was fully met as child stopped vomiting and was able to retain some amount of fluids.

On the 30/11/2021 at 3:30pm Patient's knowledge deficit was restored

On the 29/11/2021 at 7:30am objective was set for parent that she will have enough knowledge on her child's condition within 8 hours when it was known that patient and the mother have less knowledge on condition. Interventions included; reassuring mother that the health team will help her to know much about the condition, procedures carried out on patient was explained with it rationale, patient mother was allowed to ask questions bothering her mind, questions asked were answered tactfully. And on the 30/11/2021 at 3:30pm, evaluation was made and goal was fully met as mother was able to mention some causes and preventive measures of pneumonia

02/12/2021 patient regain his eating ability

Patient mother complained that child could not eat well on 29/11/2021at 5:15pm. An objective was set that patient nutritional status will be maintained throughout the period of hospitalisation. Nursing interventions were; Patient was reassured on body weight maintenance. Patient nutritional history was take using the 24houres food recall. Patient mouth was care for to stimulate appetite. Patient was involved in planning menu. Patient was provided with small but frequent and nutritious diet. On 02/12/2021 10:00am an evaluation was made, goal was fully met as patient ate all the three square meals served.

On the 30/11/2021 patient sleeping pattern was restored

On 29/11/2021 at 7:00pm patient mother complained that child had difficulty in sleeping due her persistent coughing. A nursing diagnoses sleeping pattern disturbance cough was formulated for patient with an objective set to enable patient to sleep within 48 hours. Measures put place to help master N.M.N.Y.O sleep well includes; Patient sleeping pattern was assessed and his usual sleep duration is 6hours during night and an hour in the day. Radio and televisions volume was reduced.

Patient pass urine before going to bed. Due medications were administered and vital signs assessed at the same time. A bed free of creases and crumps was prepared for patient to lie on. On 31th November 2021 at 7:00pm an evaluation was done, goal was fully met as mother verbalised that patient had his normal sleeping pattern without any interruption. On the

5.2 The Amendment of the Nursing Care Rendered

With good nursing intervention, good medication care and optimum co-operation from the family a complete recovery of patient was fully met. Therefore, there was no need for amendment of nursing care plan.

5.3 Termination of Care rendered to Master N.M.N.Y.O

Termination of care is a really difficult moment since, after patient and family had built confidence in the nurse, it becomes a problem if all of a sudden the nurse is to gradually separate herself from the patient and family which could lead to loss of memories of both patient and family and the nurse.

The termination of care for the patient and family started on the day of admission till the day of my third home visit. He was doing well on my third day of visit, this was done to enable the patient and family to cope and accept that the care would not be there forever since my aim was to help Master N.M.N.Y.O. regain and maintain his health. A Community Health Nurse was identified for continuity of care. During the home visits, I educated them on the need to seek medical treatment whenever any member of the family was sick. I advised the mother not to depend on the drugs only but also report to the hospital for further treatment.

On the 17th December, 2021, I went for my last home visit and I informed them that was my last visit to them. I handed him over to a community health nurse who willingly agreed to take good

care of Master N.M.N.Y.O. They thanked me and bid me goodbye. I promised to pass by if I happened to pass that way.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

This is the final chapter of the care study. It involves the summary and conclusions of the study thus from the day of admission to the time when the care was terminated.

6.1 Summary

According to Hornby (2000), summary is a brief account giving the main points of a health problem.

Master N.M.N.Y.O. was admitted to the paediatric ward on the 28th November, 2021 at the Holy Family Hospital Techiman, with a diagnosis of bronchopneumonia. On admission the mother complained of vomiting, sleeping difficulty, fever and breathing difficulties with cough. He was admitted for five (5) days and six (6) problems were identified on him and the mother. Objectives were set and the necessary interventions were given.

During his admission, he was treated with the following drugs;

1. IV Cefuroxime 600mg TDS x 5 days.
2. Syrup Simple Linctus 7.5mls TDS x 7days.
3. IV Gentamycin 100mg OD x 48hours
4. IV Hydrocortisone 50mg TID x a day

The following laboratory investigations were ordered to confirm the diagnosis;

1. Blood film for malaria parasites (MP's) to rule out the presence of malaria parasite.
2. White blood cell count (WBC) to know if there is any infection and Red blood cell count (RBC) done to know if there is any haemolysis.

3. Chest radiology.

He was finally discharged on the 2st December, 2021. They were asked to come for review on the 9th December, 2021. Three home visits were made to the patient and family to know the situation of their environment, to validate information given to me by patient and family and to identify the presences of any health facility in their area. Health education was given on the problems identified in the house. The care of N.M.N.Y.O. and his family was terminated on 17th December, 2021 during my last home visit when I handed him over to a community health nurse. But his mother as nurse said she is going take good care of him with the support of the community health nurse.

6.2 Conclusion

This case study has helped me gain and broadened my knowledge about bronchopneumonia, its management and understanding on how individual nursing care is rendered through the use of the nursing process. It has also helped me to practice my skills acquired in the classroom practically. This care study will also serve as a guide or reference document for future students of Holy Family Nursing and Midwifery Training College, Berekum who will undertake similar exercise. This experience will go a long way to help me impact the knowledge and skill gained to others whenever necessary.

Finally, I recommend that every student should endeavour to put the nursing process concept into practice for it enables quality nursing care to be rendered to all clients, to enhance recovery.

APPENDIX

Table 7: Vital Signs of my client Master N.M.N.Y.O

Date	Time	Temperature	Pulse	Respiration
28/11/2021	6:40am	38.8°C	101bpm	40cpm
	2:00pm	38.5°C	127bpm	39cpm
	6:00pm	38.8°C	100bpm	28cpm
29/11/2021	6:00am	37.7°C	106bpm	26cpm
	2:00pm	37.6°C	110bpm	26cpm
	6:00pm	36.8°C	124bpm	28cpm
30/11/2021	6:00am	36.3°C	82bpm	20cpm
	2:00pm	36.6°C	86bpm	22cpm
	6:00pm	37.4°C	90bpm	24cpm
31/11/2021	6:00am	36.7°C	98bpm	23cpm
	2:00pm	36.1°C	80bpm	22cpm
	6:00pm	37.1°C	88bpm	20cpm
1/12/2021	6:00am	36.1°C	88bpm	19cpm
	2:00pm	36.5°C	80bpm	20cp

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