HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT AND FAMILY CARE STUDY ON HYPERTENSION

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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 A LICENSE TO PRACTICE AS APROFESSIONAL REGISTERED GENERAL NURSE

AUGUST, 2024

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PREFACE

Formerly, nursing was just caring for the sick on the sick bed. The nursing profession began to change extremely under the inspiration of Florence Nightingale. Nursing has reformed the care for the sick to include taking of medical history and conducting physical examination which was previously the duty of the medical doctor. According to Virginia Henderson, nursing is the process of assisting the individual either sick or well in the performance of those activities which contribute to health or peaceful death that he would have performed unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him gain independence and rapidly as possible.

Due to modernization, nursing has been changed to a holistic and individual nursing care of a patient by means of new techniques employed in the profession. To provide holistic and efficient nursing care to patient and family, the student nurse employs knowledge and skills in discipline such as psychology, sociology, surgery, pharmacology, public health and medicine to meet the needs of the patient, family and the community as a whole. Patient/Family care study is a written script on individualized nursing care rendered to a patient in relation to his disease condition at a specific period of time.

The care is based on the theoretical and practical experience acquired by the student nurse through the three-year training.

The study forms part of the assessment of the student nurse by the Nursing and Midwifery Council of Ghana for the award of a license to practice as a Registered General Nurse. The patient's care was carried out using the nursing process.The study helps the student to gain

knowledge in all areas of medical science to care for patients as individuals. The patient and family care study start from the day of admission to the time of discharge and continue in the community to ensure optimum health through home visits.

The care aids the student nurse to have a clear knowledge and understanding of the disease, its incidence, frequency in human population and treatment. It also gives the patient and relatives knowledge on the disease and helps build interpersonal relationship between the nurse and the patient/family. For the purpose of confidentiality, the name of my patient and family were stated using initials instead of full names throughout the care study.

ACKNOWLEDGEMENT

My utmost gratitude goes to the Almighty God who has been my protector and offered me knowledge and understanding throughout this study.

Special thanks to my supervisor Ms. Antoinette Effum and all the tutors of Holy Family Nursing and Midwifery Training college-Berekum, for their support and advice throughout this study.

My sincere gratitude goes to my patient Mrs. A.R and family for their cooperation and provision of the necessary information for this study.

Am very grateful to the medical doctors and nursing staff of Sunyani municipal hospital especially the ward in charge of the female's ward for his immense contribution to the care provided to my patient during her admission till discharge.

I would like to extend my appreciation to my father, Mr. Osei Francis, my Mother Mrs. Mary Osei, my sister Mrs. Mary Osei, my brother Anthony Osei and my sister in-law Emmanuella Owusu Ansah, my dear friend minister Samuel Owusu , my close friend Augustina Agyapong, my Senior Sampson Acheampong, my dear room members Slyvia , Jemima and my school daughter Roseyln Appiah all my colleagues and friends who motivated and contributed in diverse ways to make the writing of this patient/family care study possible.

Lastly, I am very grateful to all the publishers and authors whose knowledge I assembled to make this script a masterpiece.

I say God bless you all and may He replenish all that you lost.

INTRODUCTION

The patient and family care study is a report of the nursing care rendered to a patient and the family. The nursing care rendered includes the interaction between the patient and the health team. This patient/family care was carried out on a sixty-eight years old woman who for confidential reasons will be referred to as Madam. A.R in the study. She was admitted on 30th November, 2022 at the Female's ward of Sunyani Municipal Hospital. She was diagnosis of Hypertension urgency with the complaint of headache, general body pains and loss of appetite. She was also looking very anxious. The following treatment were ordered: IV Hydralazine 5mg, Nifedipine 30mg daily, Lisiopril 10mg and Paracetamol 1gram and was hospitalized for five days. The script gives a sum total of all the activities rendered to maintain and achieve a high level of well-being for patient and family. The script entailed the concept of nursing process being used effectively to provide nursing care to the patient and her family with particular reference to Madam. A.R till the time of discharge. The interaction with the patient and her family started on 23rd of August, 2023 and terminated on 27/08/2023 Madam. A.R and her family were chosen for the care study in order to gain sufficient knowledge and understanding about the condition (Hypertension).The report of this patient/family care study was organized in six chapters which are;

Chapter1. Assessment of patient and family

Chapter 2. Analysis of data collected

Chapter 3. Planning for patient and family care

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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 patients psychological, physiological, sociological, and spiritual status; sorting, analyzing, and organizing the data and the documentation and communication of the data. It includes the patients' medical, personal, social and environmental status. It forms the first part of the nursing process upon which nursing diagnose is established. It also helps to render the exact nursing care to the patient and the family. Information is gathered from patient and the family through interviewing, observation, and reference of past medical records. It involves patient particulars, family medical history and socioeconomic history. Assessment provides information that forms the patient's data base. 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 Mish (2016), particulars refers to facts or detail especially the one that is officially written down and kept as records, usually of an individual's personal details such as name, address and others.

Madam A. R. is the name of the patient for this study. She is the second born of her parent and was born on 13th February, 1955 at kojokesekrom to Mr. K.E and Mrs. A.C (both late). She is sixty-eight (68) years of age. Madam A. R. stays at Sunyani fiapre with house number 149/E . Patient hails from Kojokesekrom a small town near Japakrom all in the Jaman South

Municipality of the Bono Region of Ghana. She is a widow and was once married to the late Opanin B. A. All her family members including herself are Christians.

Madam A. R. worships with the presbyterian church of Ghana Sunyani branch. Miss E.S. is the name of her younger sister 46 years of age and her next of kin. Miss E.S lives in the same house with her sister. According to the patient, she attended school to S.H.S level. She has five (5) children (four males and one female). Madam A. R. is fair in complexion, 1.50m tall and weighs 72kg. She speaks Twi and has no physical impairment. She is a farmer.

1.2 Family's medical history

Health history is a series of questions used to provide an overview of the patient's current health status (Hinkle, Cheever, & Overbaugh, 2022). According to the patient, there are no known hereditary disease such as asthma, diabetes mellitus, hypertension, or epilepsy as well as no mental illness. She also said that, mild illnesses like headaches, stomach discomfort, common cold and malaria are widespread among family members which they frequently go to Sunyani municipal hospital for treatment and occasionally buys medications from the pharmacy shop. She further stated that the family does not have any history of chronic or contagious diseases such as Tuberculosis, epilepsy, or leprosy. Education was given to her about the need to avoid over-the-counter drugs in favor of getting prompt medical assistance at a hospital if they become unwell. Her siblings are all healthy. In the course of our conversation, Madam A. R. stated that at the age of twenty (20), she lost her father through a motor accident and at age thirty-five, she also lost her mother through severe malaria at St. Mary's Hospital at Drobo.

Madam A. R. husband died of stroke seven years ago and said two of her siblings died out of unknown causes. Madam A. R. said the rest of her family are all alive and healthy. Patient further stated that the only hospitalization she had was when she was newly diagnosed of hypertension and was hospitalized for five days and discharged to continue with her medication at home. The source of their medical treatment is orthodox. There is no known allergy in the family.

1.3 Family's socio–economic history

Socio economic history presents a profile of the patient/family's social and personal world (Park, 2022). According to the patient, she is a farmer at Sunyani and the breadwinner of her family. She is supported by her elder son who is a farmer as well as her other children who are both farmers and traders trading in all kinds of foodstuffs. Due to the nature of their work, I realized that patient and family are prone to occupational hazards like cuts and animal bites such as snakes which she confirmed. According to patient, she earns averagely eight hundred Ghana cedis (800.00) each month, after selling her farm produce and her children usually give her three hundred Ghana cedis every month from their sales. Their income is used for the up-keep of the family and the family health needs when insurance does not cover because patient and all family are registered members of the national health insurance scheme. According to Madam A. R., she is the head of the family and as such associates well with all her family members. She said in instances of family disputes and misunderstandings, she settles them amicably and upon the observation during visiting hours, then realized that there was a cordial co-existing relationship among Madam A. R. and her family members. Communicated with some of the family members

like her children and some of her siblings who confirmed what she said. Patient is a Christian who worships with Persbyterian church.

Patient was unable to throw more light on some cultural practices, norms, values and taboos but said when she settled at Sunyani about thirty five years ago she was told it is a taboo to go to farm on Tuesdays. She said when one goes contrary to the set rules and regulations in the community, sanctions are applied.

1.4 Patient's developmental history

According to Rundell (2017), development refers to the biological, physiological ad emotional changes that occur in human beings between birth and the end of adolescent as individual progress from dependency till increasing autonomy. According to Thesaurus (2022) Growth is the gradual increasing in size and of the body of an organism. Factors that affect growth and development includes genetic and environmental factors. The genetic factors determine the potential and limitations of growth and development. If favorable, environmental factors such as adequate nutrition, facilitate the achievement of the genetic potential of growth and development, and the reverse is true. Maturation is the emergency of personal and behavioral characteristics through growth process.

According to the patient, her mother went through 38weeks of gestation and delivered spontaneously per vagina at term without any complications at St Mary's hospital in 1955 at Drobo. The patient was born with no congenital malformations such as cleft lip and palate and was immunized against the childhood diseases that could have impeded her development. Madam A. R. was breastfed for four months and was introduced to supplementary foods such as porridge and mashed kenkey.

According to patient, she went through normal development milestone. She could move her limbs actively at two months, she was very aware of her environment, she could raise her head and arms when she was two months old. Her teeth started erupting at the sixth month. Madam A. R. started to sit when she was six months, crawled at the eighth month and started walking when she was about twelve months old. She started talking when she was one and half years. She had no deformities.

Madam A. R. also added that, she began kindergarten at the age of three at Drobo primary and junior high school and completed her Junior High School there as well. She developed her secondary sexual characteristic such as development of breast, growing of pubic hairs in both her genital area and the armpit. She had her first menses (menarche) at the age of fifteen years. According to patient at the adolescent stage she was very sociable. She was sexually attractive to the opposite sex when she was in school. Patient is a former student of Drobo Senior High School which she started to persue general arts and wished to become a lawyer in the future. Patient said she had no difficulty in learning. Madam A. R. said she did not engage in any relationship during her adolescence period until she met and married her late husband at the age of twenty-seven years. According to Eric Erikson's (1902), theory of psychosocial development (1959), there are eight distinct stages. These are;

1. Trust versus Mistrust (birth to 18 months)
2. Autonomy versus Shame and Doubt (2 to 3 years)
3. Initiative versus Guilt (3 to 5 years)
4. Industry versus Inferiority (6 to 11 years)
5. Identity versus Role confusion (12 to 18 years)
6. Intimacy versus Isolation (19 to 40 years)
7. Generativity versus Stagnation (40 to 65 years)

8. Integrity versus Despair (65 to death)

Madam A. R. is 68 years old and falls under integrity versus despair. People in their late adult years reflect on their lives at this time and feel either satisfied or disappointed. People who are pleased with their achievements have a strong sense of self-worth and have few regrets about their lives whereas those who are not successful at this point feel as if their lives have been wasted. They concentrate on what may have been, should have been, or might have been. They are angry, depressed and despairing as they approach the conclusion of their lives.

Based on the information received from the patient, it is evident that the patient has achieved success (integrity) at this stage of life as evidenced by the fact that her female child is married and working and her boys are also in the retail industry.

1.5 Patient's Obstetric History

According to Madam A. R., she stated that she experienced her menarche at the age of fifteen (15) and had her normal menstrual flow which always lasted for five (5) days during her menstrual period without irregularities from adolescence to adulthood until she reached menopause at the age of fifty (50). Madam A. R. said she had five pregnancies with no abortion. All the pregnancies resulted in successful delivery of live babies. All the children are alive four males and one female). She explained that she did not use any of the contraceptives and other family planning methods during her pregnancy and with that the birth spacing between her children were natural Furthermore, she did not experience any complications either during, before or after birth according to her.

1.6 Patients' lifestyle and hobbies

Lifestyle as defined by Collins dictionary (2021), is a set of attitudes, habits or possessions associated with a particular person or group. And hobby too is an activity pursued in spare time for pleasure and relaxation.

According to Madam A. R., she always wakes up early from bed at 4:30am and performs her personal hygiene before she starts her day at 5:30am due to her work. Since cleanliness is next to godliness Madam A. R. doesn't joke with her personal hygiene; bath twice daily and brushes her teeth once a day. Madam A. R. likes bathing with cold water in the morning then warm water in the evening because, it enhances her sleeping pattern since she always come home tired. Madam A. R. does not share her towel with anyone in the family and uses a soft sponge for bathing, she takes her breakfast and prepare to farm with her children. Her favorite dish is fufu with light soup. Madam A. R. does not have a normal eating habit and does take in every food that is readily available being it breakfast or lunch and supper. According patient, she likes making fun most especially with her family members and like giving admonishing's to both the elderly ones and young ones, patient also likes it when one is doing the same to her. On Tuesdays and Saturdays after church, she goes to chat with her friends, neighbours or family. Patient does not take alcohol, tobacco and other illegal drugs because of her religious beliefs and encouraged her to keep on with that because medically, it can have negative implications on her health. With the exemption of Tuesdays and Saturdays, the family visit the farm every day and after farm, they cook and have supper. She is not allergic to any food, drug or animal.

Madam A. R., says she moves her bowel at least twice daily but no specific time and finds no difficulty in eating, grooming, dressing and walking. Madam A. R. is very sociable, kind and has

good communication skills which makes it easier for an effective and interactive communication to be achieved and as such impresses everyone at her first contact. She continued that, she does keep peoples' mistakes and flaws to herself when she is offended but verbalizes them to ensure unity and harmony. Patient said she attend social functions like weddings, funerals, church activities, naming ceremonies, festivals and community events occasionally. She likes chatting with her family and also listening to the radio whenever it is time for news especially 6am, 12pm and 6pm as well as watching television. She said she always takes the radio to the farm to listen to news. Their farm is far from their house, so they have built a hut in the farm where they rest for a while before they return home. Madam A. R. is the head of her family and associates well with her family members and neighbors. She likes hardworking people and encourages them but really hates lazy people.

1.7 Patients past medical history

Past medical history is a detailed summary of a person's past health (Hinkle, Cheever, & Overbaugh, 2022). According to Madam A. R. she had her first admission six years ago (2017) at Sunyani Regional hospital, where she was admitted with hypertension and spent four days at the hospital. There were no complications because of the hard-working nurses, medical doctors and all health team. Patient added that sometimes she visits the Sunyani municpal Hospital or Sunyani Regional hospital both in the of the Bono-region of Ghana whenever she experiences minor ailments like headache, general body weakness and fever but she sometimes buys and treats with over-the-counter drugs like paracetamol, diclofenac etc. Madam A. R. said she goes for regular check-ups and always complies with her treatment regimen to prevent complications. She has never undergone any surgery and through observation, she has no physical deformity. Patient is not allergic to drugs, animal or insect.

1.8 Patients present medical history

Patient present medical history involves patient actual problem that prompted him to come to the hospital (Weller, 2019).

According to patient, she started experiencing headaches, general body weakness and not able to sleep for a week before she came to the hospital and said that her anti-hypertensive drugs were completely finished. On 23rd August, 2023, patient decided to come for a check-up and was asked by the attending doctor that her blood pressure was high and needed to be admitted and monitored carefully to prevent further complications. Her vital signs were checked and recorded at the Outpatient Department as;

Temperature: 36·3°C

Pulse: 99bpm

Respiration: 22cpm

Blood pressure: 270/140mmHg

She was given IV Hydralazine 10mg stat and was to be admitted to the Female's ward for monitoring and treatment to prevent further complications.

1.9 Admission of patient

Admission is the process of receiving a patient into the ward in order to ensure continuity of the nursing care to enhance smooth and faster recovery and to prevent any complication from arising either planned or unplanned (Weller, 2019). The process of admitting patients from the

emergency department to the general medicine floor is foundation to medical practice more generally (Frush & Krantz, 2022).

Patient was brought to Female's ward through the Out Patient Department in a wheel chair by an accompanied nurse and the patient's daughter at 3:00pm on 23 August, 2023. On account of hypertension urgency with the complaints of headache, feeling of anxiety, general body pains and loss of appetite. This admission was unplanned admission. The patient's daughter and the accompanied nurse were sent to the nurse's station and warmly welcomed. A seat was offered to make them comfortable. The patient's card with the folder number was collected from the nurse and the patients name was mentioned to confirm the right patient and she responded. Self-introduction as well as Staff on duty were introduced to the patient and her daughter. The patient was then admitted into a well-prepared simple bed free from cramps and creases. They reassured of competent care to help her recover quickly. Patient and her daughter were introduced to nearby patients and made comfortable in bed F-2. Her vital signs were checked and recorded as

Temperature: 36·3°C

Pulse: 99bpm

Respiration: 22cpm

Blood pressure: 270/140mmHg

The patient is to be managed with the following;

1. IV Hydralazine 5mg stat.
2. Tablet Nifedipine 30mg daily×30 days
3. Tablet Lisinopril 10mg 30 daily×30 days
4. Tablet Paracetamolm1 gram tds ×3 days

The following diagnostic tests were requested for patient:

1. Blood for full blood count
2. Blood sample for malaria parasites estimation
3. Fasting blood sugar level (FBS)

An intravenous line was secured to administer hydralazine 5mg stat. other due medications were served. Orientation to the ward and it annex was done for patient and her daughter including other ward routines and visiting time. The patient was then assisted to change her clothing and wear light clothing. Patient's belongings were then inspected and packed into the locker by the bedside. The patient's health insurance card was inspected and his particular were entered in the admission and discharge book. As well as daily ward state. Documentation of patient's particulars, vital signs checked as well as laboratory ordered were also documented in the nurse's note. Based on the patient's complains, a care plan was formulate to help manage the patient. Permission was sought from the ward in charge to use the patient for care study.

Self-introduction was done to patient and her daughter as being a third-year student of Holy Family Nursing and Midwifery Training College, Berekum. It was explained to patient that it is a requirement by the nursing and Midwifery Council to take a patient /family and render individualized nursing care to them from admission until discharge and visit their home before and visit after discharged until she recovers fully. The desire to use her condition for the care study and consent were sought from patient and her daughter. Assurance was given to Madam A.R that all information gathered from her will be confidentially safe. It was explained to them that their cooperation will be needed in providing all the necessary information to complete the care being rendered to them. They were reluctant at first but due to rapport established earlier,

they agreed. This condition was chosen because it is a disease of public health concern, so having patient with this condition will create the opportunity to enrich the knowledge base concerning the cause of the disease, its signs and symptoms and treatment. Patient was chosen for the study because she was ready to cooperate.

1.10 Patient's concept of her illness

During interaction with the patient, she said she does not know the exact cause of the illness but believes it is not spiritual and that disease can affect any person at any time. She also said that, she was not afraid but believes that with the hard-working medical team and the best care that will be rendered throughout her hospitalization she will be restored to good health. She also believes that as far as medical interventions have begun, she would regain her normal health by the end of hospitalization.

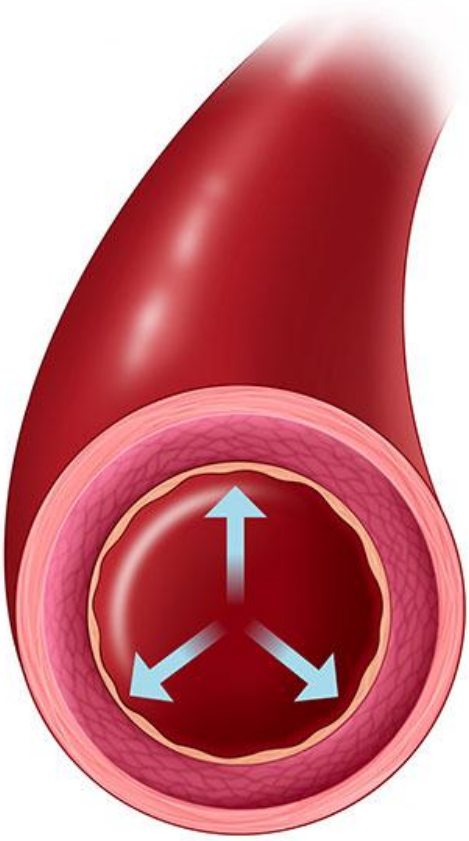
1.11 LITERATURE REVIEW ON THE DISEASE

Definition of hypertension

According to WHO (2021), they defined hypertension as an elevated loop pressure, is a serious medical condition that significantly increases the risks of heart, brain, kidney and other diseases. Blood pressure is the force exerted by circulating blood against the walls of the body's arteries, the major blood vessels in the body. Hypertension is when blood pressure is too high. Blood pressure is written as two numbers. The first (systolic) number represents the pressure in the blood vessels when the heart contracts or beats. The second (diastolic) number represents the pressure in the vessels when the heart rests between beats.

High Blood Pressure

Hypertension

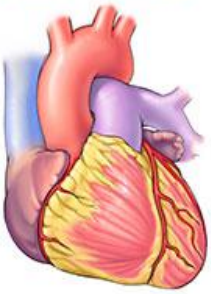


≥130

Systolic number is when the heart contracts

≥80

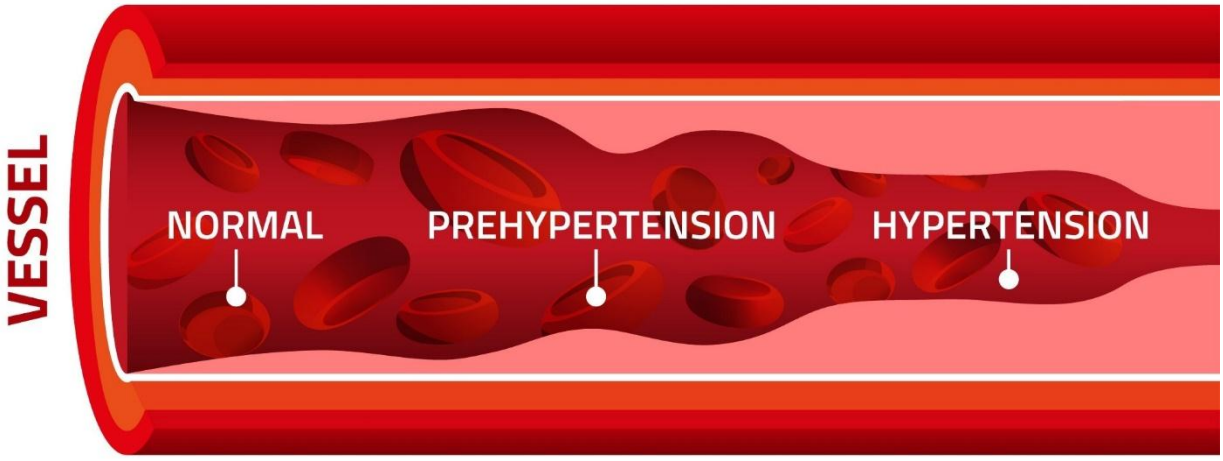
Diastolic number is when the heart rests



Force of blood on artery wall

Cleveland Clinic ©2023

SYSTOLIC PRESSURE → Is measured between when the heart contracts



DIASTOLIC PRESSURE → Is measured between beats when the heart relaxes

Incidence of hypertension

According to WHO international (2021), an estimated 1.28 billion adults aged 30-79 years worldwide have hypertension, most (two-third) living in low-and middle –income countries. An estimated 46% of adults with hypertension are unaware that they have the condition. Less than half of adults 42% with hypertension are diagnosed and treated. Approximately 1 in 5 adults 21% with hypertension have it under control. Hypertension is a major cause of premature death worldwide. One of the global targets for non-communicable diseases is to reduce the prevalence of hypertension by 33% between 2010 and 2030.

Etiology of hypertension

According to Tackling and Borhade (2021); Alexander (2019) and American Cardiology Association (2017), several factors must come into play before hypertension can ensued and these includes;

Non-modifiable risk factors of hypertension

1. A family history of hypertension.

2. Age over 65 years

3. Family History: Patients with hypertensive parents are more likely to acquire hypertension at an earlier age.

4. Race: It is more common in blacks than whites, which is likely due to inherited factors, increased salt intake, and increased environmental stress.

Modifiable risk factors of hypertension

1. Unhealthy diets (excessive salt consumption).

2. A diet high in saturated fat and trans fats,
3. Low intake of fruits and vegetables**.**
4. Physical inactivity/ secondary lifestyle.
5. Consumption of tobacco and alcohol and
6. Being overweight or obese
7. Anxiety
8. Emotional stress

Types of hypertension

According to Alexander (2019) hypertension can be classified into two main types, one being idiopathic with an unidentifiable cause and secondary which is due to an underline condition.

Primary/ essential hypertension

This type of hypertension may develop as a result of environmental or genetic uses and it accounts for 90% -95% of all adult cases.

1 Obesity.
2 Increased sodium intake.
3 Hereditary or genetic predisposition.
4 Stress.
5 Excessive intake of alcohol.
6 Excessive cigarette smoking.
7 Lack of exercise.
8 Over-stimulation with coffee.
9 Diabetes mellitus.

Essential hypertension may be classified according to the severity of the disease as follows:

1. Mild Hypertension: A diastolic pressure of 90-104mmHg is considered mild hypertension. If the diastolic pressure is between 90 and 94, the patient is normally asymptomatic and may not require medicine, but he must reduce risk factors such as excessive sodium intake, excessive alcohol use, obesity, and smoking.

2. **Moderate Hypertension**: This is defined as a diastolic pressure that is consistently between 105 and 114 mmHg. This level of hypertension will cause organ damage if it is not treated. Moderate hypertension can induce headaches, dizziness, and epistaxis, among other minor symptoms.

3. Severe Hypertension: This refers to a diastolic pressure of 115 or more. The patient may experience damage to the heart, kidneys and other organs as well as the retina.

4. Malignant hypertension is a sudden, fulminating increase in blood pressure with a diastolic reading more than 140mmHg and no history of high blood pressure. Retinal hemorrhage and exudates with papilledema, abrupt renal failure, and fast vascular deterioration are all symptoms.

Malignant hypertension strikes people between the ages of 40 and 50. Its prevalence in patients younger than 30 years old or older than 60 years old should raise suspicion of a secondary hypertension etiology.

5. Benign Hypertension: Benign hypertension is a term used to describe uncomplicated hypertension, usually of long duration and mild to moderate severity. It may be primary or secondary.

6. Systolic Hypertension: Systolic hypertension is a systolic pressure greater than 140mmHg. Patients over 65 years of age frequently have pressure over 90mmHg. For such patients, hypertension is defined as systolic pressure over 160mmHg and or diastolic pressure over 95mmHg.

7. Diastolic Hypertension: This is defined as a diastolic pressure above 90mmHg. Normally, when the systolic pressure rises, the diastolic pressure falls. When both the systolic and diastolic pressure rise, a much more serious disease is present. A very high blood pressure appears to affect the kidneys.

8. **Borderline Hypertension**: Borderline or labile hypertension is defined as intermittent elevation of blood pressure interspersed with normal readings. Patients with borderline hypertension still carry an increased risk of developing cardiovascular disease.

9. **White Coat Hypertension**: White coat hypertension is defined as hypertension in a population of patients who have normal blood pressure except when blood pressure measurements are taken by a health care professional especially a physician. The cause of this response is thought to be anxiety.

10. Refractory Hypertension: This refers to hypertension that does not respond to the pharmacologic effects of medication. It is evidence of the failure of drugs to regulate the patient's blood pressure.

Secondary hypertension

High blood pressure related to identified causes. These causes include narrowing of the renal arteries, renal parenchymal disease, hyperaldosteronism (mineralocorticoid hypertension), certain medications, pregnancy and coarctation of the aorta.

Pathophysiology of hypertension

According to Hinkle, Cheever & Overbaugh (2022), arterial hypertension is the condition of persistence elevation of systemic blood pressure (BP). BP is the product of cardiac output and total peripheral vascular resistance. Hypertension can result from an increase in cardiac output, an increase in peripheral resistance (constriction of the blood vessels), or both. Although no precise cause can be identified for most cases of hypertension, it is understood that hypertension is a multifactorial condition. Because hypertension is a sign, it is most likely to have many causes, just as fever has many causes. According to Hinkle, Cheever & Overbaugh (2022) Arteriosclerosis, hardening of the arteries and predisposes to atherosclerosis in large arteries.

Arteriosclerosis, through smooth muscle hypertrophy and intimal thickening reduces luminal diameter in smaller arteries and so increases peripheral vascular resistance and exacerbates hypertension. This happens when there is decreased vasodilation of the arterioles which may be related to dysfunction of the vascular endothelium which will lead to decrease tissue perfusion as result the kidney will increased renal absorption of sodium, chloride and water related to a genetic variation in the pathways by which the kidneys handle sodium, increase activity of the renni-angeotensin-aldosteron system and the demands of the heart will also be high due to systemic tissue hypoxia and there would be increase in the pumping action of the heart, resulting in expansion of the extracellular fluid volume be increased systemic vascular resistance as compensatory mechanism thereby resulting in increase in cardiac output and since there would also be a constrictive effect of the vessels due to the releases of aldosterone a potent vasoconstrictor from the adrenal cortex accompanied by increase in the sympathetic nervous system stimulation by catecholamine's release from the adrenal medulla which also intended

increases peripheral vascular resistance. According to Hinkle, Cheever & Overbaugh (2022), all this mechanism come into play thereby leading to hypertension of the individual. Aside sympathetic nervous system and renni-angiotensin-aldosterone system, other factors that play an important rol6e in the pathogenesis of hypertension include genetics, activation of neurohormonal systems such as the obesity and increased dietary salt intake.

Clinical manifestations of hypertension

According to Hinkle, Cheever & Overbaugh (2022), physical examination may reveal no abnormalities other than elevated blood pressure. People with hypertension may be asymptomatic and remain so for many years. However, there may be clinical manifestations and these are;

1. Headache (particularly at the back of the head and in the morning) due to decreased cerebral tissue perfusion.
2. Dizziness occur due to lack of oxygen supply to the brain.
3. Easy fatigability due to decrease tissue perfusion and hypoxia
4. Palpitations due to increase in the pumping action of the heart a compensatory mechanism sometimes causing chest pain.
5. Vertigo due to arteriolar narrowing.
6. Peripheral oedema due to increased blood pressure in the veins, fluid seeps out into the surrounding tissues.
7. Tinnitus (buzzing or hissing in the ears) due to arteriolar narrowing.

Diagnostic investigations of hypertension

According to Hinkle, Cheever & Overbaugh (2022), for one to be diagnosed of hypertension the following interventions and measures either two or more must come into play before the diagnosis can be confirmed;

1. Patient's history, physical assessment, blood pressure measurement of at least two or more readings while patient is lying, sitting and standing.
2. Chest x-ray and ECG to detect cardiac changes.
3. Complete blood count.
4. Fasting blood sugar to detect diabetes mellitus (which increases peripheral resistance)
5. Blood urea nitrogen (BUN), serum creatinine, specific gravity.
6. Serum potassium
7. Plasma renin-angiotensin and aldosterone.
8. Renal function test-Intravenous pyelogram, renal angiography, computed tomography scan.
9. Peripheral oedema and distended neck vein may indicate heart failure

Medical management of hypertension

According to Alexander (2019), the main objective treatment program selected for individuals is to keep blood pressure within normal range. With the essential hypertension, there is no specific care rendered but drug therapy, lifestyle modifications and dietary restrictions as treatment choice. Treatment of secondary hypertension is directed towards correcting primary conditions and curbing hypertension effects.

Pharmacological treatment

According to Nazario (2021), various types of anti-hypertensive drugs used to manage hypertension. The general goal of pharmacology of hypertension is to reduce and maintain diastolic blood pressure less than 90mmHg and to keep uncomfortable or disabling side effects of medication to a minimum.

Currently, the available treatment has two main actions;

1. Reduction of systemic vascular resistance
2. Decrease volume of circulating blood

They include;

1. Diuretics
2. Adrenergic Inhibiting Agents
3. Vasodilators
4. Angiotensin converting enzyme inhibitors
5. Calcium channel blockers
6. Analgesics
7. Haematinics

Nursing management of hypertension

According to Hinkle, Cheever & Overbaugh (2022), the nursing management of hypertension can be grouped into the following:

Psychological factor

1. Reassure patient that she is in the hands of competent health staff and measures are being put in place to relieve her from her present condition in the shortest possible time.

2. Diversional therapy such as watching of television and engaging patient is a conversation.

3. Explain all procedure to patient.

4. Allow patient to express fear and anxiety.

5. Allow patient to ask questions about her condition.

Observation and monitoring

1. Monitor patient's vital signs such as temperature, pulse, respiration and blood pressure regularly. Patient's blood pressure is checked regularly as ordered by the physician to know the progress of treatment given to patient.

2. Patients mental status is assessed to know whether the patient is oriented to time, place and person.

3. Intravenous fluids are also monitored to ensure that they are following at the prescribe rate.

4. The nurse observes patient for effects and side effects of drugs administered and any abnormalities detected are reported.

Diet management

1. Discuss with the patient and family the importance of achieving and maintaining a healthy body weight, as this may aid in blood pressure reduction.
2. Recommend to the patient a low-salt or no-added-salt diet. The severity of the condition determines how much sodium is restricted.
3. Encourage the patient to eat less fat.
4. Encourage the patient to cut back on alcohol consumption if he or she consumes any.

Exercise

1. Discuss with patient a plan of regular exercise to be undertaken once the patient is under control.
2. Regular physical activity is a beneficial strategy to achieve and maintain the condition.

Stress management

1. Encourage the person to articulate their stress and identify both avoidable and unavoidable stresses in their environment.

2. Teach the patient relaxation techniques that can be utilized in a variety of situations to alleviate stress.

3. At each follow-up appointment, assess the patient for consequences from uncontrolled hypertension.

4. Monitor vital indicators, especially blood pressure, on a frequent basis.

Medication

1. Inform the patient about the need of taking the medications given to control hypertension on a regular basis for the prescribed period of time.

2. Inform the patient about the medications' side effects so that he or she is prepared to deal with them if and when they occur.

3. Educate the patient not to share medications with others.

4. Educate patient to also avoid over the counter drugs.

5. Educate patient not to run out of drugs.

Smoking cessation

1.Assist the patient in comprehending the link between smoking and hypertension.

2.Then, encourage the patient to quit smoking.

Prevention of hypertension

Primary hypertension

According to Smeltzer and Bare (2018), the actual cause of primary hypertension is unknown, making it difficult for public health organizations to establish comprehensive primary prevention programs.

However, there are a number of risk factors linked to the development. Once high-risk patients have been identified, they must be educated how to change risk factors like fat intake, lack of exercise, and alcohol consumption, among others.

Businesses and industries, labor organizations, health care institutions, and local communities should all be involved in the educational campaign for it to be successful. Also, incidental screening in health care facilities or organized community screening in public settings like schools, workplaces can also help in the early detection and treatment of found individuals. Hypertensive patients must therefore be properly educated so that they can appreciate the need for compliance to treatment regimen so as to prevent or avoid the many unbearable complications.

Complications of hypertension

According to Hinkle, Cheever & Overbaugh (2022), if hypertension is not identified early for prompt and effective treatment, it results in complication such as;

1 Heart failure
2 Congestive heart failure
3 Angina pectoris
4 Renal failure (Chronic)
5 Hypertensive encephalopathy

6 Papilledema

7 Myocardial infarction

1.12 Validation of data

Validation of data actually deals with confirmation of data or information obtained as accurate, free from errors as well as misinterpretations (Hinkle, Cheever & Overbaugh 2022). Data gathered (signs and symptoms) from patient were similar to those in the literature review. Diagnostic investigations carried out on the patient were also similar to information from books and standards of measurement. Data retrieved on the patient were well cross checked with her and family to ensure that no/minimal errors. Also, during the home visit most of the information given to me by Madam A. R. and her family at the hospital were confirmed by other relatives in the house. This shows the information was valid and reliable hence suitable for this study.

CHAPTER TWO

ANALYSIS OF DATA

1.0 Introduction

According to Zhu & Duan (2019), this is the second phase of the nursing process and it involves the analysis and examination of importance pieces of information gathered from the patient, family and significant others. Analysis of data is done in the second step of the nursing process. It involves sorting out information gathered on the patient in order to draw conclusion and bring out the exact problem so as to formulate the appropriate intervention. It also entails laboratory investigations and their interpretations as compared to the normal values, causes of the disease and its clinical manifestations, health problems and nursing diagnoses. This chapter contains the following;

2.1 Comparison of data with Standard

A. Diagnostic Investigation Test

The following diagnostic test were carried out

1. Blood for Full blood count (FBC)
2. Blood sample for malaria parasite estimation
3. Fasting blood sugar

Table 1: Diagnostic test in literature review compared with those carried out on patient

Diagnostic test outlined the literature review	Diagnostic test carried out on Patient
1. Full blood count	1. Full blood count was ordered for patient
2.Fasting blood sugar to detect diabetes mellitus	2.Fasting blood sugar to detect diabetes mellitus was ordered for patient
3. Lipid profile	3. Lipid profile was not done
4. History and physical examination	4. History given by patient helped to confirm the diagnosis.
5. Chest x-ray	5. Chest x-ray was not done
6. Urinalysis	6. Urinalysis was not done
7.Blood Urea Nitrogen (BUN)	7. Blood urea nitrogen was not done

Most of the investigations mentioned in the literature review were carried out on Madam A. R. such as Full Blood Count (FBC), Fasting blood sugar and History and physical examination. Also, blood for malaria parasite estimation was done to rule out malaria infection even though it was not indicated in literature.

Table 2: Diagnostic Investigations carried out on Patient

Date	Specimen	Investigation	Results	Normal Value	Interpretation	Remarks
23/08/2023	Blood	Malaria Parasite Estimation	Negative	Malaria parasites Should not be Seen(negative)	Malaria parasites were not seen. Patient was not suffering from Malaria	Treatment was not given
23/08/2023	Blood	White blood Cell count Neutrophil	6.9×10^9/L	4.0-10× 10^9/L	Result was within the normal range	No treatment was given
23/08/2023	Blood	Red blood Count	4.77× 10^{12}/L	4.5-5× 10^{12}/L	The result was within the normal range	No treatment was given
23/08/2023	Blood	Hematocrit	39.8%	33.3-56.1%	The result was within the normal range	No treatment was given
23/08/2023	Blood	Fasting blood sugar	5.0mmol/dI	3.89-6.66mmol/l	Patient blood sugar level was within normal range indicating that she in not diabetic.	No treatment was given

B. Causes of patient condition

Considering the factors that cause hypertension as indicated in the literature review of the condition, stress may be the contributive factor due to the nature of her work, since it triggers the sympathetic nervous system to activate vascular responds which is typically associated with cardiac output and causes an elevation in blood pressure.

Table 3: clinical features exhibit by patient compared with those in literature review

Clinical features outlined in the literature review	**Clinical features exhibited by the patient**
1.Headache	1.Patient complained of headache
2.Dizziness	2.Patient did not experience dizziness
3.Increased blood pressure	3.Patient had increased blood pressure of 200/120mmHg
4.General body weakness	4.Patient was feeling weak
5.Shortness of breath	5.Patient did not have shortness of breath
6.Confusion	6.Patient did not experience confusion
7.Vertigo	7.Patient did not experience Vertigo
8.Tinnitus	8.Patient did not experience tinnitus
9.Epistaxis	9.Patient did not experience epistaxis.
10.Weak peripheral pulse	10.Patient had no weak peripheral pulse
11. Palpitation	11.Patient had palpitation
12. Nausea, vomiting and loss of appetite	12.Patient experience loss of appetite

From the comparison in table 3 shows that, Madam A. R. did not exhibit restlessness, mental confusion, numbness and blurred vision, shortness of breath and chest pain as stated in the literature review, because she was given the right medical management.

D. Medical treatment given to patient

The following were the treatment that was given to the patient.

1. IV Hydralazine 5mg stat.
2. Tablet Nifedipine 30mg daily×30 days
3. Tablet Lisinopril 10mg 30 daily×30days
4. Tablet Paracetamolm1 gram tds ×3 days

Table 4: Comparison of treatment outlined in the literature review compared with those given to Madam A. R.

Treatment outlined in the literature review	**Treatment given to my patient**
1. Antibiotics (penicillin)	1. Patient was not put on any antibiotics
2. Haematinics	2. Patient did not receive any haematinics
3. Anti-hypertensive (vasodilators, calcium channel blockers and others)	3. Patient was given Nifedipine and hydralazine
4. Management of convulsion	4. Patient was not managed for convulsion
5. Analgesics (NSAIDs)	5. The patient was given Paracetamol
6. Parental nutrition (intravenous fluids like dextrose)	6. Patient was not put on dextrose 5% in sodium chloride.

Comparing the treatment given to Madam A. R. and that of the literature review, it could be seen that the treatment given to Madam A. R. was in line with that of the treatment in the literature review and this contributed greatly to the recovery of Madam A. R.

Table 5: Pharmacology of Drugs Given to Patient

Date	Drug	Dosage/ Route as in literature Review	Dosage and route of administration to patient	Classification	Desired Effect	Actual actions observed	Side Effect
23/08/2023	IV Hydralazine	**Dosage:** 5mg-10mg daily **Route:** Per oral and IV	5mg stat intravenously	Vasodilator	Dilate peripheral blood vessels by directly relaxing vascular smooth muscles.	Blood pressure reduced from 200/120mmHg to 130/80mmHg at the time of discharge	Flushing, headache, upset stomach, loss of appetite, constipation, diarrhoea and ear tearing. Patient experienced loss of appetite.
28/08/2023	Paracetamol	**Adult dose:**500-1gram **Child dose:** 10-15mg/kg/dose-6hourly **Route:** Per oral, intravenous and rectal	**Dosage :**1g tid × 3 days **Route:** orally	Antipyretic non-steroidal anti-inflammatory analgesic	To reduce the pain by suppressing prostaglandin production	Patient was relieved of headache	Drowsiness, nausea, peptic ulcer. None was observed on the patient.

23/08/2023	Tablet Lisinopril	**Dosage:** Adult; 10mg -30mg daily **Route:** Oral	**Dosage:** Adult; 10mg × 30 days **Route:** Oral	Angiotensin converting Enzyme inhibitor. receptor antagonist	Inhibit conversion of Angiotensin I to Angiotensin II thereby preventing elevation of blood pressure.	Patient high blood pressure was controlled	Myocardial infarction, tachycardia, dry mouth, and confusion. Patient did not experience any of them.
28/08/2023	Nifedipine	**Dosage:** 10mg× 20-30 days Child dose: Not recommended **Route:** Per oral and IV	30mg daily ×30 days orally	Calcium channel blockers	Help lower blood pressure by relaxing the muscles of the heart and blood vessels throughout your body.	Patient high blood pressure was controlled	Dizziness, nausea, diarrhea, heart burn and headache. Patient experienced headache.

E. Complications

As specified by Weller (2019), Complication refers to an unfavorable health result of a disease condition. With reference to the complications indicated in the literature review such as myocardial infarction, malaria, anemia, renal failure. Madam A. R. did not experience any complication due to effective medical and nursing care rendered during hospitalization.

2.2 Patient and Family Health Problem

Patient and family difficulties, according to Mish (2016), are tough to cope with and require care. Health problems must be discovered through observation and interactions in order to provide appropriate nursing care.

These under listed health problems were identified in my patient and family;

1. Patient had high blood pressure reading (200/120mmHg) (23/08/23)
2. Patient complained of headache (23/08/23)
3. Patient complained of general body weakness (23 /08/23)
4. Patient was observed to be anxious about unknown outcome of condition (23/08/23)
5. Patient was observed to be reluctant to eat (24/08/23)
6. Patient/family were observed to have misinformation about the cause, signs and symptoms, management and complications of hypertension (25/08/23)

2.3 Patient and family strengths

Strength according to Merriam-Wester (2020), is the quality that allow someone to deal with problems in a determined and effective way. So, patient/family strength involves the activities

the patient can perform and those the patient's family can also do in helping the patient to recover without any complications. On admission, patient and family had the following strength.

1. Patient's blood pressure reduces when she takes prescribed antihypertensive. (23/08/23)
2. Patient could describe the intensity of the headache. (23/08/23)
3. Patient was able to perform daily living activities when assisted (23/08/23).
4. Patient was able to relax when she listens to music. (23/08/23).
5. Patient was able to eat about two-third of meal served in bits. (24/08/23).
6. Patient was willing to learn about her condition. (25/08/23).

2.4 Nursing diagnoses

A nursing diagnosis according to NANDA International (2016), is a clinical judgment concerning a human responds to health conditions or life processes for that responds, by an individual, family, group or community. It is clear and definite statement of the patient health status can be influence by nursing interventions. It is derived from a validated, critically analyzed and interpreted data collected during assessment. Conclusions are drawn regarding the patient's needs, problems, concerns or human responses. The nursing diagnosis, once identified provides a central focus as a reminder of the stages that is based on the nursing procedure. The plan of care is designed, implemented and evaluated, hence making it possible to give comprehensive health care to the problems. This is done by identifying, validating and responding to specific health problems. The nursing diagnosis also provides an efficient method of communicating the patients' health problems.

Nursing diagnose for Madam A. R. is as follows;

1. Risk for decreased cardiac output as evidence by increased vascular resistance.

2. Acute pain (Headache) related to decreased cerebral tissue perfusion as evidence by patient rating pain as 6 on the numerical rating scale.

3. Self-care deficit related to decreased muscle strength and endurance as evidence by lost of interest in bathing.

4. Anxiety related to unknown outcome of the condition as evidence by patient having facial flushing.

5. Imbalanced nutrition related to inadequate dietary intake as evidence by lack of interest in food.

6. Deficient knowledge related to prognosis and home care management as evidence by patient giving inaccurate response to questions asked.

CHAPTER THREE

PLANNING PATIENT AND FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patients 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 patient or family identified during the analysis phase. The objectives are set and the necessary interventions made to solve patient's health problems.

3.1 Objectives for Patient and Family

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 blood pressure will be restored to normal; systolic (100-130) mmHg and diastolic (60-89) mmHg within 48 hours as evidenced by;

a) Patient verbalizing absence of palpitation.
b) Nurse recording blood pressure within normal range (130-90).

2. Patient will be relieved of headache within 24 hours as evidenced by;

a) Patient verbalizing that she is relieved of headache.
b) Nurse observing patient having relaxed facial expression.

3. Patient will be able to perform her daily activities without support within 48 hours as evidenced by;

a) Patient verbalizing that she no longer has body weakness.
b) Nurse observing that patient participate in self-care activities.

4. Patient will be relieved of anxiety within 24 hours as evidenced by;

a) Patient verbalizing that she is no more anxious.
b) Nurses observing that patient has cheerful facial expression.

5. Patient will regain and maintain her normal appetite within 48 hours as evidenced by;

a) Patient consuming 2/3 of meal served.
b) Nurse observing patient that can eats two third of meal served.

6. Patient and family will gain adequate knowledge on hypertension throughout the period of hospitalization as evidenced by;

a) Patient verbalizing the importance of frequent blood pressure monitoring.

b) Nurse observing patient adhere to antihypertensive therapy and lifestyle changes.

Table 6a: Nursing care plan for patient /family cont'd

Date & Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date & Time	Evaluation	Sign
23/08/23 at 3:05pm	Risk for decreased cardiac output as evidence by increased vascular resistance.	Patient's high blood pressure will be restored to normal; systolic (100-130) mmHg and diastolic (60-89) mmHg within 72 hours as evidenced by; a) Patient verbalizing absence palpitation.	1. Reassure patient of competent nursing care. 2.Monitor patient's vital signs 4 hourly. 3.Ensure adequate bed rest. 4.Engage patient in diversional therapy to manage stress. 5.Educate patient on diet. 6.Administer prescribed	1. Patient was reassured that measures (administration of antihypertensive drugs) will be given to reduce her blood pressure. 2. Patient's vital signs was checked and recorded every 4hours paying particular attention to blood pressure. 3. Bed rest was ensured by explaining to the patient that, rest helps to reduce stress by provide a calm environment. 4.Patient was engaged to watch television which help to manage stress. 5.Patient was educated on the reduction of high salt intake and avoidance of caffeinated	26/08/2023 at 3:05pm	Goal fully met as patient verbalized the absence of, palpitations Nurse recording a blood pressure of136/88mm Hg.	D.O

		b) Nurse checking and recording BP to be in normal range.	antihypertensive drugs.	beverages and others. 6.Prescribed oral nifedipine 30mg bd x 30 days was served.			

Table 6b: Nursing care plan for my patient and family

Date& Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date & Time`	Evaluation	Sign
23/08/23 At 3:10pm	Acute pain (Headache) related to decreased cerebral tissue perfusion as evidence by patient rating pain as 6 on the numerical rating scale.	Patient will be relieved of headache within 24 hours as evidenced by; a.Patient verbalizing that she is relieved of headache. b.Nurse observing patient having relaxed facial expression.	1. Reassured patient of competent nursing care. 2. Assess patient's level of pain using numerical pain rating scale. 3.Check and monitor vital signs 4. Ensure enough bed rest for patient. 5. Ensure diversional therapy. 6. Administer prescribed medication.	1. Patient was reassured of measures (such as giving pain medication) to help her control pain. 2. Patient's level of pain was assessed using the numerical pain rating scale and she pointed out 6 to note her pain intensity. 3. Patient's vital signs were monitored to indicate any deviation of body physiological parameters from normal. 4. Patient position was changed every 4 hours to ensure comfort in bed. 5. Patient was engaged in watching television as a diversional therapy. 6. Prescribed paracetamol 1g tds, Nifedipine 30g daily and hydralazine 5mg were administered.	24/08/2023 At 3:10pm	Goal was fully met as patient verbalized, she is relieved of headache and nurse observed patient having relaxed facial expression.	D.O

Table 6c: Nursing care plan for patient/family cont'd

Date & Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date & Time	Evaluation	Sign
23/08/23 At 3:15pm	self-care deficit (bathing)related to decreased muscle strength and endurance as evidence by lost of interest in bathing. .	Patient will be able to perform her daily activities without support within 48 hours as evidenced by; a. Patient verbalizing that she no longer has feeling of body weakness. b.Nurse observing that patient participate in activities she can tolerate.	1. Reassure patient. 2. Encourage patient and assist on passive exercise. 3. Assist patient with the performance of self-care. 4. Encourage rest periods between activities. . 5. Place items of daily use close to patient.	1. Patient was reassured that after competence nursing she will be able to perform her daily activity. 2. Patient was encouraged to engage in passive exercises (such as flexion and extension of the hands and legs). 3. Patient was assisted to bath and brush her teeth when needed. 4. At least 90mins between activities for undisturbed rest was allowed to enable physiologic recovery. 5. Items of daily use such as drinking cup, comb and face towel were kept closed to patient for easy access to promote patient independence.	25/08/23 At 3:15pm	Goal was fully met as patient verbalized that she no longer has feelings of body weakness and nurse observed patient participating in activities that she could tolerate.	D.O

Table 6d: Nursing care plan for patient/ family cont'd

Date & Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date & Time	Evaluation	Sign
23/08/23 At 3:16pm	Anxiety related to unknown outcome of the condition as evidence by patient having facial flushing. .	Patient will be relieved of anxiety within 24 hours as evidenced by; a) Patient verbalizing that she is no more anxious. b) Nurses observing that patient has cheerful facial expression.	1. Reassure patient. 2. Establish good nurse-patient relationship. 3. Explain procedure to patient. 4. Introduce patient and family to patients recovering from the same condition. 5. Encourage patient to ask questions. 6. Answer all questions tactfully and honestly.	1. Patient was continuously reassured of speedy recovery. 2. Introduction of self and other staffs present was made to patient and her relatives. 3. Every procedure to be performed was explained to patient. 4. Patient and her family were introduced to other patients who were recovering from Cerebrovascular accident to give hope of patient's recovery. 5. Patient was encouraged to ask questions on the condition and things she does not understand. 6. All questions were answered tactfully and honestly to clear all doubts and misconceptions.	24/08/23 At 3:16pm	Goal was fully met as patient verbalized that she is no more anxious and nurses observed patient having relaxed facial expression.	D.O

Table 6e: Nursing Care plan for Patient/family

Date & Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date& Time	Evaluation	Sign
24/08/23 At 9:40am	Imbalanced nutrition (less than body requiremen t) related to inadequate dietary intake as evidence by lack of interest in food. .	Patient will regain and maintained her normal appetite within 24 hours as evidenced by; a) Patient consuming 2/3 of meal served. b) Nurse observing patient eating two third of meal served.	1. Reassure patient of good nursing care. 2. Ensure oral hygiene twice daily to stimulate appetite. 3. Involve patient in planning her meal. 4. Serve food in small quantities and attractively. 5. Serve easily digestible soft and fluid diet patient can accept. 6. Remove nauseating items away from patient.	1. Patient was reassured of good nursing care that she will regain normal eating pattern. 2. Oral hygiene was ensured as patient brushed her teeth twice daily which stimulated her appetite. 3. Patient and family were involved in planning her meal. 4. Food was always attractively served in small quantities. 5. Patient was served with fruit juice before taking her meal to increase her appetite. 6. All nauseating items such as bed pan were removed from patient.	25/08/23 At 9:40am	Goal fully met as patient consumed all her food served and nurse observed that patient ate all of her food served.	D.O

Table 6f: Nursing Care plan for Patient/family

Date & Time	Nursing diagnosis	Objective/ Outcome criteria	Nursing orders	Nursing intervention	Date& Time	Evaluation	Sign
25/08/23 At 9:05am	Deficient knowledge related to the disease condition its prognosis and home care management as evidence by patient giving inaccurate response to	Patient and family will gain adequate knowledge on hypertension throughout the period of hospitalization as evidenced by; a) Patient verbalizing the importance of frequent BP checks b) Nurse observing that patient adhering to antihyperte	1. Reassure patient and her family. 2. Assess their previous knowledge on disease condition. 3. Establish a therapeutic environment. 4. Educate patient and her family on causes of the condition. 5.Encourage patient and family to ask questions and provide answers in a simple language. 6.Educate patient on the importance of adhering to treatment regimen.	1. Patient and family were reassured that they will get to know more about condition after the conversation. 2. Patient and her family knowledge were assessed on the causes and prevention of the condition. 3. Environment of mutual trust, non-judgmental and respect was established to enhance learning. 4. Patient and her family were educated on the causes of the condition. 5. Patient and her family were encouraged to ask any question and misconceptions surrounding hypertension. 6. Positive outcomes on adhering to treatment regimen were explained to patient as well as the negative when patient defaults.	27/08/23 At 9:05am	Goal fully met as patient verbalized that frequent BP check helps her to know her health status and nurse observed patient taking her medications regularly and eating food low in salt and fat.	D.O

	questions asked. .	nsive therapy and lifestyle changes					

CHAPTER FOUR

IMPLEMENTATION OF PATIENT AND FAMILY CARE PLAN

4.0 Introduction

This chapter from the fourth part of the patient and family care study. Implementation is the actualization of the nursing care plan through nursing intervention (Hinkle, Cheever, & Overbaugh, 2022). This chapter presents the actual nursing care rendered to the patient and family throughout the hospitalization period.

4.1 Summary of Actual Nursing Care Rendered to Madam A. R. / Family

The nursing care rendered to Madam A. R. and her family commenced on the day of admission which was on 23rd August, 2023 and continued till termination of care. The management aimed at making patient comfortable, promoting her early recovery and prevention of complains. During the period of admission, routine care such as bed making, feeding of patient, administration of medications and observations were rendered to Madam A. R. Daily nursing care were also given according to patient's need. For the purpose of organization, the summary of actual using care is presented on daily basis as follow;

4.1.1 Day of Admission (23rd August, 2023)

Patient was brought to Female's ward through the Out Patient Department in a wheel chair by an accompanied nurse and the patient's daughter at 3:00pm on 23 August, 2023. On account of hypertension urgency with the complaints of headache, feeling of anxiety, general body pains and loss of appetite. This admission was unplanned admission. The patient's daughter and the accompanied nurse were sent to the nurse's station and warmly welcomed. A seat was offered to make them comfortable. The patient's card with the folder number was collected from the nurse and the patients name was mentioned to confirm the right patient and she responded.

Introduction of Staff on duty was introduced to the patient and her daughter. The patient was then admitted into a well-prepared simple bed free from cramps and creases. They reassured of competent care to help her recover quickly. Patient and her daughter were introduced to nearby patients and made comfortable in bed F-2. Her vital signs were checked and recorded as

Temperature: 36·3°C

Pulse: 99bpm

Respiration: 22cpm

Blood pressure: 200/120mmHg

The patient is to be managed with the following;

1. IV Hydralazine 5mg stat.
2. Tablet Nifedipine 30mg daily×30 days
3. Tablet Lisinopril 10mg 30 daily×30 days
4. Tablet Paracetamolm1 gram tds ×3 days

The following diagnostic tests were requested for patient:

1. Blood for full blood count
2. Blood sample for malaria parasites estimation
3. Fasting blood sugar level (FBS)

An intravenous line was secured to administer hydralazine 5mg stat. Other due medications were served. Orientation to the ward and it annex was done for patient and her daughter including other ward routines and visiting time. The patient was then assisted to change her clothing and wear light clothing. Patient's belongings were then inspected and packed into the locker by the bedside. The patient's health insurance card was inspected and his particular were entered in the admission and discharge book. As well as daily ward state. Documentation of patient's

particulars, vital signs checked as well as laboratory ordered were also documented in the nurse's note. Based on the patient's complains, a care plan was drawn to help manage the patient. Permission was sought from the ward in charge to use the patient for care study.

At 3:05pm, patient's had high blood pressure (200/120mmHg) when vital signs were checked during admission therefore a nursing diagnoses of risk for decreased cardiac output as evidence by increased vascular resistance was made and an objective of patient's high blood pressure will be restored to normal; systolic (100-130) mmHg and diastolic (60-89) mmHg within 72 hours was set. The following interventions were made; Patient was reassured that measures (administration of antihypertensive drugs) will be given to reduce her blood pressure, Patient's vital signs was checked and recorded every 4hours paying particular attention to blood pressure, Bed rest was ensured by explaining to the patient that, rest helps to reduce stress by provide a calm environment, Patient was engaged to watch television which help to manage stress, Patient was educated on the reduction of high salt intake and avoidance of caffeinated beverages and others and Prescribed oral nifedipine 30mg bd x 30 days and other medications were served.

At 3:10pm, as Madam A. R. complained of headache on admission, a nursing diagnosis of acute pain (Headache) related to decreased cerebral tissue perfusion as evidence by patient rating pain as 6 on the numerical rating scalewas formulated. An objective of patient will be relieved of headache within 24 hours was set. The following interventions were made; Patient was reassured of measures (such as giving pain medication) to help her control pain, Patient's level of pain was assessed using the numerical pain rating scale and she pointed out 6 to note her pain intensity, Patient's vital signs were monitored to indicate any deviation of body physiological parameters

from normal, Patient position was changed every 4 hours to ensure comfort in bed, Patient was engaged in watching television as a diversional therapy and Prescribed paracetamol 1g tds, Nifedipine 30g daily and hydralazine 5mg were administered.

At 3:15pm, because patient presented with general body weakness a nursing diagnosis of self-care deficit(bathing related to decreased muscle strength and endurance was formulated. An objective of patient will be able to perform her daily activities without support within 48 hours was set. The nursing interventions carried out were; Patient was reassured that after competence nursing she will be able to perform her daily activity, Patient was encouraged to engage in passive exercises (such as flexion and extension of the hands and legs), Patient was assisted to bath and brush his teeth when needed, At least 90mins between activities for undisturbed rest was allowed to enable physiologic recovery and Items of daily use such as drinking cup, comb and face towel were kept closed to patient for easy access to promote patient independence.

At 3:16pm during interaction with Madam A.R, she was observed to be anxious. A nursing diagnosis of anxiety related to unknown outcome of the condition as evidence by patient having facial flushing was made. An objective of patient will be relieved of anxiety within 24 hours as evidenced of was set. Therefore all the following interventions were made; Patient was continuously reassured of speedy recovery, Introduction of self and other staffs present was made to patient and her relatives, Every procedure to be performed was explained to patient, Patient and her family were introduced to other patients who were recovering from Cerebrovascular accident to give hope of patient's recovery, Patient was encouraged to ask questions on the condition and things she does not understand and All questions were answered tactfully and honestly to clear all doubts and misconceptions.

At 5:00pm, patient was served with rice and stew as her lunch but only took little. Patient was made to rest till 5:30pm. Patient ate Banku and groundnut soup as her supper which she only took the soup. At 6:00pm patient vital signs were checked and recorded as in the appendix and due medications were administered.

Patient was made to relax in bed till 7:30pm, when patient was assisted to take her bath. At 10:00pm, patient vital signs were checked and recorded as shown in the appendix and due medication was served and recorded. Patient slept at 10:30pm.

4.1.2 Second Day of Admission (24th August, 2023)

Madam A. R. woke up at 5:30am on the second day of her admission, August 24, 2023. The patient was assisted to bath and her oral hygiene was taken care of. The patient's bed was meticulously made out to ensure her comfort. Morning vital signs were checked and recorded at 6:00am as shown in the appendix. Also, all due medications were served and documented.

Patient took just a tea cup full of milo tea with two slice of bread in the morning as her breakfast at 6:30am.

At 7:30am doctor came for routine ward rounds and reviewed the patient's treatment plan and instructed that care should be continued.

At 9:40am, patient was observed to be feeling reluctant to eat. A nursing diagnosis of imbalanced nutrition (less than body requirement) related to inadequate dietary intake evidence by lack of interest in food was formulated . An objective of patient will regain and maintained her normal appetite within 24 hours was set. The following interventions were made; Patient was reassured of good nursing care that she will regain normal eating pattern, Oral hygiene was ensured as patient brushed her teeth twice daily which stimulated her appetite, Patient and family were involved in planning her meal, Food was always attractively served in small quantities,

Patient was served with fruit juice before taking her meal to increase her appetite and All nauseating items such as bed pan were removed from patient.

At 10:00am, patient vital signs were checked and recorded as shown in the appendix.

At 1:30pm, patient took Ampesi with Kontomire stew as lunch and was able to eat two-third of the meal. Afternoon vital signs were checked at 2:00pm and documented as in the appendix and due medications were severed.

At 3:10pm, the objective of patient will be relieved of headache within 24 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized, she is relieved of headache and nurse observed patient having relaxed facial expression.

At 3:16pm, the objective of patient will be relieved of anxiety within 24 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized that she is no more anxious and nurses observed patient having relaxed facial expression.

The patient was engaged in diversional therapy.

At 5:40pm, Madam A. R. took fufu with light soup and was encourage to take to drink enough fluids. At 6:00pm, evening vital signs were checked and due medications were served and recorded. Patient had her bath at 7:15pm. Bed was made free from creases and crumps. Patient was handed over to the night shift nurses to ensure continuity of care. At 10:00pm, patient vital signs were checked and recorded as shown in the appendix and due medications were served and recorded. Patient slept at 10:10pm.

4.1.3 Third Day of Aadmission (25th August, 2023)

Madam A. R. woke up at 5:30am and observed silent time. She appeared to be in better shape than she had been in the previous days. She went about her daily routine of personal hygiene, including brushing her teeth and taking a bath.

At 6:00am, her vital signs were checked and recorded as indicated in the appendix.

Her bed was neatly dressed to make her feel comfortable by the night nurses. She took tea and bread as her breakfast at 6:30am. Due medications were served and recorded.

At 8:00am, the doctor came around for routine ward rounds and reviewed the patient. Patient said she had no complains so the doctor ordered that we should continue treatment.

At 9:00am, patient and family were observed to have misinformation about the causes, signs and symptoms, management and complication of hypertension. A nursing diagnosis of deficient knowledge related to the prognosis and home care management as evidence by patient giving inaccurate response to questions asked was formulated for the patient. An objective of patient and family will gain adequate knowledge on hypertension throughout the period of hospitalization was set. The following interventions were done; Patient and family were reassured that they will get to know more about condition after the conversation, Patient and her family knowledge were assessed on the causes and prevention of the condition, Environment of mutual trust, non-judgmental and respect was established to enhance learning, Patient and her family were educated on the causes of the condition, Patient and her family were encouraged to ask any question and misconceptions surrounding hypertension and Positive outcomes on adhering to treatment regimen were explained to patient as well as the negative when patient defaults.

At 9:40am, the objective of patient will regain and maintained her normal appetite within 24 hours that was set on 24/08/2023 was evaluated and goal was fully met as patient consumed all her food served and nurse observed that patient ate all of her food served.

At 10:00am patient's vital signs were checked and recorded. Patient was made to watch television for a while and later took Banku and Okro stew as her lunch and due medications were served and documented.

It was explained to patient and family the intension to visit their house and was given direction to the house find out the actual and potential problems that may have contributed to her illness and find ways of solving them. The return from the patient's house to the hospital was successful in a timely manner.

At 2:00pm, patient vital signs were checked and recoded and due medications were served and documented. Patient was made comfortable in bed and was handed over to the afternoon shift nurses to ensure continuity of care.

At 3:15pm, the objective of patient will be able to perform her daily activities without support within 48 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized that she no longer has feelings of body weakness and nurse observed patient participating in activities that she could tolerate.

At 5:25pm patient was served fufu and palm nut soup. At 6:00pm, patient's vital signs were also checked and recorded as indicated in the appendix and her due medications were also served and recorded. At 10:00pm, patient's vital signs were checked and recorded as indicated in the appendix and due medications were also served and recorded. Patient slept at 10:15pm.

4.1.4 Fourth day of Admission (26th August, 2023)

On the fourth day, patient woke up around 5:30am and was looking cheerful, brushed her teeth and after that moved her bowels. At 6:00am, vital signs were checked and recorded as shown in the appendix.

Madam A. R. had her bath after which she took bread and Hausa koko as her breakfast at 6:20am. At 6:30am due medications were served.

At 9:00am the doctor came for routine ward rounds and reviewed the patient. Patient said she feels well and wants to go home but the doctor said though her blood pressure is normal she should be monitored for additional day before she can discharge her and she agreed to it, so the doctor ordered that we should continue treatment.

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

Patient's vital signs checked at 2:00pm as indicated in the appendix.

At 3:05pm, I went to chart with her and gave her education on her condition again. She asked many questions and answered them to the best of my knowledge hence she was very happy about that conversation. The objective of patient's high blood pressure will be restored to normal; systolic (100-130) mmHg and diastolic (60-89) mmHg within 72 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized that, palpitations are no more and BP was checked and recorded as 136/88mmHg.

At 4:30pm she took Ampesi with kontomire stew as supper. At 6:00pm vital signs were checked and recorded. Patient had a warm bath at 6:15pm. She had a warm bath at 7:00pm. Vital signs were checked and medications were served at 10:00pm. Patient went to bed around 10:20pm.

4.1.5 Fifth day of Admission/Day of discharge (27th August, 2023)

Patient woke up at about 5:45am, brushed her teeth and after that moved her bowels. Her vital signs were checked and recorded at 6:00am as follows;

Temperature: 36·5°C

Pulse: 70bpm

Respiration: 24cpm

Blood pressure 130/80mmHg

Madam A. R. had her bath after which she took bread and Hausa porridge as her breakfast at 6:15am.

At 9:05am, the objective of patient and family will gain adequate knowledge on hypertension throughout the period of hospitalization that was set on 25/08/2023 was evaluated and goal was fully met as patient verbalized that frequent BP check helps her to know her health status and nurse observed patient taking her medications regularly and eating food low in salt and fat.

Madam A. R. was discharged during the doctor's ward rounds at 9:20am after a detailed assessment of the patient. She was informed about her discharge and was scheduled to come for review on 4th September, 2023. Her name was written in the Daily Ward state and admission and discharge book. Reminded her of the education given to her and she was able to recall many of it. Madam A. R. was advised to continue with her medications and treatment regimen as prescribed to prevent relapse of the disease. Patient and family were also educated on the dosages of the medications and its side effects. She was asked to report to the hospital when symptoms re-occur. She was discharged on the following drugs;

1. Tablet Nifedipine 30mg daily for 30 days

2. Tablet Lisinopril 10mg daily for 30 days

Helped her packed her things and she went to show her gratitude to the ward-in-charge and other nurses who were present. She settled her bills with the national health insurance card since she was a registered member of the scheme. At 10:00am patient was ready to go home so she was helped in parking her belongings and dressed up. Escorted her to the taxi rank where she got a taxi then bade her farewell. Afterwards, went back to the ward to remove the bed linens and place into a dirty linen bin at the sluice room, carbolized the bed, bedside locker and chair with an already diluted solution of 0.5 percent bleach.

4.2 Preparation of patient/family for Discharge and Rehabilitation

Preparation of Madam A. R. and her family for discharge and rehabilitation started on the day of admission until the day of discharge. The primary aim was to enable patient take active role in her care, geared her towards speedy recovery and also to give her more insight into her condition. Emphasis was made on the need to visit the hospital immediately when illness occurs so as to promote early detection, treatment, and avoid complications. The patient and family were educated on the following;

Personal and environment hygiene

Madam A. R. and family were educated on environmental cleanliness. The patient or family were advised to bath twice a day, wash their hands frequently, wash their cloths frequently, dispose of refuse properly, weed their environment and maintain adequate drainage systems by draining water around the house to minimize mosquito breeding.

Diet

There was also instruction on the importance of drinking more fluids, eating a well-balanced diet, washing hands before and after eating, and thoroughly preparing food before eating. The

family was taught how to modify their diet by eating more vegetables such as "kontomire" and vitamin B12-rich foods such as liver, fish, and eggs which are required for the correct production of red blood cells and was also told the need to reduce her salt and spicy foods.

Drugs and review

The patient and her family were taught on the dangers of self-medication and the importance of seeking medical attention when sick. The dosing and storage of the drugs were discussed in detail. They were also taught about the drugs side effects and how to report any negative reactions. The need of taking the medications was also stressed to the patient and relatives. They were then educated on the significance of review and follow-up care as well as the importance of reporting to the hospital as soon as any family member becomes ill for treatment to avoid complications.

4.3 Follow up/ home visit for continuity of care

This is a visit to the patient's home with the aim of promoting health through education and assessment of health status (Park, 2022). It is carried out before and after discharge. The reason for this home visit was to assess the nature of patient and family's home/community and to determine people who are vulnerable of getting the disease. It helped patient's family to be educated on unhealthy living and other factors that will be identified. It also helps in validation of data collected from patient and family.

4.3.1 First Home Visit (25th August, 2023)

On the 25th August, 2023 being the third day of admission patient house was visited while she was still on admission. The main purpose of the visit was to find out the actual and potential problems that might have contributed to the patient's illness, and find ways of solving them

before the patient was discharged. It was also to validate data obtained from patient and family and to find a healthcare provider I would hand over patient to during the termination for care.

Permission was sought from the patient, Madam A.R, to visit her house in an attempt to identify any risk factors, vulnerable people and the environment conditions in the house. The visit was scheduled with the patient's son Mr. E. A., who took me to their house at Sunyani fiapre with house number 149/E.

We set off at 11:30am and reached their house (Sunyani fiapre) at 12:00pm. Introduction was done to some of the family members who were present in the house by Madam A. R.'s son. They welcomed me and my mission was asked. Introduction was made as a student nurse at Holy Family and Midwifery Training College, Berekum. Also told them that I am the student nurse taking care of Madam A. R. at the hospital and came to see where she stays and her family as well. They were very happy and welcomed me once again after the brief introduction.

The house is built with blocks, which is plastered, painted and roofed with aluminum iron sheets with five bed rooms, one bath room and no toilet. They use a public toilet which is far from their house according to Mr. E. A. (patient's son). The rooms were well ventilated. Their source of water was pipe-born and waste is disposed at the community refused dump which is also not far from their house. Education was done on the needs to cover their foods and store the uncooked ones in a hygienic environment and keep their water always safe for drinking and washing of hands thoroughly before and after visiting the toilet as well as after eating.

The surroundings were clean and tidy. I encouraged them to keep it up. They store water in a barrel in case the mechanized borehole in there are does not flow. I took the opportunity to educate them on the need to cover the water in the barrel with a lid. The family members were advised on the need to maintain good personal hygiene and weed around their house since they

were near the bush and were more prone to getting malaria. Then I educated them on the causes, signs and symptoms of malaria. They were advised to sleep under treated mosquito net, proper disposal of empty cans keeping the environment clean and tidy. Education was given to the patient's family about the risk factors, causes, signs and symptoms of hypertension; some of the contribution factors to Madam A. R.'s condition was their diet. They eat too much of fatty food all day and do not usually exercise. They were happy about the education given to them and thank me. I asked Mr. E. A. for the healthcare facility in their town of which he took me to the community clinic in Fiapre. I introduced myself to the staffs present. I told them I was looking for community health nurse who would continue to take care of patient's health needs after I terminate my care. I was introduced to a community health nurse who will offer competent care after termination of care. Permission was sought from the family members and left the house around 2:00pm. They see me off to the road side where a taxi was picked and came back to the ward.

4.3.2 Second Home visit (1st September, 2023)

On 1st September, 2023 I visited patient house. The purpose of the visit was to see how patient was feeling at home, remind them of the review date and to assess whether she was taking her drugs as ordered, as well as assess whether she has developed any complications. Set off around 12:10pm and got there around 12:40pm.

Upon entering the house, Madam A. R. was sitting in a chair resting with some of the relatives around, greetings were made and they were happy to see me. I asked of their present condition. They said they were very healthy by God's grace and I was given a seat in the corridor and was offered water. Patient asked me to wait whiles she called for other members in the house. I used

the opportunity to observe the cleanliness of the environment. They have kept their environment neat and tidy. When all the family members came, I told them I am here to find out how the patient and family were doing and to see her responds to the treatment given in the house and also to remind them of the review date. One of her sons was asked to bring her drugs and realized that she was taking her drugs as prescribed. I asked the family members questions about the health education given to them previously and they were able to answer all questions about the health education correctly. Upon observation, I realized that the house was kept tidy and devoid of weeds. The family were praised on the positive responds towards the education given during the first home visit. Lastly, I reminded them of the review date which was on the 4th September, 2023 and its importance. I informed them that my interaction with them will end on my next visit and would hand over to a community health nurse who would continue the care. I sought permission to leave after scheduling to visit them again on the 12th September, 2023. The family thanked me for the visit and I was escorted to the roadside by Mr. E. A., Madam A. R.'s sons to take a car.

4.3.3 Date of Review (4th September, 2023)

On this day, her son Mr. E. A. was called on the 4th September, 2023 at 6:00am to remind him and her mother about the review, he told me they were preparing to come. Madam A. R. accompanied by her son came to the Sunyani Municipal Hospital for review in the morning. On arrival, I went with patient's son to collect patient's folder from the records. Her vital signs were checked and they were within normal ranges, thus, Temperature: 36.6^0C, Respiration: 20cpm, Pulse: 64bpm and BP: 130/80mmHg. Upon interacting with patient, she was observed that her condition had improved. I went in with patient when she was called to the consulting room at the main Out-patient Department and upon assessment by the Doctor, he confirmed that her

condition had really improved and expressed satisfaction. The doctor did not prescribe any drugs since there were no new complications. Madam A. R. was told by the doctor to continue taking the drugs and also to keep follow-up on her care. I reminded them again of my last visit to her home. They thanked me and I escorted them and bade them goodbye.

4.3.4 Third Home Visit (12th September, **2023)**

On the said date, third home visit was made at Fiapre with a community health nurse Ms. M. M. from community clinic at Fiapre. The main aim of the visit was basically to terminate the care rendered for the patient and family also to hand over to a community health nurse for continuity of care. The visit also aimed at finding out how the patient was doing after the review and also to assess whether they were following the treatment regimen. Upon arrival, we were welcomed by the patient and family. We were offered a seat and water. Our mission for the visit was asked and we said we came to visit them and find out how Madam A.R. was feeling and also to hand her over to a community health nurse to continue with the home care. One of her sons was asked to bring her drugs and I observed that she was taking the drugs as ordered. She had no complains and since that was my last visit, the various health education given previously was highlighted. They were grateful and promises to adhere to the educations give to them. All necessary information regarding Madam A. R. and family were handed over to the community health nurse, Ms. M. M. The necessary cooperation was asked to be given to the community health nurse. I used the opportunity to thank them for giving me the chance to use the patient and family for the care study. I informed them on not being able to visit them frequently but will pay them friendly visits anytime there is an opportunity. I bade them goodbye and they escorted me to the roadside to bore a car.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Hinkle, Cheever, & Overbaugh, 2022). The chapter gives information about the statement of evaluation, amendment of nursing goals and termination of the care rendered to the patient and family.

5.1 Statement of Evaluation

After five days of admission and maximum cooperation from the patient, her family and staff of Sunyani Municipal Hospital, patient fully recovered from her illness and was discharge with all goals fully met. During the admission of Madam. A. R., six problems were identified and objectives were set to solve each of them. The degree to which the objectives set for the problems were achieved are discussed below.

1. Patient's high blood pressure was restored to normal

On 23/08/2023, at 3:05pm, patient's had high blood pressure (200/120mmHg) when vital signs were checked during admission therefore a nursing diagnoses of risk for decreased cardiac output as evidence by increased vascular resistance was made and an objective of patient's high blood pressure will be restored to normal; systolic (100-130) mmHg and diastolic (60-89) mmHg within 72 hours was set. The following interventions were made; Patient was reassured that measures (administration of antihypertensive drugs) will be given to reduce her blood pressure, Patient's vital signs was checked and recorded every 4hours paying particular attention to blood pressure, Bed rest was ensured by explaining to the patient that, rest helps to reduce stress by

provide a calm environment, Patient was engaged to watch television which help to manage stress, Patient was educated on the reduction of high salt intake and avoidance of caffeinated beverages and others and Prescribed oral nifedipine 30mg bd x 30 days and other medications were served.

On 26/08/2023, at 3:05pm, The objective of patient's high blood pressure will be restored to normal; systolic (100-130) mmHg and diastolic (60-89) mmHg within 72 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized that, palpitations are no more and BP was checked and recorded as 136/88mmHg.

2. Patient was relieved of pain (headache)

On 23/08/2023, at 3:10pm, as Madam A. R. complained of headache on admission, a nursing diagnosis of acute pain (Headache) related to decreased cerebral tissue perfusion as evidence by patient rating pain as 6 on the numerical rating scale was formulated. An objective of patient will be relieved of headache within 24 hours was set. The following interventions were made; Patient was reassured of measures (such as giving pain medication) to help her control pain, Patient's level of pain was assessed using the numerical pain rating scale and she pointed out 6 to note her pain intensity, Patient's vital signs were monitored to indicate any deviation of body physiological parameters from normal, Patient position was changed every 4 hours to ensure comfort in bed, Patient was engaged in watching television as a diversional therapy and Prescribed paracetamol 1g tds, Nifedipine 30g daily and hydralazine 5mg were administered.

On 24/08/2023, at 3:10pm, the objective of patient will be relieved of headache within 24 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized, she is relieved of headache and nurse observed patient having relaxed facial expression.

3. Patient performed her daily activities(bathing) without support.

On 23/08/2023, at 3:15pm, because patient presented with general body weakness a nursing diagnosis of self-care deficit (bathing)related to decreased muscle strength and endurance as evidence by lost of interest in bathing was formulated. An objective of patient will be able to perform her daily activities without support within 48 hours was set. The nursing interventions carried out were; Patient was reassured that after competence nursing she will be able to perform her daily activity, Patient was encouraged to engage in passive exercises (such as flexion and extension of the hands and legs), Patient was assisted to bath and brush his teeth when needed, At least 90mins between activities for undisturbed rest was allowed to enable physiologic recovery and Items of daily use such as drinking cup, comb and face towel were kept closed to patient for easy access to promote patient independence.

On 25/08/2023, at 3:15pm, the objective of patient will be able to perform her daily activities without support within 48 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized that she no longer has feelings of body weakness and nurse observed patient participating in activities that she could tolerate.

4. Patient was relieved of anxiety

On 23/08/2023, at 3:16pm during interaction with Madam A.R, she was observed to be anxious. A nursing diagnosis of anxiety related to unknown outcome of the condition as evidence by patient having facial flushing was made An objective of patient will be relieved of anxiety within 24 hours as evidenced of was set. Therefore all the following interventions were made; Patient was continuously reassured of speedy recovery, Introduction of self and other staffs present was made to patient and her relatives, Every procedure to be performed was explained to patient,

Patient and her family were introduced to other patients who were recovering from Cerebrovascular accident to give hope of patient's recovery, Patient was encouraged to ask questions on the condition and things she does not understand and All questions were answered tactfully and honestly to clear all doubts and misconceptions.

On 24/08/2023, at 3:16pm, the objective of patient will be relieved of anxiety within 24 hours that was set on 23/08/2023 was evaluated and goal was fully met as patient verbalized that she is no more anxious and nurses observed patient having relaxed facial expression.

5. Madam. A.G regained her normal appetite

On 24/08/2023, at 9:40am, patient was observed to be feeling reluctant to eat. Therefore, a nursing diagnosis of imbalanced nutrition (less than body requirement) related to inadequate dietary intake as evidence by lack of interest in food was formulated. An objective of patient will regain and maintained her normal appetite within 24 hours was set. The following interventions were made; Patient was reassured of good nursing care that she will regain normal eating pattern, Oral hygiene was ensured as patient brushed her teeth twice daily which stimulated her appetite, Patient and family were involved in planning her meal, Food was always attractively served in small quantities, Patient was served with fruit juice before taking her meal to increase her appetite and All nauseating items such as bed pan were removed from patient.

On 25/08/2023, at 9:40am, the objective of patient will regain and maintained her normal appetite within 24 hours that was set on 24/08/2023 was evaluated and goal was fully met as patient consumed all her food served and nurse observed that patient ate all of her food served.

6. Madam A.G and her family gained adequate knowledge on hypertension

On 25/08/2023, at 9:00am, patient and family were observed to have misinformation about the causes, signs and symptoms, management and complication of hypertension. A nursing diagnosis of deficient knowledge related to the prognosis and home care management as evidence by patient giving inaccurate response to questions asked was formulated for the patient. An objective of patient and family will gain adequate knowledge on hypertension throughout the period of hospitalization was set. The following interventions were done; Patient and family were reassured that they will get to know more about condition.Patient and her family knowledge were assessed on the causes and prevention of the condition, Environment of mutual trust, non-judgmental and respect was established to enhance learning, Patient and her family were educated on the causes of the condition, Patient and her family were encouraged to ask any question and misconceptions surrounding hypertension and Positive outcomes on adhering to treatment regimen were explained to patient as well as the negative when patient defaults.

On 27/08/2023, at 9:05am, the objective of patient and family will gain adequate knowledge on hypertension throughout the period of hospitalization that was set on 25/08/2023 was evaluated and goal was fully met as patient verbalized that frequent BP check helps her to know her health status and nurse observed patient taking her medications regularly and eating food low in salt and fat.

5.2 Amendment of Nursing care plan for partially met or unmet outcome criteria

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

5.3 Termination of care

This involves bringing to an end the care that was started on the patient and family (Adams & Kroshinsky, 2016). However, this a very difficult step to take after a good rapport has been established. Because of this, the reality of termination of care has to be made known to both patient and family from the day of admission. Patient and family members were made to understand that patient's hospitalization was temporal since she would be discharged after her condition had improved. They were also told that I would not be able to stay on the ward for 24 hours with them, hence the need for their cooperation with other nurses and paramedical staff on the ward is important. The preparation started on the day of admission until day of discharge. Three home visits were undertaken.

12th September, 2023 was the day of my last visit. I visited the patient and her family at Fiapre with a community health nurse from Fiapre community clinic called Ms. M. M. to ensure continuity of care. Upon observation patient was looking strong and healthy and the surrounding were tidy and family were also adhering to the education given to them.

Emphasis was made on the health education rendered previously like taking low sodium diets, keeping environment clean, regular exercise, low or no fatty foods and also ensuring enough rest. All necessary information that will be needed for Madam A. R.'s care was given to the community health nurse to promote quick and effective care that will be rendered to patient without any difficulties. I promised to visit the family as well as the community health nurse anytime. I thanked them sincerely for their cooperation. I sought their permission to leave at 2:00pm and they escorted me to the roadside.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation or compendium of previously stated facts or statements (Weller, 2019). Conclusion is the last part of something or an opinion reached after some thought (Weller, 2019).

This is the final phase in the patient/family care study, and it comprises the student's personal assessment of the therapeutic interaction with the patient as well as the application of the nursing process.

6.1 Summary

Madam A. R., a 68-year-old woman was admitted on 23rd August, 2023 around 3:00pm at the Sunyani Municipal Hospital with diagnose of hypertension. Her vital signs on the day of admission were checked and recorded as;

Temperature: 36·3°C

Pulse: 99bpm

Respiration: 22cpm

Blood pressure: 270/120mmHg

She presented with headache, anxiety, general body pains and loss of appetite. She spent a total of five days at the hospital. During her period of hospitalization six (6) health problem were identified. These were; High blood pressure, headache, general body weakness, anxiety, and inadequate information on hypertension. Nursing diagnosis was formulated for each of the problems and in order to solve these problems objectives were set, nursing orders were given,

orders were implemented and all the goals were fully met. The following diagnostic investigations were done;

1. Blood for full blood count
2. Blood sample for malaria parasites estimation
3. Fasting blood sugar level (FBS)

She was managed on the following prescribed medications:

1. IV Hydralazine 5mg stat.
2. Tablet Nifedipine 30mg daily×30 days
3. Tablet Lisinopril 10mg 30 daily×30 days
4. Tablet Paracetamolm1 gram tds ×3 days

On 27th August, 2023 patient was discharged during ward rounds. Madam A. R. was discharged with Tab nifedipine 30mg daily for 30 days and Tab Lisinopril 10mg daily for 30 days.

Patient was encouraged to continue taking her drugs and was educated on the side effects of the drug and the need to report any illness.

The need to take in medication was emphasized and review date was stressed. Patient and family were educated on how to keep the home clean and also abide by all the preventive measures already communicated to them. Three (3) home visits were embarked upon. My first home visit was on 25th August, 2023, second home visit was on 1st September, 2023 and third home visit was on 12th September, 2023.

6.2 Conclusion

According to Weller (2019), the final part that brings something to a close is referred to as the conclusion.

This care study has assisted me in becoming knowledgeable about the condition hypertension, as well as in caring for and understanding patient as individuals with diverse background, personalities and condition. It has also aided the patient and her family in receiving the necessary care. The study is significant because it is a type of individual patient study that aids in the identification of specific health problems in specific areas and the provision of necessary interventions

Despite the fact that writing a patient/family care study is time consuming. I believe that every student nurse should partake in the study because it enriches their knowledge and practice. The Nursing and Midwifery Council of Ghana should maintain it in the nursing program.

APPENDIX

Table 7:Vital Signs of Madam. A.R

Date	Time	Temperature(℃)	Pulse(bpm)	Respiratory (cpm)	Blood pressure (mmHg)
23/08/23	3:00pm	36.3	99	22	270/120
	6:00pm	36.2	72	22	190/100
	10:00pm	36.5	81	24	190/100
24/08/23	6:00am	36.5	80	20	160/100
	10:00am	36.5	71	17	150/100
	2:00am	36.3	73	21	135/90
	4:00pm	36.2	65	17	130/80
	10:00pm	36.3	72	22	125/80
25/08/23	6:00am	37.1	93	21	130/90
	10:00am	36.6	86	22	130/80
	2:00am	36.7	72	16	130/70
	4:00pm	36.6	81	24	130/80
	10:00pm	36.4	76	22	160/100
26/08/23	6:00am	36.5	70	24	125/80
	10:00am	36.4	75	22	130/80
	2:00am	37.0	80	23	130/70
	4:00pm	36.4	76	22	120/80
	10:00pm	36.3	80	20	130/80
27/08/23	6:00am	36.5	70	24	130/80

Bibliography

American Psychological Association. (2020). Retrieved from https://dictionary.apa.org

Harding, M. M., Kwong, J., Roberts, D., Hagler, D., & Reinisch, C. (2020). *Lewis's Medical-Surgical Nursing* (11th ed.). Canada: Elsevier, Inc.

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. J. (2022). *Brunner & Suddarth's textbook of medical-surgical Nursing* (15th ed.). london: Wolters Kluwer Health/ Lippinocott Williams & Wilkins.

LoveToKnow. (n.d). *Google.* Retrieved from YourDictionary: www.yourdictionary.com

Merriam-Wester. (2020). doi:https://www.merriam-webster.com/dictionary/

NANDA, I. (.-I. (2021). *Nursing Diagnoses* (12th ed.). New York, NY: Thieme Medical Publishers, Inc.

Park, K. (2022). *Park's textbook of prevention and social medicine* (27th ed.). Banarsick, India: Banarsidas Bhanot Publishers.

Smith, B. T., & Pacitti, D. F. (2020). *Pharmacology for Nurses* (2nd ed.). Canada: Jones & Bartlett Learning.

Tortora, G. J., & Derrickon, B. (2020). *Principles of Anatomy& Physiology* (16th ed.). Hopboken, New Jersey: John Wiley & Sons, Inc.

Weller, B. F. (2019). *Bailliere's Nurses' Dictionary for Nurses and Healthcare workers.* London: Elsevier limited.

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