HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A PATIENT/FAMILY CENTERED NURSING 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 LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED NURSE

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PREFACE

Modern nursing is a profession that requires knowledge, skills and attitude. It owes much of its body of knowledge to the influence of Florence Nightingale (1820 - 1910), a woman who pioneered and brought much respect to the profession through her vision. The ability to render Comprehensive nursing care rests on the nurses' ability to assess the client's condition, analysis, Plan, implement and evaluate the effects of management on patient health status. Nursing in the past four decades have brought emphasis on nursing research and the use of scientific data at the bedside. Nursing care has broadened from care of the sick to care of the people both in sickness and health and also extend to the patient's family and community at large in all aspects regardless of the background.

Patient and family care study is a report of comprehensive nursing care rendered and patient and their family from the day of admission, discharge and subsequent follow ups visits in other to help them meets their health needs. By using the nursing process in caring for the patient, emphasis is based on health promotion, maintenance and restoration or enhancing a peaceful death depending on how nature may act on the patient's condition after a holistic care has been rendered. The care involves the interaction between the nurse and the patient as well as the family.

The changing scene of nursing care has brought into being the patient and family care study, as a partial requirement by the Nursing and Midwifery Council of Ghana for the award of License to practice as a General Nurse. It is in this regard that I chose a patient with Hypertension for the care study whose name was denoted by her initials due to confidentiality purposes. The study serves as a reference paper for other student nurses and qualified health personnel who may be interested in its content.

ACKNOWLEDGEMENT

My greatest thanks goes to the Almighty God for giving me the strength and wisdom to undertake this study successfully.

My next gratitude goes to my patient, Madam K.J and her family members for their absolute co-operation. I thank them for all the information they provided towards the progress of this study. I am also grateful to the medical doctors and the entire staff nurses of the Female Medical Ward at Sunyani Municipal Hospital especially, the ward in charge.

Furthermore, my special thanks goes to Mr. Shadrack Owusu Osei for his time and energy spent in supervising me throughout this study and the entire teaching staffs of Holy Family Nursing And Midwifery Training College, Berekum.

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My sincere appreciation to my parents especially my father Adjie Timothy for their emotional, spiritual and their physical support throughout this study.

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Finally, I am very grateful to all the publishers and authors whose books I used as a source of reference during the course of my Study without fhjynuuuuuuorgetting Divine Glory Printing Press at Sunyani-Fiapre.

I have nothing but to say, may the Almighty God bless you all and answer all your heart desires abundantly.

INTRODUCTION

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

The rationale behind a care study is to assist a patient to regain health (or peaceful death) and present a report of that assistance giving account of problems that were identified and how solutions were worked out from a nursing process perspective. For confidentiality purposes, the name of the patient and her family would be replaced by initials.

Presented in this care study is a report of nursing care rendered to Madam K. J, a 78 year old woman diagnosed of Hypertension and Diabetes Mellitus who was admitted at females ward at Sunyani Seventh Day Adventist (S.D.A) hospital on 1st December, 2022, with history of headache, dizziness and general body weakness. Patient spent 5 days at the females' ward. Patient was discharge on the 5th December, 2022 after wish several home visits were carried out.

Madam K.J was managed under the following medication;

1. Amlodipine Tablet 10 mg, 1 Tablet, daily x 30

Intramuscular (IM) Diaclofenac Start (st)

2. Tablet Amlodipine 5mg daily x 60days
3. Tablet Atenolol 50mg daily x 60 days
4. Tablet Paracetamol 1g tds x 7
5. Suppositories Diaclofenac 100mg daily 5/7
6. Syrup Simple Linctus 15mls tds x 7 days

7. Syrup Lactulose 10 mls bd x days.
8. Insulin Soluble HM 100units/ml in 10ml, 20 unit(s). stat x 1
9. Losartan Tablet 50mg, I Tablet, daily x 30
10. Metformin Tablet 500mg, 2 Tablet, bd x 30
11. Sodium Chloride Infusion 0.9% (500ml), 2000ml, daily x 1

I have established a good interpersonal relationship with patient and her next of kin throughout the study. They were reassured of confidentiality. I told the patient that I am final year student, it is a requirement by the Nursing and Midwifery Council to take a patient, to render individualized nursing care to her until discharge and follow up visit after discharge until she recovers fully. As partial fulfilment for the Licence to practice as a Registered General Nurse. They were excited about the service and allowed me to do it.

Madam K.J was chosen for the study simply because, they lacked a detailed knowledge on hypertension and the family's effort of caring for her was much far from impressive. From the day of admission, I made it known to them that, the hospital's facility was going to be a temporal place for them. Hence discharge planning was initiated.

Education concerning the risks factors, clinical manifestations both pharmacological and non-pharmacological managements to hypertension were clearly elaborated to patient and the family.

Throughout patient's period of hospitalization, the following health problems were identified, headache, general body weakness, cough, constipation and difficulty in sleeping.

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

Chapter one deals with assessment of Madam K.J and her family.

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

Chapter three comprises the planning phase of the nursing process.

Chapter four tackles the actual implementation of the care plan.

In chapter five, evaluation of nursing care given to the patient and her family from encounter till termination of nurse-patient relationship is discussed.

Chapter six focuses on the summary and conclusion of the care study.

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CHAPTER ONE

ASSESSMENT OF THE PATIENT/FAMILY

1.0 Introduction

According to Javis (2018), assessment is the collection of data about individual's health state. It comprises both subjective date (what the patient says) and objective data (what the health care provider sees). It is the first and the important step in the nursing process. the assessment phase sets the tone for the rest of the process to follow. It is an essential key needed in the nursing process in other to render holistic care to patient and their relatives. In this study, assessment will be conducted based on the following methods; interview, physical examination, observations (using senses such as; the eye, nose skin, ears etc.), Laboratory results and x-ray reports. Also, sources of information from this study would be obtained from patient and the relatives as well as patients folder etc. Assessment consists of the following sub headings; patients particulars, Patient and family medical history, patient and family socio- economic history, patient developmental history, patient obstetric history, patient lifestyles and hobbies, patient past medical history, patient present medical history. It also consists of admission of patient, patient and family concept of the illness, literature review of the medical or surgical condition and finally, validation of data.

1.1 Patient Particulars

Patient particulars or biography data are the information collected from the patient at the first visit, which forms a picture of the patient as a unique individual. It includes the person name, date of birth, age, gender, occupation, hometown, nationality, marital status and the sources of data (Wilson, Fickertt & Giddens, 2020). For confidentiality purpose in this study, the patient's full name will be denoted by her initials as far as nursing ethics is concerned.

Madam K.J is a 78 year old woman born on 4th June, 1944 to Mr K.Y and Mrs B.K. Madam Y.B is the first born of her parents among her six siblings. Her mother come from Drobo in the Bono Region and the father also come from Jakufa in the Jaman District but stays with one of her daughter at Fiapre in Sunyani. She lost her husband two years ago. Hence, she is a widow now. She said, due to her age, she cannot go to farm as she use to do. Madam K.J is Christian, she attends Roman Catholic Church. She chose Mrs. Y. D (her daughter) to be her next of kin who also resides at Sunyani- Fiapre. The patient explained to me that, she has never been educated before. Her reason was that the parent did not know excess of education and as at that time they do not know important of it. She speaks Twi. Madam K.J have 14 children and 5 siblings. She is fair in complexion, weighs 68Kg, with the height of 1.6m. She has a smooth skin, medium head size, a pointed nose with a white teeth in good alignment. The patient has no physical impairment and has no tribal mark on her face. Patient's folder number is 5701/21 Seventh Day Adventist (SDA) Hospital, Sunyani. Patient's house number is C65/8.

1.2 Patient and Family's Medical History

According to Madam K.J, both her grandparents and parents has expired and it was due to old age. She continued by saying, among her six siblings, she has lost one remaining five of their siblings. She attributed some cause of their death to be generalised abdominal pain, headache and attributed others to be an idiopathic (an unknown) cause. According to patient, her husband died since two years ago as a result of Diabetes Mellitus. She was then reassured and the conversation continued. According to the patient, her mother died as a result of hypertension but there is no congenital abnormality in their family neither do they have any hereditary diseases like diabetes, hypertension, asthma nor any mental illness in their family except her who is suffering from hypertension.

But she confirmed that, once in the blue moon, some members in the family do suffer from the ailment of malaria, diarrhoea, headache and generalised body pains which they treat with the over the counter medications (pharmaceutical medications). She added that, when the needs arrives too, they combined their treatment with herbal medicine. Madam K.J said, as for her, she has been going for check-ups and medical reviews at Seventh Day Adventist (SDA) Hospital, Sunyani due to her known condition. According to the patient, there are no known allergies in their family.

1.3 Patient and Family Socio-Economic History

According to Webster (2020) it is the position of an individual on socio-economic scale that measures such factors as education, income and occupation . Madam K.J said that, the relationship that exist between their family members is so cordial and much cohering. She said, there is unity among family members hence they all work in peace and harmony together as one people. According to Madam K.J, her are well children educated hence majority of them are doing white collar jobs. Their mode of support system in the family is amazing. This is because, in terms of financial needs, each member joins hands to solve the problem out. The patient said, some members partake in religious activities but due to her age, she has isolated herself from religious activities. However, she always ensures that, she attend church every Sunday. The patient said, her source of medical care is from his next of kin (daughter). She said, National Health Insurance Scheme (NHIS) also play a vital role in the reduction of her medical cost. From Madam K.J, once her parents were alive, their occupation was farming at Drobo. She continue by saying, the risks involved in the farming activities was bites from harmful animals such as; mosquitoes, snakes etc. she said she normally goes to farm around 10:00am and comes back around 3:00pm . Madam K.J was able to give an estimated value of capital received or end at the end of each farming. However, in terms of financial status, her family is in the middle class. This means, they are neither poor nor rich.

According to the patient, it is a Taboo in their ethnic group for a woman to fornicate once married. Madam K.J was able to tell me some of their norms and values they have as an ethnic group.

1.4 Patient's Developmental History

Development is a process that creates growth, progress, positive change or the addition of physical, economic, environmental, social and demographic component (Sid, 2018)**.**

According to Madam K.J, she said, she was told by her mother that, she went through a normal pregnancy for nine successful months without any abnormality or disorder and got assisted in delivery by Traditional Birth Attendants through Spontaneous Vagina Delivery (S.V.D) without any complications. The patient was breastfed up to period of 8 months before complementary food such as porridge was introduced. She added that, her infancy stage (0-2 years), she sat without support and at her 8th months, she started walking, talking and running. At her 10th months, her parents were able to immunized her against childhood diseases by observing Bacille Calmette-Guérin *(*BCG*)* vaccine scar at the right shoulder. She said at her childhood stage (3-8 years), she started speaking their local dialect, running an errands and begun practicing personal hygiene such; bathing twice daily, brushing the teeth etc. Puberty refers to a stage in people's lives when they develop from a child into an adult because of changes in their body that make them able to have children (Walter E. , 2017). According to Madam K.J, she had her menarche (first menstrual period) at the age of 16 years and had her breast started developing. She then started growing pubic hairs around her genital region as well as under her armpit. Her hips begun broading. Madam K.J started practicing good personal and environmental hygiene such as washing of clothing and utensils, bathing twice daily and does cooking by herself. She added that, their house is well swept whenever dirty to improve upon their health. The patient explained to me that, her relationship among her fellow adolescence was not all that close especially, men.

Her reason was, she was cautioned by her relatives not to get closer to men if not, she will get pregnant. Madam K.J actually did not give any career plans of hers. According to Madam K.J, she has never been engaged in any occupation after she married. According to the patient, she got marriage at the age of 24 years to Mr O. M. She enjoyed best and found happiness in her marriage and was blessed with fourteen (14) children. Madam K.J lost her husband 2 years ago. She said, currently, as she is in her widowhood state now, she is not experiencing any problem simply because, all her needs are provided by her sons and daughters. Based on the patient 's age and other symptoms she exhibited, she is in her menopausal age. Erikson's theory of psychosocial development describes the human life cycle as a series of eight ego developmental stages from birth to death.

The following are the 8 stages of Erik Ericson psychosocial development:

1. Trust versus Mistrust (Birth to 18 months) infancy
2. Autonomy versus Shame and Doubt (18 months to 3 years) Early children
3. Initiative versus Guilt (3 to 6 years) late childhood
4. Industry versus inferiority (6 to 12 years) school age
5. Identity versus role confusion (12 to 20 years)
6. Intimacy versus Isolation (20 to 35 years) early adulthood
7. Generativity versus Stagnation (35 to 65) middle adulthood
8. Integrity versus Despair (65 to death) late adulthood

Upon my constant conversation with the patient in the study, I realized that, she falls under the 8th stage of Erik- Erickson Psychosocial developmental theory which is Ego, Integrity versus Despair.

According to Erik- Erickson, at this stage, the late adulthood reflect back on the life they have lived and come away with either a sense of fulfillment (successful) from a life lived or a sense of regret and despair over a life misspent. According to Madam K.J, she is feeling satisfaction in life in the sense that, she has raised fourteen (14) children and has a good relationship with them all. Furthermore, she feels so proud of her years educating young children and being around her young grandchildren. She concluded by saying, as she faces the end of her life, she feels a sense of being complete and is able to look back and face what is ahead with a sense of wisdom and peace.

This is what Erickson referred to as ego integrity. I was told by Madam K.J that, she did not had the opportunity to be educated.

1.5 Patient's Obstetric History

Obstetric is a field of study concentrated on pregnancy, childbirth and the postpartum period (Roth, 2018). According to Madam K.J, she gave birth to 14 children and all her deliveries were spontaneous vagina deliveries assisted by Traditional Birth Attendant at home without complications. Madam K.J told me she had her first menarche (menstrual period) at age 16 with a normal flow. According to her, she had never used contraceptives since her lifetime.

1.6 Patient's Lifestyles and Hobbies.

Lifestyle is the pattern of daily living that an individual develops (Wel14).

Hobby is a regular activity done for enjoyment, typically during one's leisure time, not professionally and not for pay (Stebbins, 2018). Madam K.J normally goes to bed around 8:30 pm and wakes exactly, 6:00am to perform her morning duties. She performs oral hygiene twice daily with a soft brush and at times uses chewing stick. She takes a warm bath twice daily. The patient performs no special assignment during the week days. During weekends, she normally attends naming ceremonies, funerals and at times do visits close relatives around.

She experiences no difficulty in eating except when she is sick. She walks a little bit slower and assumes a slightly forward -bent position when walking. The patient does not use alcohol, tobacco, coffee and uses no illicit drugs such as; cocaine, tramadol etc. and recreational drugs.

She empties her bowel at least once daily and empties her bladder more rapidly especially when she takes in more fluids. Madam K.J rarely buys food outsides but does all her cooking by herself. She takes three square meals per day with no snacks. The patient 's favorites food are, fufu and light soup with cow meat and ampesie with garden eggs stew with tilapia since Madam K.J is from the Bono Region. She has no disturbed sleeping pattern hence uses no special remedies for sleeping. She said, at times she sleeps in the afternoon and sleeps well at night too. The patient has no known allergies to food and drugs just that, her religion forbid pig and any form of meat which has not been slaughtered to be eaten. Singing gospel songs and watching television are her favorite's hobbies. She does not engage herself in any form of exercise. She has no abnormal psychological disorders such; Schizophrenia, post-traumatic stress disorder, bipolar disorders etc. She is well mentally sound and conscious alert. According to Madam K.J, her 4 grandchildren are her major source of stressors. They always makes her talk much. Her perception is, when they grow up such behavior will be halted since she always try her best advising them. She normally sleeps when she becomes stressed up and at times, does watch movies on television. Her mode of communication is by verbal means and speaks at a lower tone. She likes telling the truth, educating and helping young ones. Her dislikes are prostitution, stealing, fighting and maltreating children. She is much sociable and does not think or cares about herself alone but rather for all. Sincerely, my personal impressions about Madam K.J is so amazing and loving. This is because, she opened up whole heartedly discussing her personal issues with me in the study and always wish best for the youth.

1.7 Patient's Past Medical History

According to Madam K.J, she was told she did not experienced any childhood illness such; tetanus, whopping cough, measles, poliomyelitis diphtheria etc. However, she added that, once in the blue moon, she does experiences mild headache, abdominal pains and malaria which is treated by over the counter drugs and herbal preparations. She has no known allergies to animals, drugs, foods, insects etc. The patient has never been involved in an accident before.

She said, she had an incisional wound as a result of cut from knife several years ago and the source of treatment was hot water therapy at home. Madam K.J first hospitalization occurred at 2013. Her reason for hospitalization was headache and generalized body pains which ended up with the diagnosis of urinary tract infection (UTI) and she was well treated, later was also diagnosed of diabetes mellitus with hyperglycemia, hypertension. Currently, she is on the following antihypertensive medications, Tablet Glimepiride, Amlodipine and Atenolol. She has not developed any complications per her condition simply because, she is on antihypertensive medications which she always takes as prescribed. Her access to health care is much easier due to support from relatives and with the help of National Health Insurance Scheme (NHIS) which reduces her medical bills.

1.8 Patient's Present Medical History

According to patient's next of kin, Madam K.J is a known hypertensive patient as said earlier. He added that, she was doing well until 1st December, 2022. In the morning she started complaining of headache, dizziness and generalized body pains. He taught her complains could subside but rather, gets and keeps on aggravating. According to her daughter her mother left her antihypertensive medications in the house and went to farm. This means Madam defaulted from her drug.

Due to its severity, he quickly took a car and rushed her to Seventh Day Adventist (SDA) Hospital where she was detained at the general ward (females ward) for treatment at 1:30 pm. With references to her vital signs, physical assessment and patient complains, she was finally diagnosed of hypertension by Doctor E.

1.9 Admission of Patient

Admission of a patient into the hospital ward is a change of environment with its attendant problems (Gyang & Darko, 2020)

Patient was admitted into the Females Ward through the Out Patient Department (OPD) at Seventh Day Adventist (SDA) Hospital accompanied by a staff nurse, two student nurses and a relative in ambulatory and conscious state on 1st December, 2022. At 1:30pm with the diagnosis hypertension. Patients complains were; occipital headache, generalized body weakness and dizziness. I welcomed patient and the relative and they were reassured of competent nursing care. I made a cross-check to confirm whether patients was truly admitted into the females ward with the said diagnosis. Patient's full name was mentioned to ensure if that is the right person. An admission bed was prepared to make patient comfortable. I made a brief introduction of myself and staffs to patient and the relative. Patient's details such as, name, sex, age, address, diagnosis, occupation etc. was entered into the admission and discharge (A&D) book as well as, the daily ward state. Patient's admission notes was then written. Patient's vital signs was checked and recorded as:

Temperature	36.1^0C Degree Celsius
Pulse	84 beats per minutes (bpm)
Respiration	19 cycles per minutes (cpm)
Blood pressure	150/90 millimeters of mercury (mmHg)
SPO_2	98%

Patient and her relative were introduced to other patients. Patient's relative was oriented to the ward and its annexes such as; the nurse's station, the kitchen, wash room etc. Patient's relative was educated on visiting hours, mode of settlement of medical bills according to the hospital's protocol. Initial physical assessment was conducted on patient from head to toe and no abnormalities were seen. Patient was oriented to time, place and persons.

Patient's relative was encouraged to bring food to patient but was cautioned to avoid food containing fatty diet such as ; meat, margarine, sardine, fried rice etc. and also her personal items such as; clothing, mosquito net, bowl, toilet roll, spoon, plastic, items for mouth care etc.

Madam K.J was to be managed under the following medications;

Intramuscular (IM) Diaclofenac Start (st)

Tablet Amlodipine 5mg daily x 60days

Tablet Atenolol 50mg daily x 60 days

Tablet Paracetamol 1g Tid x 7

Suppositories Diaclofenac 100 daily 5/7

The following Laboratory Investigations were ordered;

Full Blood Count (FBC) for, Red Blood Cells (RBC), White Blood Cells (WBC), Hemoglobin (HGB) etc.

Malaria Test

Urinalysis (Urine R/E).

Random Blood Sugar (RBS) was checked and recorded as; 5.9 mmol/l. Intramuscular Diaclofenac, Tablet Atenolol 50 mg daily and Tablet Amlodipine 5mg daily was rightly administered and well documented. Patient was changed into new clothing, reassured of competency nursing care and made more comfortable in bed by ensuring bed free from creases and cramps.

Relatives were entreated to participate in the health care delivery in other to achieve patient's early recovery. I also made them aware hospitalization will be a temporal home for them. Hence, there will be a need for the continuation of care after discharge especially, with regards to her nutrition, lifestyle and pharmacological managements. I introduced myself to patient and her relative that, I am a final year student nurse of Holy Family Nursing And Midwifery Training College Berekum who wished to use them for my care study in which a report will be written after the study. I explained to them that, the care study is a requirement by the Nursing and Midwifery Council (NMC) of Ghana before Diploma Certificate will be awarded. They were assured of confidentiality. I ended by saying, they can withdraw from the study whenever they wished to do so. Patient and her relative were glad to hear and consented to my request and I thanked them. I explained to the ward in charge at females ward and she gave me the go ahead to continue my study with Madam K.J.. She always goes home and returns to the ward late. Also, patients and relative lack detailed knowledge about their condition therefore, I decided to take Madam K.J for my study in other to educate them more about hypertension since it is known as a silent killer.

1.11 Literature Review on Hypertension

Basic Anatomy and Physiology of the heart and blood vessels.

The heart is a four-chambered hollow muscular organ normally about the size of a fist. It lies within the thorax in the mediastinal space that separates the right and left pleural cavities. The heart is composed of three layers: a thin inner lining, the endocardium; a layer of muscle, the myocardium; and an outer layer, the epicardium. The heart is covered by a fibro serous sac called the pericardium. This sac consists of two layers: the inside (visceral) layer of the pericardium (part of the epicardium) and the outer (parietal) layer.

A small amount of pericardial fluid (approximately 10 to 15 mL) lubricates the space between the pericardial layers (pericardial space) and prevents friction between the surfaces as the heart contracts. The heart is divided vertically by the septum. The interatrial septum creates a right and left atrium, and the interventricular septum creates a right and left ventricle. The thickness of the wall of each chamber is different. The atrial myocardium is thinner than that of the ventricles, and the left ventricular wall is two or three times thicker than the right ventricular wall. The thickness of the left ventricle is necessary to produce the force needed to pump the blood into the systemic circulation. The four valves of the heart serve to keep blood flowing in a forward direction. The cusps of the mitral and tricuspid valves are attached to thin strands of fibrous tissue termed chordae tendineae. Chordae are anchored in the papillary muscles of the ventricles. This support system prevents the eversion of the leaflets into the atria during ventricular contraction. The pulmonic and aortic valves (also known as semilunar valves) prevent blood from regurgitating into the ventricles at the end of each ventricular contraction (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

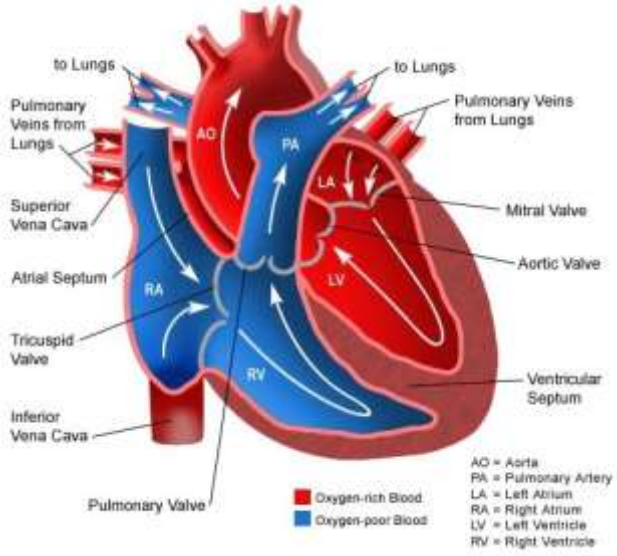

Figure 1.0 Anterior view of the anatomy of the internal structure of the heart.

Source: (Smeltzer, Bare, Hinkle, & Cheever, 2018).

Blood Supply to Myocardium.

The myocardium has its own blood supply, the coronary circulation. Blood flow into the two major coronary arteries occurs primarily during diastole (relaxation of the myocardium). The left coronary artery arises from the aorta and divides into two main branches: the left anterior descending artery and the left circumflex artery. These arteries supply the left atrium, the left ventricle, the interventricular septum, and a portion of the right ventricle. The right coronary artery also arises from the aorta, and its branches supply the right atrium, the right ventricle, and a portion of the posterior wall of the left ventricle. In 90% of people the atrioventricular (AV) node and the bundle of His receive blood supply from the right coronary artery. For this reason, blockage of this artery often causes serious defects in cardiac conduction. The divisions of coronary veins parallel the coronary arteries. Most of the blood from the coronary system drains into the coronary sinus (a large channel), which empties into the right atrium near the entrance of the inferior vena cava.

Vascular System Blood Vessels.

The three major types of blood vessels in the vascular system are the arteries, veins, and capillaries. Arteries, except for the pulmonary artery, carry oxygenated blood away from the heart. Veins, except for the pulmonary veins, carry deoxygenated blood toward the heart. Small branches of arteries and veins are arterioles and venules, respectively. Blood circulates from the left side of the heart into arteries, arterioles, capillaries, venules, and veins, and then back to the right side of the heart. Arteries and Arterioles. The arterial system differs from the venous system by the amount and type of tissue that make up arterial walls. The large arteries have thick walls composed mainly of elastic tissue. This elastic property cushions the impact of the pressure created by ventricular contraction and provides recoil that propels blood forward into the circulation. Large arteries also contain some smooth muscle. Examples of large arteries are the aorta and the pulmonary artery.

Arterioles have relatively little elastic tissue and more smooth muscle. Arterioles serve as the major control of arterial BP and distribution of blood flow.

They respond readily to local conditions such as low oxygen (O2) and increasing levels of carbon dioxide (CO2) by dilating or constricting. The innermost lining of the arteries is the endothelium. The endothelium serves to maintain hemostasis, promote blood flow, and, under normal conditions, inhibit blood coagulation. When the endothelial surface is disrupted (e.g., rupture of an atherosclerotic plaque), the coagulation cascade is initiated and results in the formation of a fibrin clot (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

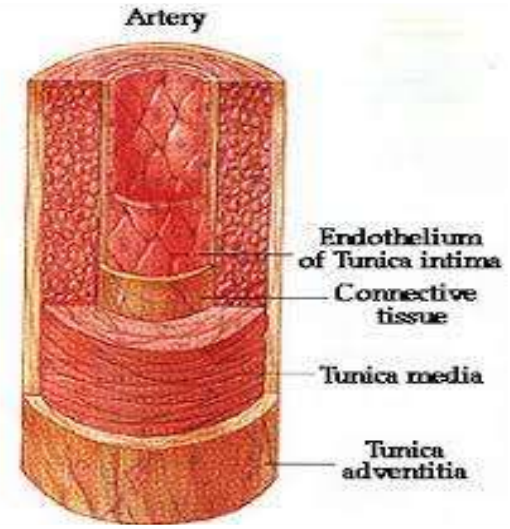

Figure 1.1: Anatomy of the Artery

Capillaries.

The thin capillary wall is made up of endothelial cells, with no elastic or muscle tissue. The exchange of cellular nutrients and meTabletolic end products takes place through these thin-walled vessels. Capillaries connect the arterioles and venules.

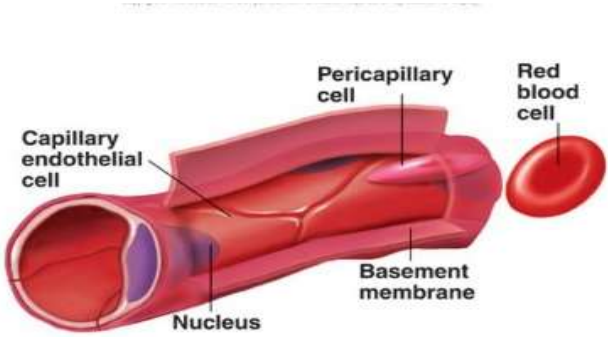

Figure 1.2: Anatomy of the Capillary

Veins and Venules

Veins are large-diameter, thin-walled vessels that return blood to the right atrium. The venous system is a low-pressure, high-volume system. The larger veins contain semilunar valves at intervals to maintain the blood flow toward the heart and to prevent backward flow. The amount of blood in the venous system is affected by a number of factors, including arterial flow, compression of veins by skeletal muscles, alterations in thoracic and abdominal pressures, and right atrial pressure. The largest veins are the superior vena cava, which returns blood to the heart from the head, neck, and arms, and the inferior vena cava, which returns blood to the heart from the lower part of the body. These large-diameter vessels are affected by the pressure in the right side of the heart. Elevated right atrial pressure can cause distended neck veins or liver engorgement as a result of resistance to blood flow. Venules are relatively small vessels made up of a small amount of muscle and connective tissue. Venules collect blood from the capillary beds and channel it to the larger veins (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

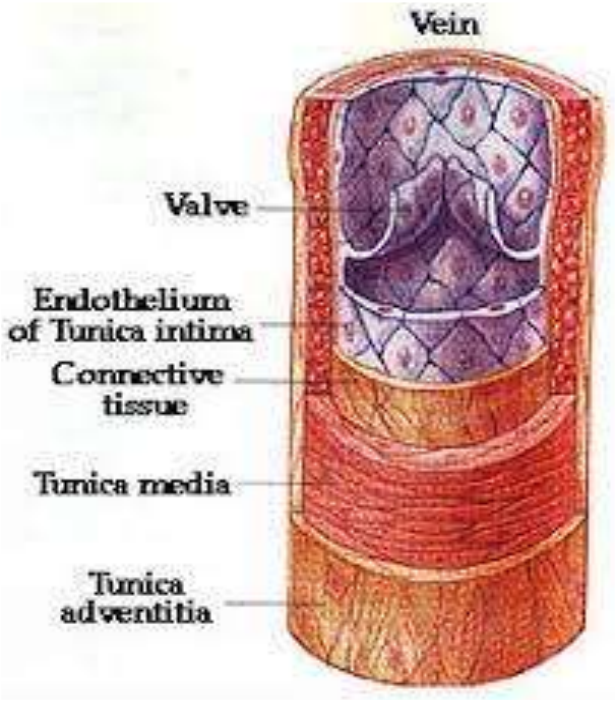

Figure 1.3: Anatomy of the Vein.

Definition of hypertension

Hypertension is defined as a persistent systolic BP (SBP) of 140 mm Hg or more, diastolic BP DBP) of 90 mm Hg or more, or current use of antihypertensive medication (Smeltzer, Bare, Hinkle, & Cheever, 2018).

Hypertension is defined by the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) as a systolic blood pressure greater than 140 mm Hg and a diastolic pressure greater than 90 mm Hg based on the average of two or more accurate blood pressure measurements taken during two or more contacts with a health care provider (Chobanian, Bakris, Blank, & Cushman, 2003).

Prehypertension is defined as SBP of 120 to 139 mm Hg or DBP of 80 to 89 mm Hg (Smeltzer, Bare, Hinkle, & Cheever, 2018).

Incidence of hypertension

About 31% of the adults in the United States have hypertension, and the prevalence increases significantly as people get older or have other cardiovascular risk factors. The prevalence also varies by ethnicity, with African Americans having the highest prevalence at approximately 37% (Smeltzer, Bare, Hinkle, & Cheever, 2018).

Types of hypertension

Hypertension can be classified as either **primary** or **secondary**. Primary Hypertension. Primary (essential or idiopathic) hypertension is elevated BP without an identified cause, and it accounts for 90% to 95% of all cases of hypertension. Primary hypertension is the major focus of this chapter because of its prevalence and impact on health. Although the exact cause of primary hypertension is unknown. However, there are several contributing or risks factors as follows (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

1. **Age:** systolic blood pressure rises progressively with increasing age.
2. **Alcohol:** Excessive alcohol intake is strongly associated with hypertension.
3. **Tobacco use:** smoking tobacco greatly increases risks of cardiovascular disease since it contains nicotinic substances that increases vasoconstriction.
4. **Obesity:** weight gain increases the risks for the accumulation of atheroma (fats) inside blood vessels which does increases blood pressure accordingly.
5. **Gender:** Hypertension is more prevalent in men in young adulthood and early at middle age (<55 years of age). After age 64, hypertension is more prevalent in women.

6. **Excessive dietary sodium intake:** Increasing excessive intake of sodium increases the risks for hypertension since sodium absorbs water from interstitial space into vascular compartment thus, increasing blood pressure leading to hypertension.
7. **Family history:** History of a close blood relative (parents or siblings) with hypertension is associated with an increase risks for developing hypertension since it runs through blood.
8. **Diabetes mellitus:** Hypertension is more common in patients with diabetes
9. **Sedentary lifestyle:** Regular physical activity can help control weight and reduce cardiovascular risks.
10. **Elevated serum lipids:** Increase levels of cholesterol and triglycerides are primary risks factors in atherosclerosis. Hyperlipidemia is more in people with hypertension
11. **Race (ethnicity):** Incidence of hypertension is two times higher in African Americans than in whites (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

Secondary Hypertension

Secondary hypertension is elevated BP with a specific cause that often can be identified and corrected. This type of hypertension accounts for 5% to 10% of hypertension in adults. Secondary hypertension should be suspected in people who suddenly develop high BP, especially if it is severe. Clinical findings that suggest secondary hypertension relate to the underlying cause. For example, an abdominal bruit heard over the renal arteries may indicate renal disease. Treatment of secondary hypertension is aimed at removing or treating the underlying cause. Secondary hypertension is a contributing factor to hypertensive crisis (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

Causes of secondary hypertension (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

- Endocrine disorder
- Drug-related
- Coarctation or congenital narrowing of the aorta
- Neurologic disorders
- Pregnancy-induced hypertension
- Renal disease
- Liver cirrhosis
- Diabetes mellitus

Other forms of hypertension

Hypertensive emergency: a situation in which blood pressure is severely elevated and there is evidence of actual or probable target organ damage.

Hypertensive urgency: a situation in which blood pressure is severely elevated but there is no evidence of target organ damage.

Isolated systolic hypertension: a condition mostly commonly seen in the elderly in which the systolic pressure is greater than 140 mm Hg and the diastolic pressure is within normal limits (less than 90 mm Hg).

Rebound hypertension: blood pressure that is controlled with medication and that becomes uncontrolled (abnormally high) with the abrupt discontinuation of medication.

Malignant hypertension: It is a severe form of hypertension. Malignant hypertension progresses rapidly and results in necrosis of the small arteries of the heart, kidneys, brain and eyes (target organ). Dysfunction of the organ ensues and without medical treatment the course of malignant

hypertension is rapidly fatal. Most persons do not survive longer than two years. This condition is seen most often in black men under the age of 40. Patient may experience headache, seizures, papilloedema and retinal haemorrhage (Smeltzer, Bare, Hinkle, & Cheever, 2018).

Pathophysiology of Hypertension

Blood pressure is the product of cardiac output multiplied by peripheral resistance. Cardiac output is the product of the heart rate multiplied by the stroke volume. In normal circulation, pressure is transferred from the heart muscle to the blood each time the heart contracts, and then pressure is exerted by the blood as it flows through the blood vessels. 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. For hypertension to occur there must be a change in one or more factors affecting peripheral resistance or cardiac output (Smeltzer, Bare, Hinkle, & Cheever, 2018). For instance: in renal ischemia due to renal disease like nephritis, stenosis of renal artery or polycystic disease, the kidneys release the enzyme renin. In the blood stream renin acts upon a plasma protein to produce angiotensin I. The angiotensin I is then converted to angiotensin II, by another enzyme called angiotensin converting enzyme. The angiotensin II (a potent vasoconstrictor) causes widespread peripheral resistance. This leads to elevation of blood pressure. The angiotensin II also increases the secretion of aldosterone by the adrenal cortex leading to sodium and water retention. As a result, there is increase in cardiac output leading to increasing blood pressure (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

STAGES OF HYPERTENSION (Lewis, Dirksen, Heitkemper, & Bucher, 2018)**.**

Stage 1 (Mild):

I. Systolic pressure: from 140 mmHg to 159 mmHg

II. Diastolic pressure: 90 mmHg to 99mmHg.

Stage 2 (Moderate):

I. Systolic pressure: from 160 mmHg to 179 mmHg

II. Diastolic pressure: 100 mmHg to 109mmHg.

Stage 3 (Severe):

I. Systolic pressure: from 180 mmHg to 209 mmHg

II. Diastolic pressure: 110 mmHg to 119mmHg.

Stage 4 (hypertensive crisis):

I. Systolic pressure: from 210 mmHg or more

II. Diastolic pressure: 120 mmHg or more

Clinical manifestations of hypertension

1. Headache
2. Palpitations
3. Fatigue
4. Angina
5. Dyspnoea
6. Nausea
7. Confusion

8. Lightheadedness
9. Vertigo
10. Blurred vision (Dizziness)
11. Convulsion
12. Transient blindness
13. Stupor
14. Coma (Smeltzer, Bare, Hinkle, & Cheever, 2018).

Diagnostic Investigations

- Health history and physical examination
- **Full blood count** to detect the amount of RBC, WBC, HB
- **Urinalysis** to detect an amount proteins, pus, glucose, bacteria and blood presents in urine.
- **Blood chemistry to** detect levels of blood K+ , Na+, creatinine, urea and high density lipoprotein (HDL)
- **Elevation of blood urea, nitrogen and creatinine levels** is suggestive of renal damage.
- **Electrocardiography (ECG)** to detect cardiac dysfunction or cardiac conduction system.
- **Chest x ray (** To show cardiomegaly)
- **Echocardiography** (to detect left ventricular hypertrophy)
- **Fastening blood sugar (FBS)** to determine blood glucose level (Smeltzer, Bare, Hinkle, & Cheever, 2018).

Nursing managements of hypertension

Psychological Care.

1. Explain all procedures to patients in other to get relieved of anxiety.

1. Reassure patient of competent nursing care.

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

4. Allow patient to express fears and anxiety

5. Allow patient to ask question about her condition.

Observation and monitoring

1. Monitor patient's vital signs especially, blood pressure every 4 hourly and temperature, pulse and respiration regularly.
2. Observe patient for occipital headache and dizziness.
3. Observe patient for complications of hypertension such as stroke and the rupture of retina vessels.
4. Patient's blood pressure is checked regularly as ordered by the physician to know the progress of treatment given to the patient.

5. Patient's mental status is assessed to know whether the patient is oriented to time, place and person.

6. The fluid intake and output is monitored and recorded in the fluid intake and output chart to know whether there is a balance in electrolytes and to assess renal function.

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

8. Intravenous fluids are also monitored to ensure that they are flowing at the prescribed rate.

9. The site of the intravenous line is also observed for any swelling, patency and also fluid overload is assessed for, to reduce stress on the heart.

10. Observes patients heart rate, rhythm at apical and peripherals to assess pulse in other to determine the effects on the heart and blood vessels.

Nutrition

1. The patient is educated to reduce the intake of alcohol consumed.

2. Patient is encourage to reduce dietary intake of sodium to less than 100mmol per day (2.4g sodium or 6g sodium chloride).

3. The Patient is encouraged to eat at least 4-5 fruits and vegeTabletles

4. Patient is encouraged to avoid the habit of smoking.

4. Limit eating canned foods and other processed foods.

5. Patient is also advised to read the labels on processed foods and avoid those that are high in sodium.

Patient Education

1. Educate patient and family on patient's condition by assessing their level of knowledge on his condition and build upon what they know.

2. Teach them on the causes/predisposing factors, treatment and prevention.

3. Patient is also educated on lifestyle modification. Thus, reducing alcohol intake, cease smoking and reduce intake of dietary saturated fat and cholesterol.

4. Teach patient to check the blood pressure regularly if only he has the equipment at home and record the reading at least twice weekly in a journal for review by the doctor at every appointment.

5. Educate him on his diet and encourage him to take in low salt, low fat as well as low cholesterol diet.

6. Educate patient on the need to exercise daily and the need for follow up.

7. Stress the importance and the need for patient to adhere to medications prescribed and educate him on the side and therapeutic effects of her medications.

8. Advise him and also emphasize the need for him to avoid strenuous activities.

9. Patient is educated on the need to comply with the lifelong chemotherapy because his condition is a chronic one.

10. Lose weight if overweight.

11. Maintain adequate intake of dietary calcium and magnesium for general health

Protection from injury

1. The Patient should be placed in a comfortable position in a low bed with bedrails mounted.

2. Bed rails should be raised to prevent patient from falling.

3. All sharps should be removed away from the patient in order not to cause harm to the patient.

4. All overgrown fingernails and toenails should be trimmed shortly to avoid the starching of her body.

Pharmacological management of hypertension

1 Thiazide Diuretics (Indapamide, hydrochlorothiazide, Chlorthalidone): Helps in decreasing blood volume, renal blood flow and cardiac output.

2. Loop Diuretics (furosemide, bumetamide, torsemide): Helps in the reabsorption of sodium chloride and water in kidney depleting volume fluid volume through urine.

3. Potassium- sparing diuretics (amiloride, triamterene): Helps in blocking sodium reabsorption by acting on the distal tubule.

4. Aldosterone Receptors Blockers (Spironolactone): competitive inhibitors of aldosterone binding.

5. Beta Blockers (Atenolol, propranolol, nadolol, timolol): Helps in blocking the sympathetic nervous system.

6. Alpha- Blockers (Doxazosin, prazosin hydrochloride): It acts directly on blood vessels by dilating them similar to hydralazine.

7. Angiotensin-Converting Enzyme Inhibitors (Captopril, enalapril, benazepril): It inhibits the conversion of angiotensin I to angiotensin II and also helps in lowering total peripherals resistance.

8. Angiotensin II Receptors Blockers (Losartan, Valsartan): Blocks the effects of angiotensin II at the receptors and also helps in reducing peripherals resistance.

9. Calcium Channels Blockers (Amlodipine, felodipine, isradipin, nicardipine, nifedipine, nisoldipine):

i. It inhibits calcium ion influx across membrane.

ii. It also has a vasodilation effects on coronary arteries and peripherals arteriole.

iii. It helps in decreasing cardiac load and energy consumption.

10. Vasodilators (Hydralazine): It helps in acting directly on smooth muscles of blood vessels to decrease peripherals resistance by dilatation of blood vessels (Lewis, Dirksen, Heitkemper, & Bucher, 2018).

Complications of hypertension

1. Left ventricular hypertrophy
2. Myocardial infarction
3. Heart failure
4. Cerebrovascular accident (CVA, stroke, or brain attack)
5. Renal insufficiency and failure
6. Retinal hemorrhage

7. Ischemic Heart Disease (Smeltzer, Bare, Hinkle, & Cheever, 2018).

1.12 Validation of Data

Validation is the extent to which a measure, indicator, or a method of data collection possesses the quality of being sound or true as far as it can be judged (Weller, 2018). During my home visits, the information received from Madam K.J and the relative such as, the location, number of rooms of the house and the type of materials made of the building were true. Also, some clinical manifestations exhibited by Madam K.J were found in textbooks, internet, journals etc. Finally, some laboratory investigations carried out on Madam K.J as well as, some of her pharmacological management were truly found in literature review such as; textbooks, internet etc. Based on the facts highlighted concerning the data collected from Madam K.J, this renders my care study valid.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

Analysis of data is the process of systematically applying statistical or logical techniques to describe and illustrate, condense and recap, and evaluate data (Weller, 2018). It is the second phase of the nursing process. Analysis of data helps the health care worker to compare the data extracted from patient to that of the standard.

2.1 Comparison of Data with Standards.

The following data will be compared with standards;

1. Diagnostic tests or investigation
2. Causes or risks factors
3. Clinical manifestations
4. Treatment
5. Complications

2.1.1 Diagnostics Tests or Investigations

Test/ investigations refers to an examination or analysis of the composition of a substance by the use of chemical reagents, and/or to determine the presence or absence of a substance (Weller, 2018).

The following diagnostic tests were carried on Madam K.J,

1. Full Blood Count (FBC): To detect the level of white blood cells (WBC), red blood cells (RBC), Haemoglobin (HGB) present in Madam K.J's blood.

2. Malaria Test: To detect the presence of malaria parasites present in the blood.

3. Urinalysis: To help detect the amount of blood, glucose, protein, pus and bacteria present in urine.

4. Random Blood Sugar (RBS) was checked and recorded as; 5.9 mmol/l: To help detect the amount of glucose present in madam K. J's blood.

Table 1: Comparison of Diagnostic Tests carried on Madam K.J with Standards.

Diagnostic Investigations in the literature review	**Diagnostic Investigations carried on Madam K.J**

1. Health history and physical examination	1. Health history and physical examination was conducted on Madam K.J.
2. Full blood count to detect the amount of RBC, WBC, HB present in blood.	2. Full blood count was investigated on Madam K.J.
3. Urinalysis to detect an amount proteins, pus, glucose, bacteria and blood presents in urine.	3. Urinalysis was tested on Madam K.J
4. Blood chemistry to detect levels of blood K+, Na+, creatinine, urea and high density lipoprotein (HDL).	4. Blood chemistry was not done on Madam K.J.
5. Electrocardiography (ECG) to detect cardiac dysfunction or cardiac conduction system.	5. Electrocardiography was not conducted on Madam K.J.
6.Chest x ray to detect cardiomegaly	6. Chest x ray was not conducted on Madam K.J.
7. Echocardiography (to detect left ventricular hypertrophy).	7. Echocardiography was not done to Madam K.J.
8. Random blood sugar (FBS) to determine blood glucose level.	9. Random blood sugar was done to Madam K.J.

With references to the Tabletle above 1.0 blood chemistry, Echocardiography, chest cardiomegaly, electrocardiography was not conducted on Madam K.J simply because diagnoses were arrived and confirmed by, health history and physical examination, Urinalysis, full blood count and random blood sugar

Table 2: Diagnostic Investigations/Tests conducted on Madam K.J Compared with Standards.

Date	Specimen	Investigation	Results	Normal Values	Interpretation	Remarks
2/12/22	Blood	Random blood sugar	7.9mmol/L	5.6mmol/L-11.1mmol/L	Madam K.J is not diabetic.	No treatment was given since the RBS was within normal range.
		Malaria	Negative	Negative	Madam K.J is not having malaria.	No treatment was given was Madam K.J**.**
		White blood cell count	9.3x10^3/^y	(4.5x10^9-11.0x10^9	White blood cell is within normal range.	No treatment was given was Madam K.J.
		Red blood cell count	4.01x10^6/^4	Females: 4.1 x1012/L-5.1 x1012/L	Red blood cell is within normal range	No treatment was given.
		Haemoglobin level estimation	12.7g/dL	12.3 g/dL -15.3g/dL	The Haemoglobin is within normal range.	No treatment given since level was within normal range.

Diagnostic Investigations/Tests conducted on Madam K.J Compared with Standards Continues

Date	Specimen	Appearance	Clear	Clear	Urine appears clearer	No treatment was given was Madam K.J.
2/12/22	Urine	Colour	Amber	Amber	Urine was amber in colour	No treatment was given was Madam K.J.
		Leucocyte	Negative	Negative	No leucocyte present	No treatment was given was Madam K.J.
		Urobilinogen	0.7	0.5-1	Was within normal range	No treatment was given was Madam K.J.
		Nitrate	Negative	Negative	No nitrate present	No treatment was given was Madam K.J.
		Protein	Negative	Negative	Protein was absent	No treatment was given was Madam K.J.

		PH	7.0	4.5-8.0	PH was within normal range	No treatment was given was Madam K.J.
		Blood	Negative	Negative	Blood was absent	No treatment given
		Bilirubin	Negative	Negative	Bilirubin was absent	No treatment given
		Specific gravity	1.005	1.005-1.025	Was within normal range	No treatment given
		Ketones	Negative	Negative	Ketones was absent	No treatment given

2.1.2 Causes or Risks Factors

The main cause of hypertension is unknown. However, there are some risks factors contributing to the cause of hypertension stated in the literature review as stated earlier. Upon a detailed interaction and physical examination on Madam K.J, her cause of the disease process is as a result of sedentary lifestyle, old age and the intake of fatty foods.

2.1.3 Clinical Manifestations

Table 3 clinical manifestations exhibited by Madam K.J compared to standards.

CLINICAL MANIFESTATIONS STATED IN LITERATURE REVIEW	CLINICAL MANIFESTATIONS EXHIBITED BY MADAM K.J.
1. Occipital headache	1. Madam K.J experience headache
2. Blood pressure above 140/90	2. Madam K.J's blood pressure was 150/90
3. Palpitations	3. Madam K.J did not experience palpitations.
4. Fatigue	4. Madam K.J experience fatigue
5. Angina	5. Madam K.J did not experience angina
6. Dyspnoea	6. The patient experiences dyspnoea
7. Nausea	7. The patient did not experience nausea
8. Confusion	8. Madam K.J did not experience confusion
8. Lightheadedness	8. The patient experiences lightheadedness

9. Vertigo	9. There was vertigo
10. Convulsion	10. There was no convulsion
11. Transient blindness	11. Madam K.J did not experience transient blindness
12. Stupor	12. Madam K.J experienced no stupor
13. Coma	13. Madam K.J experienced no coma

With reference to the table above, patient presented most of the clinical manifestations as stated in the literature review.

2.1.4 Treatments Given to Madam K.J.

The following treatments were used in the management of Madam K.J.

1. Intramuscular (IM) Diaclofenac Start (st)
2. Tablet Amlodipine 5mg daily x 60days
3. Tablet Atenolol 50mg daily x 60 days
4. Losartan Tablet 50mg, 1 Tablet, daily
5. Tablet Paracetamol 1g tds x 7 days
6. Suppositories Diaclofenac 100mg daily 5/7
7. Syrup Simple Linctus 15mls tds x 7 days
8. Syrup Lactulose 10mls bd x 5 days

Table 4: treatments given to Madam K.J compared to literature review.

TREATMENTS OUTLINED IN LITERATURE REVIEW	TREATMENTS PRESCRIBED TO MADAM K.J
1. Diuretics (furosemide, bumetamide, torsemide).	Diuretics was not prescribed to Madam K.J.
2. Calcium Channels Blockers (Amlodipine, felodipine, nicardipine, nifedipine).	Tablet Amlodipine 5mg daily x 60 days was administered.
3. Beta Blockers (Atenolol, propranolol, nadolol, timolol).	Tablet Atenolol 50 mg daily x 60 days was administered.
4. Angiotensin II Receptors Blockers (Losartan, Valsartan).	Angiotensin II Receptors Blockers was not prescribed to Madam K.J.
5. Angiotensin-Converting Enzyme Inhibitors (Captopril, enalapril, benazepril).	Angiotensin-Converting Enzyme Inhibitors was not prescribed to the patient .
6. Vasodilators (Hydralazine)	Vasodilators was not prescribed to Madam K.J.
7. Alpha- Blockers (Doxazosin, prazosin hydrochloride):	Alpha- Blockers was not prescribed to Madam K.J.
1. Aldosterone Receptors Blockers (Spironolactone)	Aldosterone Receptors Blockers was not prescribed to Madam K.J.

Aside Tablet Amlodipine 5mg daily x 60 days and Tablet Atenolol 50mg daily x 60 days that was administered as an antihypertensive medication, the following medications were also prescribed and administered as a supportive treatment to get Madam K.J. relieved of her symptons.

Intramuscular (IM) Diaclofenac as a Start (ST) dose.

Tablet Paracetamol 1g Tid x 7

Suppositories Diaclofenac 100mg 5/7.

Syrup Simple Linctus 15mls x 7 days

Syrup Lactulose 10mls bd x 5 days.

Table 5: Pharmacology Of Drugs Administered To Madam K.J

Date	**Name of drug**	**Classification of drug.**	**Standard(Literature) Dosage and Route of Administration**	**Dosage and route of administration for Madam K.J.**	**Desired effect**	**Actual effect of the drug observed.**	**Side effects and remarks**
1/12/22	Tablet Amlodipine	Antihypertensive (Calcium Channels Blockers).	Dosage-5 to a maximum dose 10mg once per day. Route- Orally.	Dosage- 5mg daily x 60 days. Route- Orally	i. It inhibits calcium ion influx across membrane. ii. It also has a vasodilation effects on coronary arteries and peripherals arteriole. iii. It helps in decreasing cardiac load and energy consumption.	Madam K.J. blood pressure reduced from 150/90mmHg to 140/80mm	Headache, nausea, fatigue, dizziness, and abdominal pains No side effect was encountered

Table 5: Pharmacology Of Drugs Administered To Madam K.J Continued

Date	**Name of drug**	**Classification of drug.**	**Standard(Literature) Dosage and Route of Administration**	**Dosage and route of administration for Madam K.J.**	**Desired effect**	**Actual effect of the drug observed.**	**Side effects and remarks.**
2/12/22	Tablet Atenolol	Antihypertensive Beta Blockers	Dosage- 25mg to a maximum dose of 100mg once daily	Dosage- 50mg daily x 60 days, Route- Orally	Helps in blocking the sympathetic nervous system.	Madam K.J's blood pressure reduced from 150/90 to 140/80 mmHg	Indigestion, dizziness, dry mouth, confusion, Madam K.J experienced no side effects

Table 5: Pharmacology Of Drugs Administered To Madam K.J Continued

Date	**Name of drug**	**Classification of drug.**	**Standard(Literature) Dosage and Route of Administration**	**Dosage and route of administration for Madam K.J.**	**Desired effect**	**Actual effect of the drug observed**	**Side effects and remarks.**
3/12/22	Tablet Paracetamol (Acetaminophen)	Analgesics and Antipyretic effects.	Dosage- 325mg to a maximum dose of 4mg daily that is qid when the needs emerges. Route- Orally, rectal, Intravenous	Dosage-Tablet Paracetamol 1g Tid x 7 Route- Orally	Helps in the reduction of pain thresh hold and also helps in temperature reduction.	Madam K.J had a reduction of pain and slightly reduction of temperature.	Skin rashes, dizziness, urticarial, nephrotoxicity, Hepatotoxicity when there is an over dose of drug. Patient experienced no side effects.

Table 5: Pharmacology Of Drugs Administered To Madam K.J Continued

Date	**Name of drug**	**Classification of drug.**	**Standard (Literature) Dosage and Route of Administration.**	**Dosage and route of administration for Madam K.J.**	**Desired effect**	**Actual effect of the drug observed.**	**Side effects And remarks.**
4/12/22	Intramuscular (IM) Diclofenac Start (ST)	Non-steroidal anti-inflammatory drugs (NSAIDs)	Dosage 100-150 mg/day in divided doses 50 mg twice a day or three times a day, or 75 mg twice a day.	Dosage- 75 mg starts Route- Intramuscular(I.M)	Indicated for management of mild- to- moderate pain and moderate- to- severe pain.	Patient had a reduction of pain.	Headache, nausea, pruritus, diarrhea, constipation, dizziness. No side effects observed.

Table 5: Pharmacology Of Drugs Administered To Madam K.J Continued

Date	**Name of drug**	**Classification of drug.**	**Standard (Literature) Dosage and Route of Administration**	**Dosage and route of administration for Madam K.J.**	**Desired effect**	**Actual effect of the drug observed.**	**Side effects and remarks.**
5/12/22	Suppositories Diaclofenac	Non-steroidal anti-inflammatory drugs (NSAIDs)	100mg up to a maximum dosage of 150 mg bd	Dosage-100mg was administered Route-Rectum	Indicated to relieve pain, swelling(inflammation) and joint stiffness	Patient's general body pains and weakness was relieved	Headache, loss of appetite, constipation, dizziness. No side effects observed.

Table 5: Pharmacology Of Drugs Administered To Madam K.J Continued

Date	**Name of drug**	**Classification of drug.**	**Standard (Literature) Dosage and Route of Administration**	**Dosage and route of administration for Madam K.J.**	**Desired effect**	**Actual effect of the drug observed.**	**Side effects and remarks.**
6/12/22	Syrup Simple Linctus	Expectorant	Dosage- 15mls qid x 7 days	Dosage- 15mls of syrup Simple Linctus x 7 days was administered Route- Orally.	To release patient from cough	Madam K.J's cough subsided	Nausea, vomiting, diarrhoea. None of these were observed by Madam K.J

Table 5: Pharmacology Of Drugs Administered To Madam K.J Continued

Date	**Name of drug**	**Classification of drug.**	**Standard (Literature) Dosage and Route of Administration**	**Dosage and route of administration for Madam K.J.**	**Desired effect**	**Actual effect of the drug observed.**	**Side effects and remarks.**
7/12/22	Syrup Lactulose	Stool Softener	10mls to a maximum dose of 30mls when necessary	10ml b.d x 5 days Route- Orally	Helps in the emptying the bowels with ease.	Patient was able to pass out stools without straining	Anal irritation, flatulence, abdominal cramps and belching. Madam K.J exhibited no side effect to the drug.

2.1.5 Complications Developed On Admission

Complication is an extra medical problem that makes it more difficult to treat an existing illness (Walter E. , 2017). Madam K.J developed no complications on admission to the above under listed complications stated in the literature review. This was because she was admitted on time.

2.2 Patient and Family's Strength

Strength refers to the ability to do things that need lot of physical or mental effort (Walter E. , 2017). The following strengths were observed in patient and family during their period of hospitalization.

1. Madam K.J was able to show the exact location of her pain on (1/12/22).
2. Madam K.J was able to tolerate some simple daily activities such as mouth care, feeding with an assistant on (1/12/22).
3. Madam K.J's cough subsided when placed in the semi-fowlers position on (2/12/22).
4. Madam K.J and her family was able to identify at most a risk factor and a symptom of hypertension on (3/12/22).
5. Madam K.J was able to sleep for 3 hours at night and 1 hours at the day time on (4/12/22).
6. Madam K.J could empty less amount of faeces with straining on (4/12/22)

2.3 Patient's and Family Health Problems

Problem is a situation, person, or thing that needs to be dealt with or solved (Walter E. , 2017).

1. During Madam K.J. experienced headache on (1/12/22).
2. On admission (1/22/22), Madam K.J could not perform daily activities.
3. Madam K.J experienced coughing on (2/12/22).

4. Madam K.J and her family had insufficient knowledge on her medical condition on (2/12/22).
5. On ((3/12/22), Madam K.J experienced difficulty in sleeping.
6. Madam K.J could not empty her bowels freely on (3/12/22)

2.4 Nursing Diagnosis.

Diagnosis is a judgment about what a particular illness or problem is, made after examining it (Walter E. , 2017).

1. 1/12/22, acute pain (headache) related to increased vascular pressure.
2. 1/12/22, activity intolerance related to general body weakness.
3. 2/12/22, altered body comfort (cough) related to irritation of the airway.
4. 3/12/22, knowledge deficit related to complexity of treatment.
5. 3/12/22, altered sleeping pattern (insomnia) related to coughing.
6. 4/12/22, alteration in bowel movement (constipation) related to inadequate intake of fiber diet and fluid.

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2018). Planning is the third phase in the nursing process which involves a deliberative and a systematic process which involves decision making and solving patient's health problem.

3.1 Objectives/outcome criteria for Patient/Family Care.

Objective refers to something that you plan to do or achieve (Walter E. , 2017).

1. Madam K.J will be relieved of headache within 24 hours as an evidenced by;

a. Patient verbalizing she has been relieved of pain.

b. The nurse recording patient's pain level of 0 using numerical rating scale.

2. Madam K.J will be able to perform activities of daily living within 72 hours as an evidenced by;

a. Patient verbalizing she is able to do daily activities such as; bathing, mouth care alone.

b. The nurse observes patient performing daily activities of living without any assistant.

3. Madam K.J will be relieved of cough within 24 hours as evidenced by;

a. Patient verbalizing she has been relieved of cough.

b. The nurse observing patient has experiences no cough.

4. Madam K.J and her family will have sufficient knowledge on hypertension throughout their period of hospitalization as evidenced by;

a. Patient and the family enumerating at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension.

b. The nurse observing patient and family utilizing the knowledge gained on hypertension into practice and answering questions posed to them on hypertension.

5. Madam K.J'S disturb sleeping pattern will be restored within 24 hours as evidenced by;

a. Patient verbalizing she had a good sleep last night.

b. The nurse observing patient had a maximum sleep of 6 hours.

6. Madam K.J will get relieved of constipation within 48 hours as an evidenced by;

a. Patient verbalizing she has been relieved of difficulty passing stools.

b. The nurse observing patient passes stools twice daily without straining.

Table 6: Nursing Care Plan for Madam K.J and the Family.

Date and Time	Nursing Diagnosis	Objective and Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
1/12/22 at 2:00 pm	Acute pain (headache) related to increased vascular pressure.	Madam K.J will be relieved of headache within 24 hours as evidenced by; a. Patient verbalizing she has been relieved of pain. b. The nurse recording patient's pain level of 0 using numerical rating scale.	1. Reassure patient of competent nursing care that her pain will get relief sooner. 2. Assess patient's pain level using numeric rating scale from (0-10). 3. Monitor and check patient's vital signs regularly especially blood pressure every 30 minutes for 1 hour,	1. Madam K.J was reassured of competent nursing care. 2. Madam K.J's pain level was assess using numerical rating scale and the value was 2. 3. Patient's vital signs especially blood pressure was checked and monitored every 30 minutes for 1 hour,	2/12/22 at 2:00pm	Goal fully met as an evidenced by patient verbalizing she has been relieved of pain and nurse recording patient's pain level of 0 using numerical rating scale.	A.J

			4. Put patient into a comfortable position that relieves her pain. 5. Employ Diversional therapies such as; watching television and interacting with patient to reduce stress. 6. Ensure adequate bed rest for patient to induce maximum sleep. 7. Administer prescribed analgesics.	4. Patient was kept into a comfortable position (semi fowlers) that relieves her pain. 5. Diversional therapies such as; watching television and interacting with patient was done. 6. Adequate bed rest was ensured to induce maximum sleep. 7. Prescribed analgesics such as; Paracetamol 1 gram tds x 7 and Suppositories Diclofenac 100mg daily was rightly administered and documented.			

Table 6: Nursing Care Plan for Madam K.J and the Family Continued

Date and Time	Nursing Diagnosis	Objective and Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
1/12/22 at 2:30 pm	Activity intolerance related to general body weakness**.**	Madam K.J will be able to perform activities of daily living within 72 hours as evidenced by; a. Patient verbalizing she is able to do daily activities such as; bathing, mouth care without assistance. b. The nurse observes patient performing daily activities of living without any assistant.	1. Reassure patient and family that measures will be put in place to help patient perform activity of daily living. 2. Assess patient's level of physical activity and mobility. 3. Assist patient to increase activity with active range of motion exercises in bed, increasing to sitting and standing.	1. Madam K.J and the family was reassured of measures that will be kept in place to enable her perform daily activities. 2. Patient's level of physical activity and mobility was assessed. 3. Active range of motion exercise such as; sitting and standing was assisted in bed.	4/12/22 at 2:30pm	Goal fully met as an evidenced by; patient verbalizing she has been relieved of activity intolerance and nurse observing patient performing daily activities of living such as; mouth care, feeding and bathing without any assistant.	A.J

			4. Check and record patients vital signs every 4 hourly. 5. Assist patient with activity of daily living such as; bed bathing, mouth care, feeding. 6. Teach patient on energy conservation techniques such as; sitting when performing tasks, pushing rather than pulling and sliding rather than lifting.	4. Madam K.J's vital signs was checked and recorded. 5. Madam K.J was assisted with daily activities such as; bed bath, mouth care, feeding etc. 6. Madam K.J was taught on energy conservation techniques such as; pushing rather than pulling, sliding rather than lifting and sitting whilst performing tasks.			

Table 6: Nursing Care Plan for Madam K.J and the Family Continued

Date and Time	Nursing Diagnosis	Objective and Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
2/12/22 At 7:30am	Altered body comfort (cough) related to irritation of the airway.	Madam K.J will be able to clear the airway within 24 hours as evidenced by; a. Patient verbalizing she has been relieved of cough. b. The nurse observing patient has experiences no cough.	1. Put patient into a semi-fowlers position and encourage patient to perform deep breathing exercise and coughing exercise to help expand the lungs in a well-ventilated area. 2. Assess patients respiratory pattern including; the rate, rhythms and the depth to assess for respiratory distress. 3. Suction patient to remove mucus in the airway. 4. Encourage patient to cover the mouth when coughing to help	1. Madam K.J was kept in the semi- fowler's position to help expand the lungs to aid in easy breathing. 2. Patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress. 3. Patient was suctioned. 4. Patient was educated on covering the mouth when coughing to help	3/12/22 At 7:30am	Goal partially met as evidenced by patient verbalizing she stills coughs and nurse observing patient coughing intermittently.	A.J

			reduce the spread of infections. 5. Encourage patient on the intake of copious fluids to help liquefy mucus for easy expectoration. 6. Administer prescribed expectorants.	reduced the spread of infections. 5. Patient was encouraged to take in adequate fluids. 6. Prescribed Syrup Simple Linctus 15mls tds was rightly administered and documented.			

Table 6: Nursing Care Plan for Madam K.J and the Family Continued

Date and Time	Nursing Diagnosis	Objective and Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
3/12/22 At 2:10 pm	Knowledge deficit related to complexity of treatment.	Madam K.J and her family will have sufficient knowledge on hypertension throughout their period of hospitalization as evidenced by; a. Patient and the family been able to enumerate at least 5 predisposing factors, 5 clinical manifestations and 6 dietary managements to hypertension. b. The nurse observing patient and family utilizing the knowledge gained on hypertension into practice and answering questions on hypertension.	1. Provide noise free environment for the education and ask patient the language she understands. 2. Explain all procedures to patient to gain her attention and cooperation. 3. Assess Madam K.J's knowledge concerning the diagnosis, risks factors, clinical manifestations and the management for hypertension. 4. Explain to patient and family the risks	1. Noise free environment on the education of hypertension was ensured using language patient understand. 2. All procedures were clearly explained to patient and her family. 3. Patient and family's knowledge concerning the diagnosis, risks factors and clinical manifestations on hypertension was assessed. 4. The risks factors, clinical manifestations and management of	5/12/22 At 2:10pm	Goals fully met as an evidenced by; patient and the family been able to enumerate at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension and nurse observing patient and family utilizing the knowledge gained on hypertension into practice and answering	A.J

			factors, clinical manifestations and the management of hypertension 5. Encourage patient and family to ask questions to clarify any misconceptions about hypertension. 6. Allow patient and family to verbalize knowledge gained on hypertension. 7. Answer patient and family's questions in a simple and clear language tactfully	hypertension was explained to patient and the family. 5. Patient and her family were encouraged to ask questions in other to clarify any misconceptions with regards to hypertension. 6. Madam K.J and her family tried answering a lot of questions that were asked on hypertension. 7. A clear language was used in answering Madam K.J and her family tactfully.		questions on hypertension.	

Table 6: Nursing Care Plan for Madam K.J and the Family Continued

Date and Time	Nursing Diagnosis	Objective and Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
3/12/22 At 6:35 am	Altered sleeping pattern (insomnia) related to coughing.	Madam K.J'S disturb sleeping pattern will be restored within 24 hours as an evidenced by; a. Patient verbalizing she had a good sleep last night. b. The nurse observing patient had a maximum sleep of 2 hours at day time and 6 hours at night time.	1. Put patient into a semi-fowlers position to expand lungs for easily breathing. 2. Educate patient on deep breathing and coughing exercises. 3. Keep away noxious and irritational substances away from patient. 4. Educate patient to cover the mouth with a clean handkerchief when coughing. 5. Encourage patient on the need to take in adequate fluid to loosen mucus.	1. Patient was put in a semi-fowlers position to expand lungs for easily breathing. 2. Patient was educated on deep breathing and cough exercises. 3. Noxious and irritational substances was kept away from patient's environment. 4. Patient was educated to cover the mouth whenever coughing. 5. Patient was encouraged to take in adequate fluids to help loosen mucus.	4/12/22 At 6:35am	Goals fully met as an evidenced by patient verbalizing she had a good sleep last night and nurse observing patient had a maximum sleep of 2 hours at day time and 6 hours at night time.	A.J

			6. Suction patient. 7. Administer prescribed expectorant. 8. Give warm bath. 9. Serve warm beverages like milo. 10. Administer prescribed sedatives	6. Patient was suctioned. 7. Prescribed expectorant Simple Syrup Linctus 15mls tds was administered. 8. Patient was given warm bath. 9. Patient was served with warm beverage like milo. 10. Prescribed sedatives were administered.			

Table 6: Nursing Care Plan for Madam K.J and the Family Continued

Date and Time	Nursing Diagnosis	Objective and Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/12/22 2:43 pm	Alteration in bowel movement (constipation) related to inadequate intake of fiber diet and fluid.	Madam K.J will get relieved of constipation within 48 hours as evidenced by; a. Patient verbalizing she has been relieved of difficulty emptying her bowels. b. The nurse observing patient passing stools twice daily without straining	1. Serve patient with a balanced diet containing adequate fiber, fresh fruits, vegeTabletles and grains. 2. Encourage patient adequate intake of fluids. 3. Assist patient to perform passive exercise in bed. 4. Educate patient to empty her bowls regularly to avoid postponing faeces. 5. Provide privacy for patient when emptying her bowls. 6. Administer prescribed syrup Lactulose.	1. A well balanced diet containing adequate fiber, fresh fruits, vegeTabletles and grains were served. 2. Patient was educated on the need to take in adequate fluids. 3. Patient was assisted to perform passive exercise in bed. 4. Madam K.J was encouraged to empty her bowl regularly in other to avoid postponing faeces. 5. Privacy was ensured so as patient could feel the edge to empty her bowls freely. 6. Prescribed Syrup Lactulose was rightly administered.	5/12/22 2:43pm	Goals fully met as an evidenced by; patient verbalizing she has been relieved of difficulty emptying her bowels and nurse observing patient passes stools twice daily without straining.	A.J

Table 6: Nursing Care Plan for Madam K.J and the Family Continued

Date and Time	Nursing Diagnosis	Objective and Outcome Criteria	Nursing Orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/12/22 6:30am	Altered body comfort (cough) related to irritation of the airway.	Madam K.J will be able to clear the airway within 24 hours as evidenced by; a. Patient verbalizing she has been relieved of cough. b. The nurse observing patient experiences no cough.	1. Put patient into a semi-fowlers position to expand lungs for easily breathing. 2. Educate patient on deep breathing and coughing exercise. 3. Assess patients respiratory pattern including; the rate, rhythms and the depth to assess for respiratory distress. 4. Educate patient to cover the mouth with a clean handkerchief when coughing. 5. Encourage patient on the need to take in adequate fluid to loosen mucus.	1. Patient was put in a semi-fowlers position to expand lungs for easily breathing. 2. Patient was educated on deep breathing and cough exercises. 3. Patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress. 4. Patient was educated to cover the mouth with a clean handkerchief when coughing.	5/12/22 6:30am	Goal fully met as evidenced by patient verbalizing she had been relieved of cough totally and nurse observing patient experiences no cough.	A.J

			6. Suction Patient to remove mucus from the airway. 7. Ensure adequate bed rest for patient. 8. Serve patient with a well-balanced diet. 9. Educate patients relative to wash patient's handkerchief and dry under sun to reduce microorganisms present. 10. Administer prescribed expectorant.	5. Patient was encouraged to take in a adequate fluid to loosen mucus. 6. Patient was suctioned. 7. Adequate bed rest was ensured. 8. A well-balanced diet was served. 9. Patient's relative was educated to wash patient's handkerchief and dried under sun in other to reduce the number of microorganisms. 10. Prescribed Syrup Simple Linctus 15mls tds was administered.			

CHAPTER FOUR

IMPLEMENTATION OF NURSING CARE PLAN

4.0 Introduction

Implementation refers to the act of putting a plan into action or starting to use something (Walter E. , 2017). The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, other members of the nursing team, and other members of the health care team, so that the schedule of activities facilitates the patient's recovery (Smeltzer, Bare, Hinkle, & Cheever, 2018). This chapter gives a vivid account of the nursing care that was rendered to the patient/family from the day of admission until discharge based on the health problems identified. It also deals with follow up visits/home visits to ensure continuity of care.

4.1 Summary of Actual Nursing Care Rendered to Patient and the Family.

4.1.1 First Day of Admission: 1st December, 2022

Patient was admitted into the females ward through the Out Patient Department (OPD) at Seventh Day Adventist (SDA) Hospital accompanied by a staff nurse, two student nurses and a relative in ambulatory and conscious state on 1st December, 2022. At 1:30pm with the diagnosis hypertension. Patients complains were; occipital headache, generalized body weakness and dizziness. I welcomed patient and the relative and they were reassured of competent nursing care. I made a cross-check to confirm whether patients was truly admitted into the females ward with the said diagnosis. Patient full name was mentioned to ensure she was the right person. An admission bed was prepared to make patient comfortable in bed. I made a brief introduction of myself and staffs to patient and the relative. Patient's details such as, name, sex, age, address, diagnosis, occupation etc. were entered

into the admission and discharge (A&D) book as well as, the daily ward state. Patient's admission notes was documented. Patient's vital signs checked and recorded at 1:30 pm were;

Temperature 36.6^0C degree celcious

Pulse 67 beats per minute (bpm)

Respiration 20 cycles per minutes (cpm)

Blood pressure 160/90 millimeters of mercury (mmHg)

Patient and her relative was introduced to other patients. Patient's relative was oriented to the ward and its annexes such as; the nurse's station, the kitchen, wash room etc. Patient's relative was educated on visiting hours, mode of settlement of medical bills according to the hospital's protocol. Initial physical assessment was conducted on patient from head to toe and no abnormalities were seen. Patient was oriented to time, place and persons. Patient's relative was encouraged to bring food to patient but was cautioned to avoid food such as ; meat, margarine, oily foods and also her personal items such as; clothing, mosquito net, bowl, toilet roll, spoon, plastic, items for mouth care etc.

Madam K.J was to be managed under the following medications;

Intramuscular (IM) Diaclofenac Start (st)

Tablet Amlodipine 5mg daily x 60 days

Tabblet Atenolol 50mg daily x 60 days

Tablet Paracetamol 1g Tid x 7 days

Suppositories Diaclofenac 100 daily 5/7

The following Laboratory Investigations were ordered;

Full Blood Count (FBC), Radom Blood Sugar (RBC), White Blood Cell (WBC), Haemoglobin HGB etc.

Malaria Test

Urinalysis (Urine R/E).

Random Blood Sugar (RBS) was checked and recorded as; 5.9 mmol/l. Intramuscular Diaclofenac 75mg, Tablet Atenolol 50 mg daily and Tablet Amlodipine 5mg daily was administered. Patient was changed into new clothing, reassured of competency nursing care and made more comfortable in bed by ensuring the bed is free from creases and cramps. Relatives were entreated to participate in the health care delivery in order to achieve patient's early recovery. I also made them aware hospitalization will be a temporal home for them. Hence, there will be a need for the continuation of care after discharge especially, with regards to her nutrition, lifestyle and pharmacological managements. I introduced myself to patient and her relative that, I am a final year student nurse of Holy Family Nursing and Midwifery Training College Berekum who wished to use them for my care study in which a report will be written after the study. I explained to them that, the care study is a requirement by Nursing and Midwifery Council (NMC) before Diploma Certificate will be awarded. They were assured of confidentiality. I ended by saying, they can withdraw from the study whenever they wished to do so. Patient and her relative were glad to hear and consented to my request and I thanked them. I quickly informed the ward in charge at the female ward that, I would like to use madam K.J for my care study and she gave me the go- ahead to startI decided to take madam K.J for my study in other to educate them more about hypertension since it is known as a silent killer.

At 2:00 pm, a nursing diagnosis of acute pain (headache) related to increase in vascular pressure was made. This was due to Madam K.J's complains of headache. An objective was set to help relieved her of headache within 24 hours. The following nursing interventions were implemented; patient was reassured of competent nursing care to relief pain, Patient level of pain was assessed using numerical rating scale of 0-10. Madam K.J scored 7 on the scale denoting her pain intensity. Patient was put in a comfortable position of choice that relieves her pain. Vital signs especially, blood pressure was checked and recorded for every 30 minutes for 1 hour,. Diversional therapy such as; watching television was employed. This was purposefully done to divert patient's attention from stress. Adequate bed rest was ensured to help reduced Madam K.J's blood pressure. Prescribed analgesics and antihypertensive medications such as; Tablet Atenolol 50mg daily, Tablet Amlodipine 5mg daily and Tablet Paracetamol 1gram tds and Suppositories Diclofenac 100mg daily were rightly administered and documented as 2:00 pm medications. At 2: 30pm, I realized that, patient could not perform any daily activities by herself. Quickly, a nursing diagnosis of activity intolerance related to general body weakness was made. A goal was set to relieved Madam K.J from activity intolerance within 72 hours. I implemented the following nursing interventions; Madam K.J and her family members were reassured that measures will be kept in place to help patient perform activities of daily living by self. Patient's level of physical activities and mobility were assessed. Range of motion exercise in bed were performed to enable Madam K.J sit and perform some activities in bed by herself. Vital signs were checked and recorded every 4 hourly. Madam K.J was assisted in mouth care, feeding and bed bath. At 5:00 pm, patient's vital signs especially, blood pressure were checked and documented as follows;

Temperature 36.3^0C degree celcious

Pulse 78 beats per minute

Respiration 21 cycles per minutes

Blood Pressure 140/84mmHg

At 5:30 pm, patient was assisted to eat rice and kontomire stew as her supper, after which warm water was sent to the bath room for patient bath. Vital signs were checked and recorded as;

Temperature 35.8^0C degree celcious

Pulse 67 beat per minutes

Respiration 19 cycle per minutes

Blood pressure 130/80 mmHg

At 6:00 pm, patient's prescribed medications such as; Tablet Paracetamol 1gram was administered and well documented. I monitored the side effects of medications administered until we handed over to the night staffs at 8:00 pm. Patient's 10:00pm vital signs were checked and recorded as shown in the appendix. I bid them a bye and left.

4.1.2 Second Day of Admission: 2nd December,2022.

Madam K.J woke up from bed at 6:00 am on the second day of admission. I greeted Madam K.J and she responded. I asked about her health and she replied saying, her headache had subsided. Patient's side lockers were cleaned and I changed her bed linen and prepared a comfortable bed for her. Throughout our interaction, patient had several episodes of cough. According to patient, the cough started at dawn. She was encouraged to cover her mouth whenever she is coughing.

Patient's vital signs checked and documented at 6:00am are as follows

Temperature 36.0^0C degree celcious

Pulse 74 beats per minute

Respiration 17 cycles per minutes

Blood Pressure 140/80 mmHg

Patient was assisted in mouth care after which she took in porridge as her breakfast. At 6:30am, a nursing diagnose of altered body comfort (Cough) related to irritation of the air way was formulated. An objective was set to relieve Madam K.J from cough within 24 hours. The following nursing interventions were carried out; Madam K.J was kept in the semi- fowler's position to help expand the lungs to aid in easy breathing, patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress, Patient was suctioned, patient was educated to cover the mouth whenever coughing to help reduced the spread of infections to others. Madam K.J was also encouraged to take in adequate fluids to help moisten and loosen mucus. Ward rounds started at 8:20 am where patient was reviewed by Dr. E. After the review, Madam K.J's treatments were ordered to be continued and Syrup Simple Linctus 15mls tds x 7 was prescribed. At 10:00 am, patient vital signs was checked and recorded as;

Temperature 36.5^0C

Pulse 70 beats per minutes

Respiration 20 cycles per minute

Blood pressure 130/70mmHg

Patients due medications such as Tablet Atenolol 50mg daily, Tablet Amlodipine 5mg daily and Tablet Paracetamol 1gram tds were administered and documented at 10:00am.

On 2nd December,2022 at 7:30am an evaluation of the objective set on 1st December,2022 to relieved patient from headache within 24 hours was done and goal fully met as patient verbalizing she has been relieved of pain and nurse recording patient's pain level of 0 using numerical rating scale. At 12:45 pm, Madam K.J was assisted to take rice ball and palm nut soup as her launch.

At 2:00 pm, Madam K.J's vital signs especially blood pressure were checked as shown in the appendix. At 2:48 pm, I realised that the management of hypertension does not based on only drugs but lifestyle and dietary modifications also play a major role in the management. Hence, I decided there will be a need to make an enquiry from patient and the family if they have sufficient knowledge concerning the risks factors, clinical manifestations and the prevention of hypertension. According to patient and the relative, all what they know concerning hypertension is moderate intake of salt in patient's diet. At 2:10 pm, a nursing diagnose of knowledge deficit related to complexity of treatment was made. An objective to increase their knowledge on the condition throughout their period of hospitalization. The following nursing interventions were implemented; noise free environment was ensured. All procedures were clearly explained to patient and her family. Patient and family's knowledge concerning the diagnosis, risks factors and clinical manifestations on hypertension was assessed. Education was given on the causes, risks factors and management. Patient and her family were encouraged to ask questions in other to clarify any misconceptions with regards to hypertension. Madam K.J and her family tried answering a lot of questions that were asked on hypertension. A clear language was used in answering Madam K.J and her family tactfully. At 4:25pm patient went to the wash room to empty her bowls after which she took a bath. Madam K.J took in rice and cabbage stew as her supper at 5:15pm. At 6:00 pm,

patient's vital signs was checked and recorded as shown in the appendix. Tablet Paracetamol 1gram tds and Syrup Simple Linctus 15mls were administered and documented. Patient 10:00pm vital signs were checked and recorded as follows:

Temperature 36.8^0C degree celcious

Pulse 69 beat per minutes

Respiration 20 cycle per minutes

Blood pressure 130/80 mmHg

4.1.3 Third Day of Admission: 3rd December,2022.

On the third day of admission, I met Madam K.J already awaken in bed at 6:20am. I greeted and asked about her health. She replied by saying, she was not able to sleep well last night due to the cough she experienced. Patient was able to perform mouth care without assistant. Patient's vital signs at 6:20am were checked and documented as;

Temperature 36.5^0C

Pulse 82 beat per minute

Respiration 22 cycles per minute

Blood Pressure 110/70 mmHg

Madam K.J took in porridge and koose as her breakfast.

On 3rd December,2022 at 7:30am an evaluation of the objective set on 2nd December,2022 to relieved Madam K.J from cough within 24 hours was made and goal partially met as evidenced by patient verbalizing she still coughs and nurse observing patient coughing intermittently.

A nursing diagnosis of altered sleeping pattern related to cough was formulated. At 6:35am, a goal was set to relieved Madam K.J from difficulty in sleeping within 24hours. The following nursing interventions were carried out; patient was put in a semi-fowlers position to expand lungs for easily breathing, patient was educated on deep breathing and cough exercises, noxious and irritational substances were kept away from patient's environment, Patient was educated to cover the mouth whenever coughing. Patient was encouraged to take in adequate fluids to help loosen mucus. Also, patient was suctioned and prescribed expectorant Simple Syrup Linctus 15mls tds was administered.

My first home visit was made on 3rd December,2022 whiles patient was on admission. The visit was made to Fiapre in the Bono Region a suburban of Sunyani in the Sunyani district West. The journey commenced at 7:40am after I bored a taxi at Seventh Day Adventist Hospital Junction-Sunyani and arrived at Fiapre junction at 7:48am. The patient daughter warmly welcomed me and I was offered a seat. The main reason for my visit was to identify if there is any contributing factor to Madam K.J's disease and also to verify as to whether the information received from patient and the relative were indeed valid. The patient daughter took me around all the four corners of the house and later sent me into patient's room. The following observations were made; the house is in two apartment.

Daily ward rounds begun at 8:15am and patient's treatment were ordered to be continued. At 10:00am, Madam K.J's vital signs were checked and documented as shown in the appendix.

Patients due medications such as were administered and documented. Patient's vital signs at 2:00pm were checked and documented as:

Temperature 36.2^0C degree celcious

Pulse 70 beat per minutes

Respiration 21 cycle per minutes

Blood pressure 120/80 mmHg

At 2:17pm, Madam K.J reported to me that, she has visited the toilet twice since morning but she always strains with difficulty before passing small amount of stools. Syrup Lactulose 10mls bd x 5 days was prescribed for patient. At 2:43 pm, a nursing diagnosis of alteration in bowel movement (constipation) related to inadequate intake of fiber and fluid was formulated. An objective was set within 48 hours to help patient relieved of constipation. The following nursing interventions were carried out. A well balanced diet containing adequate fiber, fresh fruits, vegetables and grains were served. Patient was educated on the need to take in adequate fluids. Patient was assisted to perform passive exercise in bed. Madam K.J was encouraged to empty her bowl regularly. Prescribed Syrup Lactulose 10mls bd x 5 days was administered and documented at 2:30pm. At 5:13 pm, patient took her bath after which she ate fufu and light soup as supper. At 6:00 pm, patient's vital signs were checked and documented as shown in the appendix. Prescribed medications such as; Syrup Simple Linctus 15mls tds x 5 days and Tablet Paracetamol I gram tds x 7 days were administered and documented at 6:00pm. Patient 10:00pm vital signs were checked and recorded as shown in the appendix.

4.1.4 Fourth Day of Admission: 4th December 2022.

On the fourth day of admission, patient woke up from bed at 6:00am. I greeted patient and she responded. I asked about her health and she replied by saying, she slept well. Patient perform mouth care on her own without any assistant after taken her bath. I cleaned Madam K.J's bed side lockers

with an antiseptic solution and changed her bed linen after which I prepared a comfortable bed. Patient vital signs at 6:00 am were checked and recorded as follows;

Temperature	36.8^0C
Pulse	80 beat per minute
Respiration	22 cycle per minute
Blood Pressure	136/80 mmHg

On 4th December, 2022 at 6:35am, an evaluation of the objective set on 3rd December,2022 to relieved Madam K.J from difficulty in sleeping was evaluated and goals fully met as evidenced by patient verbalizing she had a good sleep last night and nurse observing patient had a maximum sleep of 2 hours at day time and 6 hours at night time.

At 7:19 am, patient took her bath after which she took in rice porridge with little sugar. At 8:20 am, Madam K.J was reviewed and her treatments were asked to continue. After the review, Madam K.J made an enquiry from me that, when will she be discharged? According to patient, she does not know how the condition will end with her. This is because, the disease condition has been with her for several years yet still no solution. At 8:33 am, a nursing diagnose of anxiety related to an unknown outcome of medical condition was made. A goal was set within 12 hours to relieved patient and family from anxiety. The following nursing interventions were carried out successfully. Madam K.J and her family were reassured of competent nursing care in other to relieve them from fears causing anxiety. Patient's level of anxiety was assessed to help plan appropriate nursing interventions. Madam K.J and her family were educated on the risks factors, clinical manifestations and managements to hypertension. All nursing procedures and interventions were explained to Madam K.J and her family to help gained their cooperation. Patient was encouraged to verbalize

her fears and feelings and clear and simple language was used. Madam K.J and her family were oriented to the ward, equipment and daily routine at ward in other to reduce their level of anxiety.

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

Prescribed medications such as Tablet Amlodipine 5mg daily and Tablet Paracetamol 1gram were administered and documented at 10:00am.

On 1st December,2022 at 2:30am an evaluation of the objective set on 3rd December,2022 to relieved patient from activity intolerance within 72 hours was done and goal fully met as evidenced by; patient verbalizing can perform activities on her own and nurse observing patient performing daily activities of living such as; mouth care, feeding and bathing without any assistant. At 1:45pm, Madam K.J took in Tuozaafi with oyoyo soup. At 2:00 pm, patient's vital signs were checked and documented as shown in the appendix.

Prescribed medications such as Tablet Amlodipine 5mg daily and Tablet Paracetamol 1gram were administered and documented at 2:00pm. At 5:13 pm, patient took her bath after which she ate rice and stew as her supper. At 6:00 pm, patient's vital signs were checked and documented as shown in the appendix as well as 10:00 pm vital signs.

Prescribed medications such as Tablet Amlodipine 5mg daily and Tablet Paracetamol 1gram were administered and documented at 6:00pm.

On the same day (3rd December, 2022) at 8:33pm, an evaluation of the objective set on 3rd December, 2022to relieved Madam K.J and the family from anxiety was evaluated and goals fully met as evidenced by; patient and family verbalizing they are feeling less anxious and nurse observing patient and family had good facial expression and freely communicating with other patients.

4.1.5 Fifth Day of Admission/ Day of Discharge: 5th December, 2022.

On this very day of admission, Madam K.J woke up at 6:35 am and performed her own personal hygiene such as, mouth care and bathing. I greeted patient and asked about her health. Madam K.J responded to my greetings and said, she is fit today without any new alarming complains. Madam K.J's vital signs checked and documented at 6:00am were;

Temperature 36.2^0C

Pulse 83 beats per minutes

Respiration 18 cycles per minute

Blood pressure 130/80 mmHg

Patient ate all the porridge and koose that was bought. At 8:30 am, patient was reviewed and no new health complaints were raised by both patient the relative. The reviewed Doctor explained to patient and her relative that, they may have a possible discharge after 2:00 pm when there are no new complains and when her vitals especially, blood pressure is within normal range.

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

All prescribed medications were administered and documented at 10:00am. Patient and her family were educated on the need to continue proper personal hygiene and proper environmental sanitation as well. Patient was educated to sleep under treated insecticide mosquito net so as to prevent the occurrence of malaria. Madam K.J was educated on the need to avoid alcohol intake, take low sodium diet, avoidance of saturated fatty diets, embarking on reviews, reporting to the health facility whenever symptoms emerges, avoidance of over the counter medications, reduction of stress, involvement in passive exercise and reduction of weight to prevent obesity. Patient and her family

were also educated on the need to follow the drugs prescribed. Patient and the family were also educated on the side effects of the medications. Madam K.J was educated on the negative effects of defaulting medications since she is already on same medications. Patient and her family were encouraged to renew their National Health Insurance Scheme card whenever it expires since it helps in the reduction of medical bills. At 2:00 pm, patient's vital signs were checked and documented as;

Temperature 36.0^0C

Pulse 80 beat per minute

Respiration 20 cycle per minute

Blood Pressure 120/84 mmHg

On the day of discharge 5th December, 2022 at 2:10pm, an evaluation of the objective set on 2nd December,2022 to increase Madam K.J and the family's knowledge on hypertension throughout their period of hospitalization was evaluated and goals fully met as patient and the family were able to enumerate at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension and nurse observing patient and family utilizing the knowledge gained on hypertension into practice and answering questions on hypertension correctly.

At 2:30pm, the Doctor returned to the ward and re-confirms patient's discharge since, there were no other complains and her vital signs especially, blood pressure was within the normal range as expected. Madam K.J and her family were informed about their discharge. I sent patient's folder to the account office for medical settlement of bills accompanied by patient's relative. All the needed details on the receipt were documented correctly and the receipt was then returned to patient and her relative.

4.2 Preparation of Patient and Family for Discharge/Rehabilitation

Preparation of patient/family for discharge started from the day of admission when I informed Madam K.J and her family that the hospital was not going to be her permanent living environment for them but they will be discharged home soon. On 5th December, 2022 at 2:30 pm, patient and relative were informed about their discharge. I explained to patient and the relative that, there will be the need for continue treatments and subsequent follow ups. I informed them about the review date which was on 14th December 2022. Since medical bills have already been settled earlier on, I helped in parking patient's and her family belongings. Patient and her family were educated on the risks factors, clinical manifestations and the management of hypertension. Patient and her family were once again educated on the need to continue proper personal hygiene and proper environmental sanitation as well. Patient was educated to sleep under treated insecticide mosquito net so as to prevent the occurrence of malaria. Madam K.J was educated on the need to avoid smoking, alcohol intake, low sodium in diet, avoidance of saturated fatty diets, embarking on reviews, reporting to the health facility whenever symptoms emerges, avoidance of over the counter medications, reduction of stress, involvement in passive exercise and reduction of weight to prevent obesity. Patient and her family were also educated on how to take her medications at home. Patient and the family were also educated on the side effects of the medications. Madam K.J was educated on the negative effects of defaulting medications since she is already on same medications.

On 5th December,2022 at 2:43pm, an evaluation of the objective set on 2nd December,2022 to relieved Madam K.J from difficulty in emptying her bowels was evaluated and goals fully met as patient verbalizing she has been relieved of difficulty emptying her bowels and nurse observing patient passes stools twice daily without straining.

Patient and her family were encouraged to renew their National Health Insurance Scheme card whenever it expires since it helps in the reduction of medical bills. The date for the review, was re-echoed to patient and her relative. Patient's bed side lockers were disinfected and her bed was cabolized. This was performed to reduce the risks of transferring infection from one patient to the other. Patient's date of discharge was entered into the admission and the discharge book as well as the daily ward state. I intentionally quizzed patient and her relative on the date for the review as well as questions concerning the managements of hypertension. Madam K.J and her family did their best by answering most of the questions that were posed to them. I congratulated them for their effort. Madam K.J and her family gave their appreciation to the entire staffs for the holistic rendered to them. I accompanied patient and her relative to the hospital entrance at 3:17pm. I stopped a taxi and they bored after which I returned to the ward.

4.3 Follow Up/Home Visits/Continuity of Care

Home visit is defined as providing the services to family at their door step to maintain the health and to reduce mortality and morbidity in family (Tuitui & Suwal, 2017). It requires technical skills, resourcefulness, good judgement and relationships between a health care worker and patient and the family.

A home visit is one of the essential parts of the community health services because most of the people are found in the home. Home visits fulfils the needs of individuals, family and community in general for nursing service and health counselling. A home visit is considered as the backbone of community health service. A home visit is a family-nurse contact which allows the health worker to assess the home and family situation in other to provide the necessary nursing care and a health-related activities (Tuitui & Suwal, 2017).

4.3.1 First Home Visit (5/12/2022).

My first home visit was made on 3rd December,2022 whiles patient was on admission. The visit was made to Fiapre in the Bono Region a suburban of Sunyani in the Sunyani district West. The journey commenced at 7:40am after I bored a taxi at Seventh Day Adventist Hospital Junction-Sunyani and arrived at Fiapre junction at 7:48am. I called patient's daughter when I alighted and she took me to the house. The patient daughter warmly welcomed me and I was offered a seat. The main reason for my visit was to identify if there is any contributing factor to Madam K.J's disease and also to verify as to whether the information received from patient and the relative were indeed valid. The patient daughter took me around all the four corners of the house and later sent me into patient's room. The following observations were made; the house is in two apartment. One apartment has 6 rooms and the other one has 5 rooms. The front view for both lane is painted violet and the lateral view painted with yellow. The house is roofed with aluminium sheets. The compound was neat. The house has one kitchen, two bath rooms and two toilet facilities which were neat. The house has a good electrical connection system and their source of water was from the bore-hole. I educated her that, the water should either be purified by the addition of chlorine or boiled before domestic usage. There was a waste bin which was not covered with a lid. Hence, I educated him on the need to always cover the bin in other to prevent the spread of infections. I asked for the room where patient lives and her daughter sent me over there. Upon entering, it was identified that, patient was not using insecticide mosquito net. I educated her daughter to tie mosquito net for the mother to prevent the occurrence of malaria. Furthermore, her windows were covered with rubbers hence the ventilation within the surrounding was poor. Therefore, I educated him to always remove the rubber so as to promote good ventilation in the room. Again, I saw a little boy with a wound on the right lower limb. Therefore, I educated the mother to send the child to the nearest health care centre

for treatment in other to help heal the wound. Also, a nursing mother was asked to always embark on anti-natal care for regular check-ups. I made an enquiry from the son concerning her mother's nutritional lifestyle. According to the son, since patient is the one who does her own cooking, she eats whatever she likes. He said, patient mostly uses canned foods, eggs and meat when cooking and mostly eats at night. I explained to the daughter that, since she is the one who does her own cooking, then there will be the need to educate her directly when I come home next time. I thank her daughter for her cooperation and left the house at 10:30am.

4.3.2 Second Home Visits (9th December, 2022).

My second home visit was embarked on 9th December, 2022 that was two days after patient was discharged. The purpose for this visit was to assess patient's health status and also offer more education to patient on her condition. I arrived at patient's house at 8:45am. Madam K.J and her family was very glad to see me. They offered me a seat and warmly welcomed me once again. I asked about her health and she replied saying, since the day of discharge she has not encountered any health complaints again. I carried along with me the following equipments, blood pressure apparatus and thermometer. Truly, she was clinically stable as an evidenced of her vital signs recording;

Temperature	36.5^0C
Pulse	75 beats per minutes
Respiration	18 cycles per minutes
Blood Pressure	120/70 mmHg

I inspected patient's antihypertensive medications and realised that, she was taking them as prescribed. I congratulated patient to continue to take her medications without defaulting. Patient and her family were given the following education; avoidance of fatty foods like meat, eggs, canned foods such as; sardine, corner beef, margarine etc. Patient was also educated to use soya beans oil and sunflower oil when cooking, minimizing sodium intake, reduction of stress to have adequate rest, involving herself in passive exercises, avoidance of alcohol and smoking, taking her medications as prescribed, attending to medical reviews regularly and reporting to the hospital whenever experiencing any symptoms that are unusual. Madam K.J was also educated to sleep under treated insecticide mosquito net and remove rubbers covered on her windows to promote adequate and good ventilation.

4.3.3 Day of Review/ Follow up (14th December,2022).

On the review date, patient was met at the hospital entrance. Patient was sent to the Outpatient department where her vital signs were checked and recorded as;

Temperature	36.2^0C
Pulse	73 beats per minutes
Respiration	17 cycles per minutes
Blood Pressure	120/80 mmHg

Patient was accompanied to the consulting room and reviewed by Dr. E. On review patient gave no complaints. She was advised on the need to take medications as prescribed without defaulting and encouraged patient to report to the hospital whenever she was not feeling well and avoid the usage

of over the counter drugs. After the review, I escorted patient to the hospital entrance where she bored a taxi and left.

4.3.4 Third Home Visit (17th Decemer,2022).

On 17th December, 2022 I embarked on my last home visit in other to terminate the care. I reached patient's house at 10:15am. The entire family were much exited to see me once again. I carried along with me the following vital signs equipment, blood pressure apparatus and thermometer. I checked her vital signs and the readings were as follows;

Temperature	36.3^0C
Pulse	75 beats per minutes
Respiration	19 cycles per minutes
Blood Pressure	130/80 mmHg

Since there was no nearest healthcare facility around, I humbly handed Madam K.J to a Registered General Nurse whose house was nearer to patient's own to offer an assistant to patient whenever the needs arrives. I educated Madam K.J on the need to take her medications as prescribed even though she was taking them accordingly when I inspected. Patient's daughter was encouraged to monitor her mother's medications so as she will not default. The entire family especially Madam K.J, was educated to report to the hospital whenever experiencing any symptoms that are unusual. Also, the entire family were educated on the need to stop the usage of over the counter drugs. All the education given to patient on the day of admission were restated and clearly defined to the entire family since that day was the day of terminating my care with them. I finally terminated my care with them and thanked the entire family especially, Madam K.J for their cooperation throughout

the entire study. They looked a bit sad when they heard the termination of care with them. But I encouraged them by saying, my time to the School is due therefore I have to go and continue with my studies in other to learn more to render holistic care to others whenever the needs emerge. Within a movement, the entire family put on a smiling facial expression and also expressed their profound gratitude to me for been with them from day one till now. Madam K.J encouraged me to study harder and continue to remain in my humble state. I thanked her and the entire family and left the house at 1:40pm.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

Evaluation refers the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Smeltzer, Bare, Hinkle, & Cheever, 2018). The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient and family.

5.1 Statement of Evaluation

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

Madam K.J was Relieved of Headache within 24 hours. (2nd December, 2022).

On the day of admission (1st December, 2022) at 2:00pm Madam K.J complained of headache. A nursing diagnosis was formulated as, acute pain (headache) related to increase in vascular pressure. An objective was set to relieve patient from headache within 24 hours. The following nursing interventions were carried out to meet the objective set; Madam K.J was reassured of competent nursing care that measures will be kept in place to relieve her from headache, Madam K.J's pain level was assess using numerical rating scale and she chose 7 denoting her pain intensity, patient was kept into a comfortable position that relieves her pain, diversional therapies was employed to reduce Madam K.J from stress. Adequate bed rest was ensured to induce maximum sleep. Prescribed analgesics such as; tablet Paracetamol 1 gram tds was administered and documented.

On 2nd December,2022 at 2:00pm an evaluation of the objective set on 1st December,2022 to relieved patient from headache within 24 hours was done and goal fully met as an evidenced by patient verbalizing she has been relieved of headache and nurse recording patient's pain level of 0 using numerical rating scale.

Madam K.J was able to perform daily activities of living within 72 hours (4th December, 2022).

On the day of admission (1st December, 2022) at 11:30am Madam K.J complained of general body weakness. A nursing diagnosis was formulated as; activity intolerance related to general body weakness. An objective was set to help patient perform activities on her own within 72 hours. The following nursing interventions were carried out to meet the objective set; Madam K.J and the family were reassured of measures that will be put in place to enable her perform daily activities, patient's level of physical activity and mobility was assessed, active range of motion exercise such as; sitting and standing was done, Madam K. J's vital signs was checked and recorded, she was assisted with daily activities such as; bed bath, mouth care, feeding etc. Madam K.J was taught on energy conservation techniques such as; pushing rather than pulling, sliding rather than lifting and sitting whilst performing tasks.

On 4th December, 2022 at 2:30pm an evaluation of the objective set on 1st December,2022 to help patient perform activities on her own within 72 hours was done and goal fully met as patient verbalized she has been able to perform daily activities with ease and nurse observing patient performing daily activities of living such as; mouth care, feeding and bathing without any assistant.

Madam K.J was partially relieved of cough within 24 hours (3rd December, 2022.)

On the second day of admission (2nd December, 2022) at 7:30am, Madam K.J experienced coughing. A nursing diagnosis was formulated as; altered body comfort (cough) related to irritation of the airway. An objective was set to help patient relieved of coughing within 24 hours. The following nursing interventions were carried out to meet the objective set; Madam K.J was put in the semi- fowler's position to help expand the lungs to aid in easy breathing, her respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress, Madam K.J was taught on deep breathing exercise, and was educated on covering the mouth when coughing to help reduced the spread of infections. Patient was encouraged to take in adequate fluids to help loosen mucus, prescribed expectorant was administered such as, Simple Linctus syrup 15mls was administered.

On 3rd December, 2022 at 7:30am, an evaluation of the goal set on 2nd December, 2022 to help patient relieved of cough within 24 hours was made and goal partial met as evidenced by patient still coughing and nurse observing patient having an intermittent cough. Therefore, the nursing care was amended and reinforced for another 24 hours. The following nursing interventions were reinforced and carried out; patient was put in a semi-fowlers position to expand lungs for easily breathing, patient was educated on deep breathing and cough exercises, noxious and irritational substances were kept away from patient's environment, patient was also educated to cover the mouth whenever coughing, patient was encouraged to take in adequate fluids to help loosen mucus, patient was suctioned, prescribed expectorant Simple Syrup Linctus 15mls tds was administered and documented. Patient's relatives were educated to wash and dry patient's handkerchief under sun in other to minimize microorganisms present.

On 4th December, 2022 at 6:30am, the amendment made on 3rd December, 2022 was evaluated and goal fully met as evidenced by; patient verbalizing she has been relieved of cough totally and nurse observing patient experiences no cough.

Madam K.J and the Family gained sufficient knowledge on Hypertension throughout their period of hospitalization (5th December,2022).

On the second day of admission 2nd December, 2022 at 2:00pm upon my constant interaction with patient and the relative, I realised that they lacked sufficient knowledge concerning the risks factors, clinical manifestations and management of hypertension. A nursing diagnose of knowledge deficit related to inadequate information on risks factors, clinical manifestations was formulated to help increase patient and the family's knowledge on hypertension at 2:10pm. The following nursing interventions were carried out to help meet the objective set; noise free environment on the education of hypertension was ensured, all procedures were clearly explained to patient and her family, patient and family's knowledge concerning the diagnosis, risks factors and clinical manifestations on hypertension was assessed, patient and her family were encouraged to ask questions in other to clarify any misconceptions with regards to hypertension, Madam K.J and her family tried answering a lot of questions that were asked on hypertension, a clear and simple language was used in answering Madam K.J and her family tactfully.

On the day of discharge (5/12/2022) at 2:10pm, an evaluation of the objective set on 2nd December, 2022 to help increase patient and the family's knowledge on the risks factors, clinical manifestations and the management of hypertension throughout their period of hospitalization was made and goals fully met as evidenced by patient and the family enumerating at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension and nurse observing patient and

family utilizing the knowledge gained on hypertension into practice and answering questions on hypertension correctly.

Madam K.J's disturbed sleeping pattern was restored within 24 hours (4th December, 2022.)

On the third day of admission 3rd December, 2022 at 6:35am, patient complained of difficulty in sleeping. At 6:35am a nursing diagnosis was formulated as, altered sleeping pattern related to cough. An objective was set within 24 hours to help relieved patient from difficulty in sleeping. The following nursing interventions were carried out to help meet the objective set. Madam K.J was kept in the semi- fowler's position to help expand the lungs to aid in easy breathing, patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress. Also, patient was suctioned. Patient was educated on covering the mouth when coughing to help reduced the spread of infections, patient was encouraged to take in adequate fluids. Prescribed Syrup Simple Linctus 15mls tds was rightly administered and documented.

On 4th December, 2022 at 6:35am, an evaluation of the objective set on 3rd December,2022 to relieved Madam K.J from difficulty in sleeping was evaluated and goals fully met as patient verbalizes she had a good sleep last night and nurse observing patient had a maximum sleep of 2 hours at day time and 6 hours at night time.

Madam K.J was relieved of constipation within 48 hours (5th December, 2022).

On the third day of admission, 3rd December, 2022 at 2:43pm patient gave a complain of straining when emptying bowel. At 2:43pm, a nursing diagnosis was formulated as; alteration in bowel movement (constipation) related to inadequate intake of fiber and fluid. An objective was set to help relieved patient from constipation within 48 hours. The following nursing interventions were carried out to help meet the objective set; a well-balanced diet containing adequate fiber, fresh

fruits, vegetables and grains were served, patient was educated on the need to take in adequate fluids, patient was assisted to perform passive exercise in bed, Madam K.J was encouraged to empty her bowl regularly in other to avoid postponing faeces, privacy was ensured so as patient could feel the edge to empty her bowls freely. Prescribed Syrup Lactulose was rightly administered.

On 5th December, 2022 at 2:43pm, an evaluation of the objective set on 3rd December,2022 to relieved Madam K.J from difficulty in emptying her bowels was evaluated and goals fully met as patient verbalizes she has been relieved of difficulty emptying her bowels and nurse observing patient passes stools twice daily without straining.

5.2 Amendment of Care Rendered to Madam K.J

On 3rd December, 2022 at 7:30am, an evaluation of the goal set on 2nd December,2022 to help patient relieved of cough within 24 hours was made and goal partial met as evidenced by patient verbalizing she still coughs and nurse observing patient having an intermittent cough. Therefore, the nursing care was amended and reinforced for another 24 hours. The following nursing interventions were reinforced and carried out; patient was put in a semi-fowlers position to expand lungs for easily breathing, patient was educated on deep breathing and cough exercises, noxious and irritational substances were kept away from patient's environment, patient was also educated to cover the mouth whenever coughing, patient was encouraged to take in adequate fluids to help loosen mucus, patient was suctioned and prescribed expectorant Simple Syrup Linctus 15mls tds was administered and documented.

On 4th December,2022 at 7:30am, the amendment made on 3rd December,2022 was evaluated and goal fully met as evidenced by; patient verbalizing she has been relieved of cough totally and nurse observing patient experiences no cough.

5.3 Termination of Care

Patient and Family's care ended on the 17th December,2022 which was the very day I embarked on my last home visit. This ended the interaction between the health team and Madam K.J and her family. The preparation for termination of care started on the day of admission through discharge, review to the third home visit. On that day, I educated patient and the family with regards to the risks factors, clinical manifestations, lifestyle and dietary modifications without forgetting the pharmacological managements prescribed for patient. I congratulated the entire family for the care they rendered to Madam K.J in one way or the other. I also expressed my profound gratitude to the entire family especially, Madam K.J for their marvellous co-operation rendered to me throughout the study. Patient was handed over to a Registered General Nurse whose house was nearer to patient's own to offer an assistant to patient whenever the needs arrives. They were informed that, now that Madam K.J's health had been restored, the care for her has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. I informed them of my leaving and looked a bit unhappy. But I encouraged them by saying, my time to the School is due therefore I have to go and continue with my studies in other to learn more to render holistic care to others whenever the needs emerge. Within a movement, the entire family put on a smiling facial expression since they were prepared psychologically from the day of admission till date. I bid them a bye and left the house at 1:40 pm.

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. Conclusion is something that you decide when you have thought about all the information connected with the situation (Weller, 2018).

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

6.1 Summary

Summary is a brief statement of the main points of something (Carol B., Jaime W., Monique B., Susan P.,& Nicole R., 2020).

Patient was admitted into the Females Ward through the Out Patient Department (OPD) at Seventh Day Adventist (SDA) Hospital accompanied by a staff nurse, two student nurses and a relative in ambulatory and conscious state on 1st December, 2022. At 1:30pm with the diagnosis hypertension. Patients complains were; occipital headache, generalized body weakness and dizziness. I welcomed patient and the relative and they were reassured of competent nursing care. Patient was educated on the risks factors, clinical manifestations and both pharmacological and non-pharmacological management of hypertension. Aside the education, Madam K.J were assisted in maintaining good personal hygiene, nutrition and passive exercises. The following medications were used in the management of patient throughout her period of hospitalization;

1. Intramuscular (IM) Diaclofenac Stat (st)

2. Tablet Amlodipine 5mg daily x 60days

3. Tablet Atenolol 50mg daily x 60 days

4. Tablet Paracetamol 1g tdd x 7

5. Suppositories Diaclofenac 100mg daily 5/7

6. Syrup Simple Linctus 15mls tds x 7 days

7. Syrup Lactulose 10 mls bd x days

Patient was discharged on her fifth day of admission on the 5th December, 2022. Patient came for a review on the 14th December,2022. Upon assessment, patient looked very healthy as an evidenced by her vital signs within normal range with no new complaints and she was complying to her medications as prescribed without defaulting. Three home visits were made in this study. The first home visit was made on 3rd December, 2022 whilst patient was on admission, second home visit was made on 9th December, 2022 after patient was discharged home and the third visit was embarked on 17th December, 2022 purposefully to terminate patient's care.

6.2 Conclusion/Recommendation

Conclusion is the final part of something. Recommendation is a suggestion that something is good or suitable for a particular purpose or job (Walter E. , 2017).

The study has equipped me with knowledge on how to care for a patient as an individual. Through this study, have been able to put into practice actual and holistic nursing care as has been learnt theoretically. The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (family) relationship as well as broadened my knowledge on peptic ulcer disease, its prevention, management and treatment. It has also helped me to practice

my skills acquired in the classroom theoretically. It has deepened my relationship with patients, families and the people in a given community as a whole. The study also provided the platform for the patient/family to receive individualized care. Based on the testimonies given by patients who receive individualized nursing at hospitals, it prompts most of the community members to seek medical help at the various hospitals. This helps to redeem the image of the hospital and the staff nurses as a whole. Also this patient/family care study also helps to change the community's wrong perceptions about staff nurses and also improve the people's attendance to the hospital.

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

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APPENDIX

Table 7: Vital Signs for Madam K.J.

Date	Time	Temperature (0^0C)	Pulse (Bpm)	Respiration (Cpm)	Blood Pressure (mmHg)
1/12/22	1:30pm	36.6	67	20	160/90
	5:00am	36.3	78	21	140/84
	5:30pm	35.8	67	19	130/80
	10:00pm	36.1	70	20	136/80
2/12/22	6:00am	36.0	74	17	140/80
	10:00am	36.5	70	20	130/70
	2:00pm	36.1	80	21	120/70
	6:00pm	36.0	74	17	140/80
	10:00pm	36.3	77	19	140/70
3/12/22	6:00am	36.5	82	22	110/70
	10:am	37.0	73	19	130/80
	2:00pm	36.6	78	20	120/80
	6:00pm	36.5	83	21	130/80
	10:00pm	36.4	80	20	130/70
4/12/22	6:00am	36.8	80	22	136/80
	10:00am	37.0	86	25	130/80
	2:00pm	36.2	77	20	130/70
	6:00pm	36.4	81	19	130/80

	10:pm	36.2	80	20	130/70
5/12/22	6:00am	36.2	83	18	130/80
	10:00am	36.0	80	19	130/80
	2:00pm	36.0	80	20	120/84
	2:30pm	36.2	78	19	120/80

SIGNATURIES

The Student Nurse

Name: Adjei Jordan

Signature:.....

Date: 26/06/2023

The Nurse-In-Charge Of The Female's Ward (Suyani-SDA Hospital)

Name: Asante Lawrencia

Signature:.....

Date: 14/07/2023

The Supervisor, Holy Family Nursing And Midwifery Training College, Berekum

Name: Mr. Shadrack Owusu Osei

Signature:.....

Date: 07/07/2023

The Principal, Holy Family Nursing And Midwifery Training College, Berekum

Name: Monica Nkrumah

Signature:.....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM

Date: 17th July, 2023