

**HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM**

**A PATIENT/FAMILY CARE STUDY ON**

**HYPERTENSION**

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

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## PREFACE

The patient/Family care study is a detailed description report of nursing care rendered to a patient and his or family from the day of admission till discharge whereby possible follow-up visits are made to maintain maximum health of the patient and prevent relapse. It gives an indepth description and a vivid explanation of how a patient response to a specified disease condition and the measures taken to resolve it. The patient/Family care study involves a record of nursing care, documenting the problems of the patient and how they are dealt with by the nurse and other multidisciplinary team members.

It provides a systematic way of collecting data, analyzing information and reporting the results of the nursing care. This patient/family care study is based on the concept of holistic care, it uses the knowledge acquired through the nursing process approach.

Nursing process is a systematic way of identifying the client's problems, making plans to solve them, initiating the plans or assigning others to implement it and evaluating the extent to which the plan was effective in resolving the problems identified. Due to confidentiality and respecting patient's rights, client and relatives names will be replaced by abbreviations.

This care study was carried out in partial fulfillment for the award of professional license by the Nursing and Midwifery Council of Ghana. It is an integral part of the curriculum for educating nursing students hence a prerequisite for completing the nursing program. It helps the student nurse transform his or her theoretical knowledge acquired into practice so that the necessary skills and knowledge could be obtained for professional work. This care study was done to acquire more knowledge about hypertension and its outcome to patient and family.

## ACKNOWLEDGEMENT

“To God be the Glory and undoubtedly in his time, he beautifies everything.” First and foremost, I would like to thank the Lord God Almighty for His guidance and protection over me throughout the entire study. This endeavor would not have been possible without the willingness and cooperation of Mrs. A.Z and family, their time and information provided during the amalgamation of this study has been a tremendous one. A heartfelt gratitude to my supervising coordinator, Mrs. Antoinette Effum for her generous support, training, invaluable patience and feedback to mentor and oversee me as I completed this entire journey. Special thanks to the matron, the preceptor, the ward in –charge and the nursing staffs of Female’s Medical Ward of Regional Hospital, Sunyani. Finally I appreciate the effort of my parents Mr. George Oppong and Mrs. Veronica Oppong and my adorable siblings Margaret and Ernest who have supported me in diverse ways throughout my study. I say a big thanks to them. Not forgetting all RGN 24 members and my friends who have supported me in one way or the other throughout the writing of this care study, May God bless them all. Finally I acknowledge and thank all authors and publishers whose work have been used as reference materials in this care study.

## INTRODUCTION

The motive backing care study is to assist the patient to regain his or her health or to nurse him/her to a peaceful death in order to present a unique report of assistance putting into consideration the identified problems interventions and solutions were carried out using the nursing process prospectively.” The special function of a nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery [or to peaceful death] that he would perform unaided if he had the necessary strength, knowledge or will to do so in such a way as to help him regain independence as quickly as possible ‘’[Virginia Henderson,1966.]

Below is a care study report rendered to Miss A.Z, a 50year old woman with the diagnosis of Hypertension. She was admitted to the female’s ward of Regional Hospital, Suyani and stayed in the ward for seven days. Mrs. A.Z was admitted to the ward from Friday, 18thAugust, 2023,to 23<sup>rd</sup> August,2023 when she was discharged. On assessment she presented the following complaints, chest pain, headache, weakness and dizziness. Patient was fully conscious on the day of admission and her condition at the time of discharge was satisfactory. The care rendered to patient/family continued after discharge with home visits and frequent phone communication till nurse-patient /family relationship was terminated finally on 15<sup>th</sup> September, 2023.

This study has been written arranged in six chapters using the systematic approach in the nursing process. Chapter one deals with assessment. This chapter elaborates more about the patient’s particulars, family medical/surgical history, family socio-economic history, patient’s developmental history, patient’s lifestyle and hobbies, patient’s past medical/surgical history, the present medical/surgical history of the patient, admission process of the patient and family, patient/family’s concept of her illness, literature review on hypertension and validation of data.

Chapter two entails comparing the result of the investigation carried out, the causes, clinical manifestations, treatments [pharmacology of drugs] and complications of the patient's condition [hypertension] with standards in the literature review.

Chapter three comprises the planning phase of the nursing process and has the tabulated plan of care for the stated nursing diagnosis including the objectiveness and the outcome criteria, and the nursing orders to meet the objectives set.

Chapter four covers the actual implementation of the care plan. It gives a summary description of activities which were undertaken from the moment of first contact with the patient at the time of admission to the ward till discharge and subsequent review and home visits.

In chapter five, objectives set for patient/family are evaluated and amendment for partially met and unmet goals are stated.

Lastly, chapter six, entails the summary and conclusion that ends this care study report by reviewing thematic issues that arose in the care study from admission to last home visit after discharge as well as recommendation.

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## **CHAPTER ONE**

### **ASSESSMENT OF PATIENT AND FAMILY**

#### **1.0 Introduction**

Assessment is the systematic collection of data to determine the patient's health status and any actual or potential health problems (Cheever & Hinkle, 2014).

Assessment is very important and as the nursing process is concerned it is the first phase of the nursing process. This data is obtained through physical examination of patient, observation and direct interviews of the patient, family and health workers who rendered care to the patient, medical records, laboratory investigations, physical examinations and literature review. The information gathered from patient and family help in the identification of patient/family's problems and the appropriate and recommended nursing intervention rendered to them. The assessment covers patient particulars, family medical/surgical history of the patient, admission process of the patient, patient/family concept of illness, literature review on the condition and validation of data. This data helps in caring for the patient and family, using the nursing process. The data of the patient was obtained through observations, physical examinations, interviewing, investigations such as laboratory examinations, physical examination etc.

#### **1.1 Patient's 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's name, date of birth, age, gender, occupation, hometown, nationality, marital status and the sources of data, (Weller, 2018).

Miss A.Z is a 45year old Christian, born on 4<sup>th</sup> April, 1978 to the late Opanin S.K and L.K.

She is the first child of five children. She is fair in complexion. She is 70kg of body weight

6feet tall. She speaks Twi and Hausa. She is not educated. She currently stays at Adomako Junction. She is a farmer. She is blessed with five kids, three boys and two girls. Mrs A.Z folder number isAAD8601. (Suyani Regional Hospital).

### **1.2 Family's Medical/Surgical History**

Health history is a series of used to provide an overview of the patient's current health status. Attention is focused on the impact of psychosocial, ethnic and cultural background on a person's health. Information is obtained on both paternal and maternal sides of family (Hinkle &Cheever, 2014).

According to Mrs. A.Z there are no genetic diseases like sickle cell, cystic fibrosis, heart disease and communicable disease like hepatitis, tuberculosis and chlamydia in the family except hypertension that is recognized in the family, of which Mrs. A.Z has been diagnosed already, the fourth person to be diagnosed after her mother and her two siblings. She said infrequently some family members experience mild ailments like common cold headache, stomach pains and diarrhea as minor illness which are usually treated at home. Mrs. A.Z source of income is through her profession as a farmer and from her husband. There are no known food allergies or drug allergies.

### **1.3 Socio-Economic History**

Past medical history is a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health (Merriam-Webster, 2022).

Patient and family stay in their own house. She is a farmer. Mrs. A. Z's husband is the breadwinner of the home. She is a very hardworking woman and her husband supports her in her farming. According to the patient, she attends church service on Sundays at the church of Pentecost at Adomako junction. There is cordial relationship between Mrs., A.Z and her family members. Patient gets financial support from her husband who is a mason.

According to the earnings of the family which is 2000cedis per month the family belongs to the middle-income stage.

Patient also said that she does not drink alcohol or smoke. She has no history of the use of cocaine and other hard drugs.

#### **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 components. It is also meaning transformation or improvement (Scott & Marshall, 2015)

Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2016) Maturation is the process of developing (Weller, 2016).

According to Mrs. A.Z, she was delivered per vagina at home by the assistance of Traditional birth attendant without any abnormalities. She was exclusively breastfed and immunized against the six childhood killer diseases now known as vaccine preventable diseases such as poliomyelitis, whooping cough, diphtheria, and measles, as evidenced by the scar at the right deltoid region which indicates that she received the vaccine, Bacillus Calmette Guerin at birth. She went through the developmental stages normally. At the age of five months as told by her mother, she was able to sit, at ten months, she was able to stand, at one year, she was able to walk and then at fifteen months she was able to talk. She stated that she started menstruating at age 14. According to Erick Erickson theory of psychosocial Development (1959), there are eight distinctive changes.

These are;

1. Trust versus Mistrust (birth to 2years)

2. Autonomy versus Shame and Doubt(2 to 3years)
3. Initiative versus Guilt (3 to 5years)
4. Industry versus Inferiority(6 to 11 years)
5. Identity versus Role confusion
6. Intimacy versus Isolation(19 to 40years)
7. Generativity versus Stagnation (40 to 65years)
8. Integrity versus Despair(65 to death)

Patient is 45ears old. She falls within the stage of Generativity Versus stagnation according to the seventh stage of Eric Erickson theory of psychosocial development. Mrs. A.Z has reached Generativity because she shows unconditional love and positive parental love and care towards her children. She also shows love and care towards her husband and family. Patient has made positive impact and has contributed to the development of her family and society by raising children, mentoring others and engaging in meaningful work.

### **1.5 Patient's Obstetric History**

It is the collection of information about a patient's past pregnancy, childbirth and the postpartum period (Cheever &Hinkle, 2014).

Mrs. A.Z had history of six pregnancies. She safely delivered per vagina without any complications. The children are all alive. Mrs. A.Z had no known obstetrical complications including menstrual disorders. She had her menarche at the age of 12. She has not undergone any abortion. She also said she does not use any contraceptive to prevent pregnancy.

### **1.6 Patient's lifestyle /Hobbies**

Lifestyle is the pattern of daily living that an individual develops (Weller, 2018).

Patient is very active and sociable. She wakes up at 5:00 am daily. She empties her bowels two times daily and takes her bath. She brushes her teeth and prepare her six kids for school. She

takes her breakfast after seeing her children off to school. She wakes her kids up and asks them to take their bath and brush their teeth. She serves their breakfast at 7:00am.

At 7:30am, she gets her children ready for school. She starts preparation of supper at 5:30pm after going to the farm. She eats her supper at 6:30 and takes her bath after. Mrs. A.Z loves listening to radio and singing. She goes to sleep when it is about 9:00pm.

### **1.7 Patient's Past Medical History**

Past medical history is a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health (Merriam-Webster, 2022) According to patient, she has no history of measles, whooping cough, mumps etc. Patient has no known allergies to drugs, animals, insects or food. Mrs. A.Z has never been involved in any road traffic accident or major injuries.

According to patient she was once hospitalized for malaria of which she was treated and went back home the next day. Patient has no physical impairment

### **1.8 Patient's Present Medical History**

History of present illness is a complete, clear, and chronologic account of the problems prompting the patient to seek care (Merriam-Webster, 2022).

The patient was well until 14<sup>th</sup> August, 2023 when she started experiencing severe headache, fatigue, dizziness, blurred vision, general body weakness, vertigo and vomiting. She thought these signs and symptoms will subside on it own after realizing it was not subsiding she then came to Emergency unit of Suyani Regional Hospital on 18<sup>th</sup> August 2023 and finally was admitted to the Female's medical ward through the emergency ward accompanied by her children and two staff nurses. She was diagnosed of hypertension.

## 1.8 Admission of Patient

Assessment encompasses the gathering of subjective and objective data and review of past information provided by the patient/family, or found within the patient chart, (Weller, 2018)

On the 18<sup>th</sup> August, 2023 at 7:30am Mrs. A.Z was admitted at the Female's Medical ward after being detained at Emergency Ward for 24 hours. Patient was brought to the ward in a wheel chair accompanied by two staff nurses, and her children. She was diagnosed of hypertension at the Emergency unit. I welcomed them to the Female's medical ward, patient was given a comfortable bed to lie on whiles all the necessary document and the patient folder were taken from the accompanying staff nurses. Patient looked very ill on assessment. All the information was gathered to confirm patient's admission to the ward. They included; her name, age, sex, residential address. On assessment she presented the following complaints; chest pains, headache, dizziness, and general body weakness. Her vital signs checked and recorded as follows;

Temperature                      36.8 degree Celsius

Pulse                                78 beats per minute

Respiration                        22 cycles per minute

Blood pressure                  150/100 millimeters of mercury The following

treatment were ordered for patient:

1. Intravenous hydralazine 5mg stat should be given slowly.
2. Tablet Nifedipine 20mg bd x 30 days
3. Tablet Bendroflumethiazide 2.5g daily x 30 day
4. Tablet Aspirin 75mg daily x 30 days
5. Tablet Paracetamol 1g x 5 days

The intravenous hydralazine 5mg stat was immediately given to patient to stabilize patient's condition and it was given at a slower rate because a faster rate can increase patient's cardiac output. Checking of Blood pressure four hourly was also ordered for the patient.

Due to Patient condition, orientation of patient to the ward could not be done initially. Her children were oriented to the ward by showing them the nurse's station, the toilet and bathroom. Patient was also introduced to other patients in the ward with similar condition responding to treatment. She was reassured that all the necessary care will be rendered for her recovery. I informed her about the time for medication and other routine works at the ward. I made them aware of time for visiting which start from 5:00am to 6:00am in the morning, 12:00pm to 1:00pm in the afternoon and 4:30pm to 5:30pm in the evening. She was educated on her meals. Patient had National Health Insurance, no deposit was made but I made her aware that some medications are non-insured and must be paid when discharged. I documented information in the admission and discharged book, the daily ward state and progress sheets. I made her comfortable in bed, and reassured her relatives. I introduced myself as a final year student of

Holy Family Nursing and Midwifery Training College, Berekum, who would like to take her family and herself for my care study. I made patient and her family aware that the care study is a requirement by the Nursing and Midwifery Council of Ghana in partial fulfilment towards the award of a license to practice as a General Registered Nurse. I wanted to take her as my patient, give her a holistic care to ensure her early recovery, study her condition and write a patient/family care study on the condition. I assured her that all information will be kept confidential. Patient and her family agreed after I explained to them and said they will cooperate with me and give me all the necessary information to complete the care. Discharge planning was initiated with patient and family, thus they will continue the care by administering medication and adhering to treatment at home at home once she is well and discharged home. I

decided to choose this patient for the study because I wanted to have much understanding on Hypertension.

### **1.9 Patient/Family Concept of Illness**

According to Merriam-Webster's Learners Dictionary (2016) patient's concept of illness can be defined as an abstract or generic idea generalized from one's illness or condition.

Mrs. A.Z has no idea about the cause of her condition, however she does not attribute her disease to any supernatural means. She believes that diseases are natural phenomenon occur in the life of every individual.

The patient however, related the cause of her illness to spiritual factor but believed that after her treatment, she will be healthy once again.

### **1.10 Literature Review On Disease Condition**

According to Creswell (2005), literature review is a written summary of journal articles, books and other documents that describes the past and current state of information, organizes the literature into topics and documents a need for a proposed study.

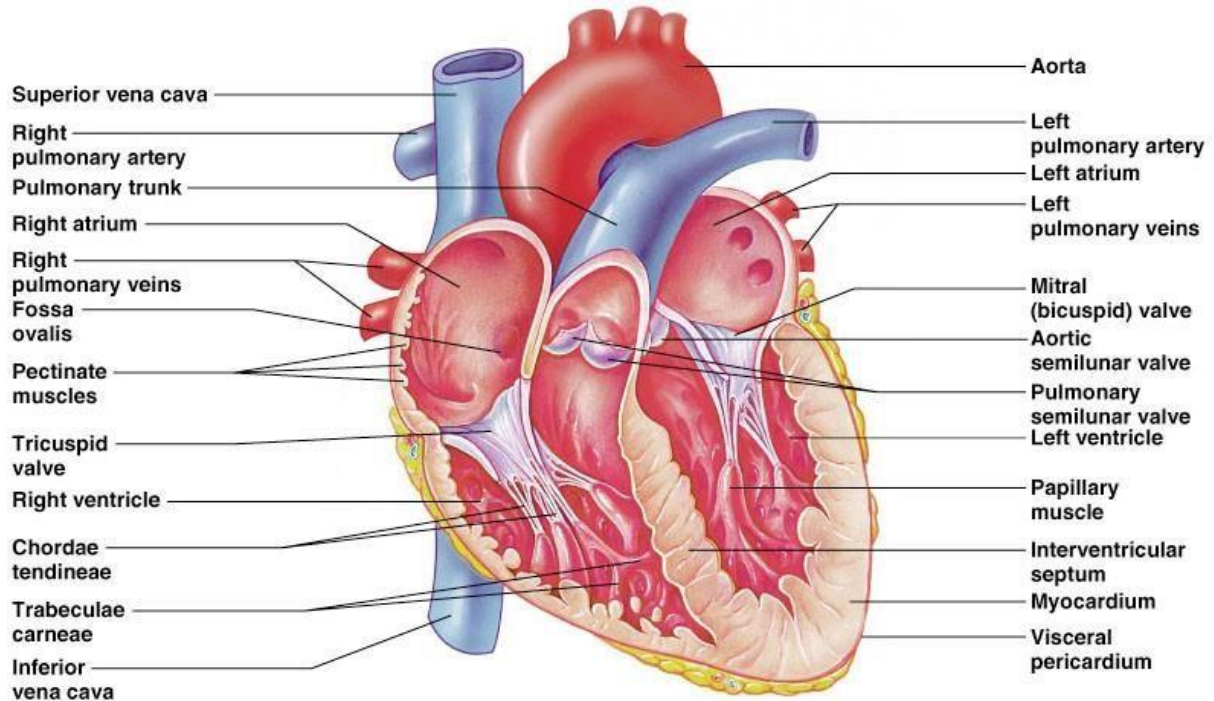
This section reviews the material that is relevant to the medical and nursing diagnosis of the patient. It contains the standards of the patient's clinical manifestations, diagnostic investigations, treatment and other issues.

### **Review of Anatomy and Physiology Of The Heart**

According to (Waugh & Grant, 2016) the heart is relatively small, roughly the same size (but not the same shape) as your closed fist. It is about 12 cm (5 in.) long, 9 cm (3.5 in.) wide at its broadest point, and 6 cm (2.5 in.) thick, with an average mass of 250 g (8 oz.) in adult females and 300 g (10 oz.) in adult males. The heart rests on the diaphragm, near the midline of the thoracic cavity. It lies in the media-sternum. It extends from the level of the second rib to about

the level of the sixth rib and its slightly left of the midline. Anteriorly by the sternum, Superiorly by the great blood vessels, Rests on the diaphragm inferiorly, Superiorly by the great blood vessels and Rests on the diaphragm inferiorly

**Figure1: Diagram of the Heart**



**Blood Supply to the Heart**

The first branches of the aorta, which carry freshly oxygenated blood, are the right and left coronary arteries that feed the heart muscle itself. Branches of the coronary arteries feed many capillaries of the myocardium. The heart muscle requires a continuous supply of freshly oxygenated blood, so smaller branches of arteries often have anastomoses as alternate pathways for blood, should one pathway become blocked. Cardiac veins drain blood from the heart muscle and carry it to the coronary sinus, which empties into the right atrium.

Hypertension is 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 (Brenda, Janice, Suzanne, & Kerry, 2014).

## **Blood Vessels**

A. The blood vessels (arteries, arterioles, capillaries, venules, and veins) form a closed tube that carries blood away from the heart, to the cells, and back again.

1. Arteries are strong, elastic vessels adapted for carrying high-pressure blood.
2. Arteries become smaller as they divide and give rise to arterioles.

Hypertension is defined as systolic pressure above 160 mmHg and diastolic pressure 90 mmHg. Hypertension rates are much higher in black Africans (40-45% of adults) (Clark & Kumar, 2017).

Hypertension is sometimes called “the silent killer” because people who have it are often symptom free and when symptoms become obvious, it is usually life threatening.

## **Incidence**

About 20% of adults develop hypertension than 90% of those who have essential (primary) hypertension which has no identifiable medical cause. The remainders develop elevation in blood pressure with specific cause. Secondary hypertension, such as endovascular narrowing or parenchyma renal disease, certain drugs, organ dysfunctions, tumors and pregnancies. It affects more women than men. According to health records because most men who have the condition do not visit the hospital. Most especially black males are less able to tolerate the condition. It also affects more blacks than whites (Brauwald, Libby, & Zipes, 2019).

Hypertension mostly affects people who are:

1. Aged
2. Obese

3. Alcoholic
4. Oral contraceptives users
5. Smokers (tobacco use)
6. Pregnant women

### **Types Of Hypertension**

There are two (2) types of hypertension (Smeltzer et al., 2014).

1. Primary Hypertension
2. Secondary Hypertension

### **Primary Hypertension**

It is the commonest type of hypertension. It is also called essential or idiopathic hypertension. It forms 90% of all causes of hypertension. It means that the reason for the elevation in blood pressure cannot be identified. It usually begins as a labile (intermittent) process. It's common among persons between 30yrs-50yrs.

### **Secondary Hypertension**

This type of hypertension results from renal disease or another identifiable cause. It accounts for 5% to 10% and could be related to specific causes, such as narrowing of the renal arteries, hyperaldosteronism, certain medications, pregnancy, and coarctation of the aorta.

### **Causes**

The cause of hypertension is unknown. However, there are predisposing causes to hypertension.

### **Primary hypertension**

### **Predisposing causes**

1. Family history: Level of BP is strongly familial. Risk of hypertension increases for those with a close relative having hypertension. (Dirksen, Heitkemper, & Lewis, 2015)
2. Race: The prevalence also varies by ethnicity, with African Americans having the highest prevalence at approximately 37% (Wong, Lopez, L'Italien, et al., 2019).
3. Emotional disturbance: When one is stressed up, there is released of catecholamine (norepinephrine and epinephrine). These hormones cause vasoconstriction. The vasoconstrictive action causes an increase in the peripheral resistance, hence increasing the blood pressure.
4. Obesity: Weight gain is associated with increased frequency of hypertension. The risk is greatest with central abdominal obesity.
5. Diet high in sodium or saturated fat: High sodium intake can contribute to hypertension in some patients and can decrease the efficacy of certain antihypertensive medications.
6. Excessive intake of alcohol: Excessive alcohol intake is strongly associated with hypertension. Patients with hypertension should limit their daily intake of alcohol.
7. Prolong use of oral contraceptives: Contraceptives contains hormones (estrogen, progesterone). These hormones have vasoconstriction effect. This increases peripheral resistance, blood clotting, hence increasing the blood pressure.
8. Aging: BP rises progressively with increasing age. Elevated BP is present in approximately 50% of people over 60 years of age.
9. Stress: People exposed to repeat stress may develop hypertension more frequently than others. People who become hypertensive may respond differently to stress than those who do not become hypertensive.

10. Excessive smoking: Smoking greatly increases the risk of cardiovascular disease. People with hypertension who smoke are at even greater risk for cardiovascular.

11. Gender: Hypertension is more prevalent in men young adulthood and early middle age.

After age 55, hypertension is more prevalent in women.

### **Secondary Hypertension**

Secondary hypertension could result from;

1. Renal diseases
2. Cushing syndrome
3. Diabetes mellitus
4. Dysfunction of thyroid or pituitary gland

### **Classification**

Hypertension have been classified into two, we have according

1. Severity
2. Aetiology

**Table 1: Classification According To Severity ( $\geq 18$  yrs)**

<b>BLOOD PRESSURE CLASSIFICATION</b>	<b>SYSTOLIC (mmHg)</b>	<b>DIASTOLIC (mmHg)</b>

Normal	<120	<80
Prehypertension	120-139	80-89
Stage 1 hypertension	140-159	90-99
Stage 2 hypertension	≥160	≥100

### **Other Classification According To Severity**

1. Benign hypertension – often asymptomatic but the high BP causes cellular damage that is not evident. It becomes apparent when long term complication has occurred such as stroke or cardiac arrest.
2. Malignant hypertension - symptomatic and rapid and severe rise in BP which almost straight away becomes life threatening with cerebral oedema occurring.

### **Classification According To Aetiology**

1. Primary, essential, or idiopathic hypertension: here no obvious cause is found to account for the high blood pressure. This forms about 90-95% of all cases.
2. Secondary or symptomatic hypertension: this is where pressure elevation is as a result of a specific or potentially treatable cause.

### **Pathophysiology**

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 (Waugh & Grant, 2016).

The pathogenesis of essential hypertension remains unclear. In some young clients, there is an early increase in cardiac output, in association with increase pulse rate and circulating catecholamines. This could result in changes in baroreceptor sensitivity, which would then operate at a higher blood pressure level. In chronic hypertension, the cardiac output is normal

but it is an increased peripheral resistance that maintains the elevated blood pressure. The resistance vessels show structural changes in hypertension. There is an increase in wall thickness with a reduction in the vessel lumen diameter. This results in an increased overall peripheral vascular resistance. Hypertension also causes changes in the large arteries. There is thickening of the media, an increase in collagen and secondary deposition of calcium. These changes result on loss of arterial compliance, which in turn leads to a more pronounced arterial pressure wave. Atheroma also develops in the large arteries. Changes in the renal vasculature eventually lead to a reduced renal perfusion reduced glomerular filtration rate and, finally, a reduction in sodium and water excretion. The decreased renal perfusion may lead to activation of the renin-angiotensin-aldosterone system with increased secretion of aldosterone and further sodium and water retention. All these lead to further increase in the blood pressure.

### **Clinical Features of Hypertension**

According to Smeltzer et al., (2014), some signs and symptoms of hypertension include;

1. Headache, often occipital and particularly in the morning
2. Occasional palpitation
3. Dizziness
4. Breathlessness
5. Chest pain
6. Confusion
7. Fatigue
8. Seizures
9. Coma
10. High Blood Pressure
11. Vomiting

## **Diagnostic Investigations**

According to Smeltzer et al., (2014), some diagnostic investigations for hypertension include;

1. History and physical examination are very necessary
2. Echocardiography for hypertrophy (Left ventricular hypertrophy)
3. Chest radiology
4. Urinalysis
5. Blood chemistry (i.e., analysis of sodium, potassium, creatinine, fasting glucose, and total and high-density lipoprotein, [HDL] cholesterol levels)
6. Ultra sonogram for e.g. polycystic kidney
7. Kidney function test

## **Complications**

Smeltzer et al., (2014) outlined the following as complication of hypertension;

1. Left ventricular hypertrophy: This occurs as a result of the heart working harder to pump blood against the elevated blood pressure to leading to hypertrophy of the tissues of the myocardia.
2. Myocardial infarction: The excess strain and resulting damage from high blood pressure/hypertension causes the coronary arteries serving the heart to slowly become narrowed from a build-up of fat cholesterol and other substances that together are called plaque.  
As arteries harden with plaque, blood clots become more likely to form.
3. Heart failure: As the heart pump against the higher pressure in blood vessels, it must work harder. Over time, this causes the heart muscle to muscle to thicken. When combined with cholesterol deposits in the blood vessels, the risk of heart attack and stroke increase.

4. Transient Ischemic Attack (TIAs): High blood pressure damages arteries throughout the body, creating conditions where they can burst or clog more easily. Weakened arteries in the brain, resulting from high blood pressure, put individuals at a much higher risk for stroke.
5. Cerebrovascular accident: High blood pressure damages arteries throughout the body, creating conditions where they can burst or clog more easily. Weakened arteries in the brain, resulting from high blood pressure, put you at a much higher risk for stroke which is why managing high blood pressure is critical to reduce your chance of having a stroke.
6. Renal insufficiency and failure: The nephron in the kidneys are supplied with a dense network of blood vessels, and high volumes of blood flow through them. Over time, uncontrolled high blood pressure can cause arteries around the kidney to narrow, weaken or harden. These damage arteries are not able to deliver enough to the kidney tissue.
7. Retinal hemorrhage: Hypertension occurs when the force of blood against the artery walls is too high, causing the arteries to stretch, narrow and become damage over time. Hypertensive retinopathy occurs when the blood vessels supplying blood to the retina in the back of the eye become damaged.
8. Angina pectoris: High blood pressure can cause damage to the coronary arteries, leading to blockages in the arteries and abnormal blood flow to the heart, which causes angina due to inadequate blood flow to the heart.
9. Impotence in men: High blood pressure medications that can cause sexual dysfunction as a side effect. Diuretics can decrease forceful blood flow to the penis, making it difficult to achieve an erection. They can also deplete the body of zinc, which is necessary to make sex hormone testosterone.

## **Medical Management**

## **Goal of Treatment**

According to Smeltzer et al., (2014) if the hypertension is secondary to a condition, that condition is treated to return the blood pressure to normal. However, if the hypertension is of the primary type, treatment is aimed at lowering the blood pressure and assisting patient to adjust lifestyle to reduce the demand on the cardiovascular system and kidneys. Drug treatment include;

1. Thiazide diuretic example Bendroflumethiazide
2. Loop diuretics example furosemide
3. Beta blockers such as labetalol and Propranolol.
4. Centrally acting anti adrenergic such as methyldopa
5. Vasodilators example hydralazine
6. Angiotensin converting enzyme inhibitors example Lisinopril, Captopril,
7. Calcium channel blockers (antagonist) example Nifedipine

## **Nursing Management**

According to Smeltzer et al (2010) the nursing management of hypertension can be grouped into the following headings;

### **Reassurance**

1 The patient is reassured that everything possible will be done to get the blood pressure at normal range so far as she remains in the hospital.

2 Reassure patient /family that all will be well since the patient is in competent hands to allay fear and anxiety.

3 Make patient relaxed and calm to gain her cooperation

### **Position**

- 1 Patient is placed in an upright position to ensure breathing and to expand the chest supported with back rest pillows.
- 2 The patient is also allowed to assume a comfortable position example semi-fowlers position
- 3 The position must not be contraindicated with patient's condition to help prevent complication such as bedsore

### **Rest and Sleep**

- 1 Ensure rest and sleep to conserve energy and promote relaxation.
- 2 Patient is given warm bath to improve circulation and induce sleep
- 3 Open windows to allow proper circulation of air
- 4 Bed is made free from creases and cramps to make patient comfortable
- 5 Ensure a quiet environment to enable patient have a maximum rest and sleep
- 6 Educate patient to empty the bladder

### **Observation**

1. Vital signs such as temperature, pulse, respiration, oxygen saturation and blood pressure should be monitored every four hourly to know the state of patient condition.
2. Patient's mental status should be assessed to know whether she is oriented to time, place and person
3. Observe possible complication of the condition so that preventive measures can be observed.
4. The intravenous site must be observed for patency of line and the flow of infusion
5. Desired effects, side effects and contraindications of drugs to be administered should be observed.

6. Pain should be observed from facial expression
7. Breathing pattern assessed since there is difficulty in breathing.

### **Personal Hygiene**

1. Patient is assisted to take her bath twice daily to remove dirt, improve circulation and induce sleep.
2. The hair is washed to prevent pediculosis infestation.
3. Finger and toe nails should be trimmed and washed to prevent patient from harboring organisms.
4. Bed linens are changed frequently including patient clothing to prevent infections
5. Pressure areas must be treated to prevent patient from developing pressure sores.
6. The perineum must be washed to prevent infection

### **Nutrition**

1. Patient is helped to meet her nutritional requirement by giving a well-balanced diet. with low fat to prevent arteriosclerosis.
2. There must be reduction of dietary fats and cholesterol.
3. Low salt diet should be encouraged and vitamin supplement to increase the body's immune system.
4. Obese patient should not be given too much of carbohydrate
5. There should be avoidance of coffee as well as smoking and alcohol.
6. Meals should be served in bits and attractively.

### **Exercise**

1. Patient is encouraged to undertake mild to moderate exercise to improve circulation, prevent joint stiffness and aid in peristalsis and also prevents constipation.
2. Assist patient to sit up in bed, walk around the bed and gradual turning of the head.

## **Elimination**

1. Serve bedpan or assist patient to visit the toilet on request. Urinal should also be served on request.
2. When patient is not able to eliminate, nursing measures such as opening of taps, putting of cold compresses is encouraged to prevent constipation.
3. More roughage and fluids are given to soften the stool.
4. Patient is assisted to take her bath twice daily to remove dirt, microbes and sweat from the skin.
5. Patient is encouraged to undertake mild to moderate exercise to improve circulation, prevent joint stiffness and aid in peristalsis and also prevents constipation.
6. Serve bedpan or assist patient to visit the toilet on request. Urinal should also be served on request.

## **Health Education**

1. Educate patient on her condition by assessing the level of knowledge on condition and build upon it.
2. Teach her on the causes, predisposing factors, treatment and prevention.
3. Patient is also educated on lifestyle modification. Thus, reducing drinking alcohol, stop smoking and reduce intake of dietary saturated fat and cholesterol.
4. Teach patient to check the blood pressure regularly and record the reading at least twice weekly in a journal for review by the doctor at every appointment
5. Educate patient on intake on intake of low salt, low fat and cholesterol diet.
6. Educate patient to exercise daily and the avoidance of strenuous activities

## **Lifestyle Modification**

1. Lose weight if overweight
2. Limit alcohol intake
3. Increase aerobic physical activity
4. Reduce sodium intake to not more than 100mmol per day.
5. Maintain adequate intake of dietary calcium and magnesium for general health.
6. Stop smoking and reduce intake of dietary saturated fat and cholesterol.

### **1.11 Validation Of Data**

This is the process to confirm or verify that data collected is valid. The purpose of data collected is to keep it free from any errors, bias and misinterpretations (Mosby's Medical Dictionary 2019). The information given by the patient and her relatives were found to be true. To confirm this, I kept on asking the same questions but there was no difference in answers. Patient children were also interviewed and the answers they gave did not vary from what was given by patient. The clinical features presented by patient and diagnostic investigation conducted, with the data collected from her children with much emphasis on the literature review, confirmed that she was suffering from hypertension. All data collected were valid and free from errors or bias.

## **CHAPTER TWO**

### **ANALYSIS OF DATA**

#### **2.0 Introduction**

Analysis is the act of determining the component of parts of a substance (Weller, 2014) this aspect of the care study deals with the critical examination and interpretation of the data collected during the assessment of the patient. Here, there is a comparison between the results of the investigations carried out and the normal values to detect any abnormality from normal. This chapter also deals with the patient and family strengths, their health problems and the corresponding nursing diagnosis.

This chapter forms the second phase of the nursing process. It entails comparing the results of the investigation carried out, the causes, clinical manifestations, treatments and complications of the patient's condition (hypertension) with standards in the literature review. The chapter also presents the patient/family strengths, the health problems identified and nursing diagnoses formulated from Patient's health problems.

#### **2.1 Comparison of Data with Standards.**

Data obtained from Mrs. A.Z were compared with those of the diagnostic investigations, causes, signs and symptoms, treatment and complications stated in literature. The comparison is illustrated in the tables below.

##### **2.1.1 Diagnostic Investigations/Tests**

Diagnosis is the determination of the nature of a disease (Weller, 2014). Investigation refers to procedures performed to establish a diagnosis, to monitor a person's health, disease or the effectiveness of treatment (Weller, 2014). The literature as cited by Bare and Smeltzer (2010) points out urinalysis blood chemistry done for analysis of sodium, potassium and creatinine; fasting blood glucose and High Density Lipoprotein (HLD) cholesterol levels; full blood count to check hemoglobin level to rule out anemia and white blood cells to rule out any infection,

fasting blood sugar to check patient's blood sugar level; blood urea, electrolytes and creatinine level test is also done to evaluate the kidneys function, chest X-ray to detect cardiomegaly; electrocardiography to find out the conducting activities of the heart as the diagnostic measures for confirming hypertension.

The following diagnostic investigations/tests were carried out on Mrs. A.Z

1. Full Blood Count
2. Malaria parasite Test
3. Blood urea and creatinine

**Table 2: Comparison of Diagnostic investigations carried on Mrs. A.Z to the literature review**

<b>Diagnostic investigations in the literature review</b>	<b>Diagnostic investigations conducted on Mrs. A.Z</b>
1.Previous medical history and physical examination will help in the diagnosis	Physical examination and medical history was conducted on patient
2.Electrocardiography to assess the size and function of the heart	Electrocardiography was conducted on patient
3.Echocardiography to assess left ventricular hypertrophy	Echocardiography was not conducted on patient
4.Blood urea and creatinine and electrolyte analysis	Blood urea, creatinine and electrolyte analysis was conducted on patient
5.Urine analysis to identify renal diseases	Urine analysis was conducted on patient
6.Angiography to assess veins	Angiography was not conducted on patient
7.Kidney function test	Kidney function test was conducted on patient
8.Chest radiology	Chest radiology was not conducted on patient
9.Urinalysis	Urinalysis was conducted on patient
10.Malaria parasite test	Malaria parasite test was conducted
11.Full blood count	Full blood count was conducted

Based on the diagnostic investigations in the literature review on table 4 above, some of these investigations were conducted on Mrs. A.Z other test done Malaria parasite test, WBC, Hemoglobin level estimation which are not part of the literature review were done to rule out anemia, malaria and other infection.

**Table 3: Diagnostic Investigation/Test conducted on my patient**

DATE	SPECIMEN	INVESTIGATIONS	RESULTS	NORMAL VALUES	INTERPRETATIONS	RESULTS
17/08/23	Blood	<b>FULL BLOOD COUNT</b>				
		Hemoglobin level estimation	15.4g/dl	<b>Males-(13.5-17.5g/dl)</b> <b>Females-(12.0-15.5g/dl)</b> <b>Children-(11.3-14.1g/dl)</b>	Within normal range	No treatment given
		White blood cell count	9.5x10 <sup>9</sup> /L	4.0-10x10 <sup>9</sup> /L	Within normal range	No treatment given
17/08/23	Blood	Malaria parasite	Negative	Negative	Negative (-).  Plasmodium falciparum was not seen	No treatment given
17/08/23	Blood	Blood Urea creatinine	Blood Urea Nitrogen (BUN): 10 mg/dL.  Creatinine: 96 mmol/l	7.00–18.00 mg/dL  (50–110 mmol/L)	Within normal range  Within normal range	No treatment given  Blood, Urea, Nitrogen (BUN) and creatinine levels were within the normal range.

### 2.1.2 Causes of Patient Condition

With regards to the data collected, the patient condition is primary hypertension. The cause is unknown but the predisposing factor such as hereditary, persistent stress, and old age predisposed her to the condition. History from patient reviews there is hypertension in the family.

**Table 4: Comparison of Clinical Features of Patient and That of Literature Review**

<b>Signs And Symptoms Outlined In Literature Review</b>	<b>Signs And Symptoms Exhibited By Patient</b>
1.Headache	Patient experienced headache
2.Palpitations	Patient experienced palpitation
3.Dizziness	Patient experienced dizziness
4.Breathlessness	Patient experienced no breathlessness
5.Chest pain	Patient experienced chest pain
6.Confusion	Patient was not confused
7.Fatigue	Patient was fatigue
8.Seizures	Patient had no Seizures
9.Coma	Patient was not in coma
10.High blood pressure	Patient blood pressure was high
11.Vomiting	Patient experienced vomiting

In table 3 above, Mrs. A.Z exhibited more than half of the features from the literature review which helps to confirm the diagnosis.

### 2.1.3 Treatment Given To Patient

Treatment refers to the management and care of a patient to combat disease or disorder (Merriam Webster University, 2018). Based on the clinical manifestations presented by the

patient and the laboratory investigations conducted, she was to be treated and managed on the following;

1. Intravenous hydralazine 5mg stat
2. Tablet Nifedipine 20mg bd x 30
3. Tablet Aspirin 75mg daily x 30
4. Tablet Bendroflumethiazide 2.5g daily x 30
5. Tablet Paracetamol 1g td for 5 days orally

**Table 5: Comparison Of Drugs (Treatment) Outlined In The Literature Review With Those Given To Patient.**

<b>Treatment outlined in the literature review</b>	<b>Treatment Given to patient</b>
1. Thiazide diuretics e.g. Bendroflumethiazide	1. Tablet Bendroflumethiazide 2.5mg daily x 30 was administered
2. Loop diuretics e.g. Furosemide	2. Loop diuretics was not administered to patient
3. Beta-blockers such as labetalol and propranolol	3. Beta blockers was not administered to patient
4. Centrally acting anti adrenergic such as methyldopa	4. Centrally acting anti adrenergic was not administered to patient
5. Vasodilators eg. Hydralazine	5. Intravenous hydralazine was administered
6. Angiotensin converting enzyme inhibitors e.g. Lisinopril, Captopril	6. Angiotensin converting enzyme inhibitors was not administered
7. Calcium channel blockers (antagonist) e.g. Nifedipine	7. Tablet Nifedipine was administered

In table 4. Above most of the drugs in the literature review were ordered for the patient, which shows that the patient had received the right treatment which led to her early recovery.

**Table 6: Pharmacology of Drugs Given To Mrs. A.Z**

<b>Date</b>	<b>Drugs</b>	<b>Dosage/Route Of Administration Per Literature Review</b>	<b>Dosage/Route Of Administration To Patient</b>	<b>Classification</b>	<b>Desire Effects</b>	<b>Actual Action Observed</b>	<b>Side Effect And Remarks</b>
19/08/23	Tablet Nifedipine	<b>Adult</b> dosage; 20 to 60mg twice daily. <b>Child</b> dosage; not recommended for use in children <b>Route:</b> Orally	20mg bd for 30 days <b>Route: Orally</b>	Calcium channel blocker.	Decrease cardiac work load and energy consumption.	Blood pressure reduced gradually to 130/85mmHg	Constipation, dizziness, nausea, headache, sore throat, muscle cramps. Constipation was observed in patient and roughage diet was encouraged.
19/08/23	Tablet Bendroflumethiazide	<b>Dose:</b> 2.5 – 5 mg bd. <b>Route:</b> orally	2.5mg bd x 30 days <b>Route : Orally</b>	Thiazide diuretics.	It inhibits sodium reabsorption at the beginning of the distal convoluted tubule to reduce blood pressure	Blood pressure reduced gradually to 130/85mmHg	Rash, swelling mouth, chest tightness, breathing difficulty. Patient exhibited none.
19/08/23	Intravenous hydralazine	20 -40mg IV/IM for adults. Children dose; 0.10.2mg/kg administered every 4-6hours <b>Route:</b> <b>Intravenous</b>	5mg stat <b>Route : intravenously</b>	Vasodilators	Dilates blood vessels	Blood pressure reduced gradually from 150/100mmHg to 140/100mmHg	Anorexia, nausea, diarrhea, vomiting, and anxiety but patient exhibited none.

**Table 5: Pharmacology of Drugs Given to Mrs. A.Z continued**

<b>Date</b>	<b>Drugs</b>	<b>Dosage/Route Of Administration Per Literature Review</b>	<b>Dosage/Route Of Administration To Patient</b>	<b>Classification</b>	<b>Desire Effects</b>	<b>Actual Action Observed</b>	<b>Side Effect And Remarks</b>
19/08/23	Tablet Paracetamol	<b>Adult dose;</b> 500mg tid for 5 days orally. <b>Children dose:</b> 250mg tid for 3days <b>orally Dosage:</b> 325-650mg tds daily. <b>Route: Oral, Rectal, Intravenous</b>	<b>Dosage</b> 1g tid for 5 days <b>Route: Orally</b>	Analgesics/Antipyretic	To relieve pain by blocking generation of pain impulses, probably by inhibiting prostaglandin	Patient's headache was relieved.	Leukemia, Hemolytic anemia and liver damage.  None of the above effect was experienced.
19/08/23	Tablet Aspirin	<b>Adult dose;</b> 75mg-300mg orally. <b>Children dose;</b> 16years and above. Doses in child depends on child's weight <b>Route: Oral</b>	75mg daily x 30/7 <b>Route: Orally</b>	Anticoagulant	Analgesia Antipyretic	Reduced patient sensitivity to pain and prevent blood clot.	Epigastric distress, nausea, Heartburn, vomiting, confusion, and hallucination but, none was observed.

### **2.1.4 Complications Developed By Patient**

Complication is an unanticipated problem that arises as a result of a procedure, treatment, or illness. (RXList, 2021).

With reference to the complication indicated in the literature review such as cerebrovascular accident, left heart failure, renal failure, angina pectoris, Mrs. A.Z did not experience any complication of hypertension due to effective medical and nursing care given during hospitalization.

### **2.2 Patient Health Problem**

(Weller, 2018), defines problems as any health care conditions that requires diagnostic therapeutic or educational action.. From the data collected during assessment, the following health problems were identified.

1. Patient complains of pains in the chest (18/08/23)
2. Patient complains of Headache (18/08/23)
3. Patient complains of dizziness (18/08/23)
4. Patient had difficulty in sleeping (19/08/23)
5. Patient complained of loss of appetite (19/08/23)
6. Patient had difficulty in emptying her bowel, (constipation) (20/08/23).

### **2.3 Patient Family /Strength**

Strength refers to ability to do things that need lot of physical or mental effort (McIntosh, 2013).

Problem is defined as a situation, person that needs attention and needs to be dealt with or solved (McIntosh, 2013) The following strengths were identified from Mrs. A.Z problems.

1. Patient's pain subsides when lying.
2. Patient could verbalize intensity of headache .

3. Patient was able to verbalize that she is dizzy.
4. Patient was able to sleep three (3) hours in a day.
5. Patient could eat five table spoon of rice
6. Patient could tolerate roughage diet

## **2.4 Nursing Diagnosis**

According to NANDA International, nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community (Herdman & Kamitsuru, 2018). The nursing diagnoses made were;

1. Acute chest pain related to inflammatory process of the disease condition secondary to inflammatory process in the lungs (18/08/23)
2. Impaired comfort (headache) related to increase cerebral vascular pressure as evidenced by complains of severe pain at the occipital region (18/08/23)
3. Risk for injury as evidenced by dizziness (18/08/23)
4. Insomnia related to unfamiliar hospital environment as evidence by patient having intermittent sleep (19/08/23)
5. Altered nutrition pattern (less than body requirement) related to loss of appetite as evidence by patient not having interest in food. (19/08/23).
6. Impaired bowel elimination pattern (constipation) related to insufficient intake of roughages and fluids as evidence by patient straining during defecation. (20/08/23).

## CHAPTER THREE

### PLANNING FOR PATIENT/FAMILY CARE

#### 3.0 Introduction

Planning is the process of thinking about and organizing the activities required to achieve a desire goal (Anderson, 2018; Anderson, 2018; Herdman & Kamitsuru, 2018; MerriamWebster, 2022; Scott & Marshall, 2015; Smeltzer, Bare, Hinkle, & Cheever, 2018; Tuitui & Suwal, 2017; Walter, 2020; Tuitui & Suwal, 2017; Weller, Bailliere's Nurses' Dictionary for Nurses and Healthcare workers, 2018).

This is the third component of the nursing process which involves setting of objectives that will help solve the problems identified. The nursing care plan serves as a tool for record keeping which enables continuity of care for patient and family during and after hospitalization. It involves setting of objectives based on the potential and actual problems identified. The nursing care plan facilitates achievement of client goals. It communicates clearly the nature of the client problem and specifies the nursing and medical interventions necessary for the client.

#### 3.1 Objectives/outcome criteria for Patient/Family Care

The following objectives and outcome criteria were set for patient;

1. Patient's chest pain will be relieved within 24hours as evidenced by ;
  - a. Nurse assessing patient level of pain on the numerical rating scale (1-10) and recording 2
  - b. Patient verbalizing that chest pain has been relieved.
2. Patient will be relieved of headache within 24hours as evidenced by;
  - a. Nurse observing the patient comfortable in bed.

- b. Patient verbalizing the absence of headache.
3. Patient will be free from injury throughout the period of hospitalization as evidenced by;
- a. Patient verbalizing the absence of dizziness.
  - b. Nurse observing patient showing no signs of injuries.
4. Patient will resume her normal sleeping pattern within 48 hours as evidenced by;
- a. Nurse observing patient sleeps comfortably in bed
  - b. Patient verbalizing the absence of insomnia.
5. Patient will regain normal nutritional pattern within 48 hours as evidenced by the;
- a. Nurse observing patient eat more than half of meal served.
  - b. Patient verbalizing regain of appetite.
6. Patient will resume her normal bowel movement within 48 hours as evidenced by;
- a. Nurse observing that patient empties her bowel with no difficulty.
  - b. Patient verbalizing that she empties her bowel with no difficulty.

### **Nursing care plan**

Nursing care plans are essential tools that guide nursing practice and ensure comprehensive and individualized patient care. They serve as roadmaps for nurses, helping them provide quality care and achieve positive patient outcomes.(WHO,2023).

**Table 7: Nursing care plan for Mrs. A.Z.**

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE/ TIME</b>	<b>EVALUATON</b>	<b>SIGN</b>
18/08/23 at 7:30am	Acute chest pain related to inflammatory process of the disease condition secondary to inflammatory process in the lungs .	Patient chest pain will be relieved within 24hours as evidenced by 1. Nurse assessing patient level of pain on the numerical rating scale(1-10) and recording 2 2. Patient verbalizing that chest pain has been relieved	1. Reassure patient that she is in competent hands of professional health workers. 2. Assesss patient level of pain using a scale of 1-10 3. Make patient comfortable by placing patient in a favorable position that minimizes pain. 4. Remove tight clothing around patient's neck, chest and waist 5. Serve prescribe medication	1. Patient was reassured that she in competent hands of professional health workers. 2. Patient level of pain was assessed using a scale of 1-10 and rated 2 3. Patient was made comfortable by placing patient in a semi fowlers position 4. Tight clothing was removed from patient's neck, chest, and waist to aid in breathing. 5. Tablet paracetamol 1g was served	18/08/23 at 7:30am	Goal fully met as nurse assess patient level of pain on the numerical rating scale and rating 2	<b>N.O</b>

**Nursing care plan for MRS. A.Z Cont.**

**Table 6:**

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE/ TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
18/08/23 at 7:40am	Impaired comfort (headache) related to increase cerebral vascular pressure as evidenced by complains of severe pain at the occipital region	<p>Patient will be relieved of headache within 48hours as evidenced by;</p> <ol style="list-style-type: none"> <li>1. Nurse observing the patient sleeps comfortably in bed.</li> <li>2. Patient verbalizing the absence of headache.</li> </ol>	<ol style="list-style-type: none"> <li>1. Reassure patient/Family.</li> <li>2. Monitor vital signs especially Blood Pressure every 4 hourly.</li> <li>3. Apply cold compress to patient forehead.</li> <li>4. Reduce noise at the ward.</li> <li>5. Educate patient to have enough rest.</li> <li>6. Serve prescribe medications.</li> <li>7. Document care rendered to patient for continuity of care.</li> </ol>	<ol style="list-style-type: none"> <li>1. Patient/Family were reassured.</li> <li>2. Vital signs were checked especially Blood Pressure every 4 hourly.</li> <li>3. Cold compress was applied to patient forehead to relieve patient of pain.</li> <li>4. A quiet environment was ensured by reducing volume of television.</li> <li>5. Patient was educated to have enough rest.</li> <li>6. Tablet Paracetamol 1g and tablet nifedipine 20mg was administered.</li> <li>7. All care rendered to patient were documented.</li> </ol>	18/08/23 at 8:30am	<p>Goal was fully met as; 1. Patient verbalized the absence of headache.</p> <p>2. The nurse observed patient is comfortable in bed.</p>	<b>N.O</b>

**Table 6: Nursing care plan for MRS. A.Z Cont.**

<b>DATE/ TIME</b>	<b>NURSING DIADNOSIS</b>	<b>NURSING OBJECTIVES/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE/ TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
18/08/23 at 7:50am	Risk for injury as evidenced by dizziness	Patient will be relieved from injury throughout the period of hospitalization as evidenced by: 1. Patient verbalizing that she has not sustained any injury. 2. Nurse observing patient showing no signs of injuries.	1. Reassure patient 2. Raise side rails of bed to prevent falls. 3. Ensure complete bed rest 4. Remove sharp/injurious object from Patient's reach. 5. Monitor patient vital signs 4 hourly 6. Inform patient to call for assistant when needed 7. Educate patient to wake up slowly in bed.	1. Patient was reassured that she will be able to carried out activities of daily living without assistance. 2. Side rails of bed were raised to prevent patient from falling. 3. Complete bed rest was ensured by restricting visitors during sleep and rest hours. 4. Injurious objects like needles were removed from patient's reach. 5. Vital signs especially blood Pressure was monitored every 4 hourly and recorded. 6. Patient was informed to call for assistance from the nurses when needed. 7. Patient was informed to sit-up on bed, for 5 minutes before standing up.	18/08/23 7:50am	Goal fully met as; 1. Patient verbalized the absence of injury. 2. Nurse observed patient showing no signs of injuries.	N.O

**Table 6: Nursing care plan for MRS. A.Z Cont.**

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/ OUTCOME CRITERA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE/ TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
19/08/20 at 8:00am	Insomnia related to unfamiliar hospital environment as evidence by patient having intermittent sleep.	Patient will resume normal sleeping pattern within 24 hours as evidenced by 1. Patient verbalizing the absence of insomnia. 2. Nurse observing the patient is able to sleep for 12 hours.	1. Reassure patient/family. 2. Minimize noise and restrict visitors 3. Ensure proper circulation of air to promote sleep. 4. Educate patient to take warm bath before she goes to bed. 5. Educate patient to empty her bladder before bed time. 6. Serve prescribed medication.	1. Patient/family were reassured. 2. Noise was minimized and visitors were restricted to enhance sleep 3. Proper circulation of air was ensured to promote sleep 4. Patient was educated to take a warm bath before going to bed. 5. Patient was educated to empty her bowel before going to bed. 6. Tablet Paracetamol 1g and tablet nifedipine 20mg was administered	19/08/20 At 8:00am	Goal was fully met as; 1. Patient verbalized the absence of insomnia. 2. Nurse observed the patient is able to sleep for 12 hours.	<b>N.O</b>

**Table 6: Nursing care plan for MRS. A.Z Cont.**

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE/ TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
19/08/23 at 8:00am	Altered nutrition pattern (less than body requirement) related to loss of appetite as evidence by patient not having interest in food	Patient would regain normal nutritional pattern within 48 hours as evidenced by the; 1. Nurse observing patient eat more than half of meal served. 2. Patient verbalizing regain of appetite.	1. Reassure patient. 2. Give mouth wipes. 3. Encourage and assist patient to feed frequently. 4. Eliminate unpleasant sights and odors before meals. 5. Serve food attractively and in bits.	1. Patient was reassured that the necessary measures would be rendered to improve appetite. 2. Patient's mouth was cleaned every morning and evening. This was done to keep the mouth clean and to stimulate appetite. 3. Patient was assisted to feed to provide energy and nutrients. 4. Unpleasant sights such as bed pans and odors were eliminated before meals. 5. Relatives was encouraged to serve food attractively and in bits.	19/08/23 at 8:00am	Goal was fully met as; nurse observed patient eat more than half of meal served and Patient verbalized regain of appetite.	N.O

**Table 6: Nursing care plan for MRS. A.Z Cont.**

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE/ TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
20/08/23 9:00am	Impaired bowel elimination pattern (constipation) related to insufficient intake of roughages and fluids as evidence by patient unable to empty bowel for more than a day	Patient will resume normal bowel movement within 12 hours as evidence by 1. Patient verbalizing that she empties her bowel with no difficulty. 2. The nurse observing that patient empties her bowel with no difficulties.	1. Reassure patient/family. 2. Advice patient to take in copious fluids and fruits. 3. Serve patient with high roughage diet. 4. Encourage patient to do passive exercises. 5. Educate patient to empty her bowel when she feels the urge. 6. Document care rendered	1. Patient/family were reassured 2. Water was served at regular interval. 3. Patient was served with roughage diet and educated on the importance of roughages in diet. 4. Patient was encouraged to do passive exercise example walking around. 5. Patient was educated to empty her bowel frequently to prevent constipation. 6. Care rendered to patient was documented for continuity of care.	20/08/23 at 9:00am	Goal was fully met as; 1. Patient verbalized that she empties her bowel with no difficulty. 2. Nurse observe patient empties her bowel with no difficulties.	<b>N.O</b>

## 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, 2020). This chapter involves detailed description of how the nursing orders were carried out to solve the health problems of Mrs. A.Z and family from the day of admission till discharge. This chapter also includes the preparation of the patient and her family towards discharge, home visit and continuity of care.

#### 4.1 Summary of Actual Nursing Care Rendered to Patient/Family.

Management of the patient was aimed at a successful medical treatment and nursing care to relieve Patient of her problems as well as maintaining optimal physiological function of patient so that she could return to normal health. Nursing of Mrs. A.Z started on the 18<sup>th</sup> August, 2023- and continued until discharge on 21<sup>st</sup> August, 2020.

During admission, daily routine nursing care were carried out such as bed making and serving of prescribed medications. Vital signs especially the blood pressure was monitored and recorded accordingly. Specific care was rendered according to patient's needs and necessary documentation done.

##### 4.1.1 First Day of Admission: 18<sup>th</sup> August, 2023.

On the 18th August, 2023 at 7:30am Mrs. A.Z was admitted at the Female medical ward after been detained at Emergency Ward for 24 hours. Patient was brought to the ward in a wheel chair accompanied by two staff nurses, and her children. She was diagnosed of hypertension at the

Emergency unit. I welcomed them to the Female's medical ward and made patient comfortable at the nurses station all the necessary document and the patient folder were taken from the accompanied staff nurses. Patient looked ill on assessment. All the information was gathered to confirm patient's admission to the ward. They included; her name, age, sex, residential address. She was then given an admission bed and made comfortable. On assessment she presented the following complaints; chest pains, headache, dizziness, and weakness. Her vital signs was checked and recorded as follows;

Temperature	36.8degree Celsius
Pulse	78 beats per minute
Respiration	22 cycles per minute
Blood pressure	150/100 millimeters of mercury
Oxygen saturation	92%

The following treatment were ordered for patient:

1. Intravenous hydralazine 5mg stat should be given slowly.
2. Tablet Nifedipine 20mg bd x 30 days
3. Tablet Bendroflumethiazide 2.5g daily x 30 day
4. Tablet Aspirin 75mg daily x 30 days
5. Tablet Paracetamol 1g x 5 days

Due to patient condition, orientation to the ward was not done initially. Her children were oriented to the ward by showing them the nurse's station, the toilet and bathroom. Mrs. A.Z. was also introduced to other patients in the ward with similar condition and responding to treatment and reassured them that all the necessary care will be rendered for her to recover fully. I told her

about the time for medication and other routine works at the ward. I made her aware of time for visiting which start from 5:00am to 6:00am in the morning, 12:00pm to 1:00pm in the afternoon and 4:30pm to 5:30pm in the evening. She was educated on her meals. Since patient had National Health Insurance, no deposit was made but I made her aware that some medications are noninsured and must be paid when discharged. I documented her information in the admission and discharged book, the daily ward state and the rest of the progress sheets. I made her comfortable in bed, and reassured her relative.

On this day at 7:30am Patient complains of chest pains. A nursing diagnosis of acute chest pain related to inflammatory process of the disease condition. An objective was set to help patient's pain subside to normal within 24hours.

The following nursing interventions were carried out; Patient was reassured that she is in competent hands of professional health workers, Patient level of pain was assessed using a scale of 1-10, Patient was made comfortable by placing patient in a semi fowlers position, Tight clotting was removed from neck, chest and waist to aid in breathing, Tablet paracetamol 1g was served. All care rendered was documented.

At 7:40am, Patient complained of headache. A nursing diagnosis of impaired comfort (headache) related to increase cerebral vascular pressure was formulated. An objective set to relieve patient from headache within 24hours and the following nursing interventions were carried out; Patient and relatives was reassured, Paracetamol 1gm x 5 days and anti-hypertensive nifedipine 20mg was administered, cold compress was applied to patient's forehead to relieve her of headache, enough rest was ensured, A quiet environment was ensured by minimizing noise and restricting visitors. All care rendered was documented.

At 7:50am, patient complained of dizziness and a nursing diagnosis of Risk for injury as evidenced by dizziness was formulated. An objective set up to relieve patient of dizziness throughout the period of hospitalization and the following nursing interventions were carried out; patient was reassured that she will be able to carry out activities of daily living without assistance, Side rails of bed raised to prevent patient from falling, complete bed rest was ensured by restricting visitors during sleep and rest hours, Injurious objects like needles removed from patient's reach, vital signs especially blood pressure was monitored 4 hourly and recorded, patient was informed to call for assistance from the nurses when needed. Patient was educated to sit up on bed for 5 minutes before standing up. The care plan for Mrs. A.Z was formulated with the help of the patient/family to promote recovery. All nursing interventions carried out on her were documented. Patient slept at 10:50pm.

#### **4.1.2 Second Day of Admission: 19<sup>th</sup> August, 2023**

On the second day of admission, patient woke up at 5:30am. Patient was assisted to maintain her personal hygiene such as brushing teeth, and taking of her bath. At 6:00am, routine vital signs were checked and due medication were served accordingly and recorded. She took milo drink and bread for breakfast.

At 8:00am on this day, patient complained of difficulty in sleeping (insomnia). A nursing diagnosis of insomnia related to unfamiliar hospital environment was formulated. An objective was set to relieve patient of insomnia within 48hours and the following nursing interventions were carried out, Patient/family was reassured, quiet environment was ensured by minimizing noise and restricting visitors, Proper circulation of air was ensured, Patient was educated to take warm bath before going to bed and empty her bladder before going to bed.

At 8:00am a nursing diagnosis of altered nutrition pattern (less than body requirement) related to loss of appetite was also formulated. An objective was set to help patient regain her normal nutritional pattern within 48 hours.

Nursing interventions implemented included: Patient was reassured that the necessary measures would be rendered to improve appetite. Patient's mouth was cleaned every morning and evening. This was done to keep the mouth clean and to stimulate appetite. Patient was assisted to feed to provide energy and nutrients. Unpleasant sights such as bed pans and odors were eliminated before meals. Relatives was encouraged to serve food attractively and in bits.

Enough bed rest was ensured. She was reassured that the necessary measures would be rendered to improve appetite.

At 1:30pm I visited patient and she was eating Banku and light soup with less salt as her launch but she still could not eat much, interventions were continued. She was encouraged to have enough bed rest to improve upon her condition.

At 6:00pm, I went to Mrs. A.Z to carry my routine care. Vital signs checked and recorded were;

Temperature	35.6 degree Celsius
Pulse	74 beats per minute
Respiration	20 cycles per minute
Blood pressure	130/100 millimeters of mercury

After taking her bath, she ate Fufu and garden eggs soup as supper. Due medication was served corresponding to its dose and dosage to her and documented in the medication chart for continuity of care. She was made comfortable in bed.

### 4.1.3 Third Day Of Admission: 20<sup>th</sup> August, 2023

Patient wake up around 6:00am, vital signs were checked and recorded, due medication was served and her bed was dressed and made free from creases and cramps to promote.

At 7:30am, evaluation was made for the objective set to restore patient's breathing pattern, Goal fully met as nurse observed patient breathe without use of accessory muscles and patient reported relieve of chest pains and recorded respiratory rate of 18 and oxygen saturation level of 96%.

At 8:00am, evaluation was also done on insomnia and patient verbalized having uninterrupted sleep for 8 hours, Goal set to relieve patient of insomnia was fully met.

At 9:00am, Patient complained of difficulty in emptying her bowel. A nursing diagnosis was formulated as impaired bowel elimination (constipation) related to insufficient intake of roughages and fluids. An objective was set to relieve patient of constipation within 48hours and the following nursing interventions were carried out; Patient/family reassured that everything possible would be done to relieve her of constipation , water was served at regular intervals and appropriate fruits like water melon, Patient was served with roughage diet and educated on the importance of roughages in diet, Patient was encouraged to do passive exercise , example walking around, Patient was educated to empty her bowel frequently to prevent constipation. She had already performed her personal hygiene without assistance.

At 9:00am afterward rounds, I informed patient and went for the first home visit around 1:00pm.

At 6pm, vital signs were checked and recorded as

Temperature            35.6-degree Celsius

Pulse                      88 beats per minute

Respiration                    22 cycle per minute

Blood pressure                130/90 millimeters per mercury

Mrs. A.Z ate yam with light soup with low salt as supper. At 8:00pm due medication was served.

All care rendered was documented in the nurse's note for continuity of care.

#### **4.1.4 The Fourth Day Of Admission: 21th August 2023(Day Of Discharge)**

Patient woke up around 5:30am. After she had taking her bath, brushes her teeth and groomed.

Her vital signs were checked and recorded. Due medications were served.

I arrived at the ward around 7:00am. Patient present no complain upon seeing me.

At 7:50am, evaluation was done on dizziness and patient verbalized absence of dizziness and I also observed that patient showed no sign of injuries which shows that therefore goal set on 18/08/20 on the first day was fully met. I reassured her and went on to carry my routine care at 10:00am.

On the same day of admission at 8:00am evaluation was done on the objective set to help patient regain normal nutritional pattern. Goal was fully met as; nurse observed patient eat more than half of meal served and Patient verbalized regain of appetite.

At 8:30am, the goal set to relieve patient of headache was evaluated and goal was fully met as patient verbalized the absence of headache and nurse observed patient is comfortable in bed.

At 9:00am, Evaluation was done on constipation and the objectives set on 21/12/23 at 9:00am to relieve patient of constipation was fully met as she verbalized that she emptied her bowel that morning with less difficulty.

Afterward rounds at exactly 10:00am. Patient and her children were educated on her condition, the predisposing factors, signs and symptoms and its management. I educated them to seek immediate medical care in case of any abnormality and the need to continue and complete her prescribed medication. Patient was educated on the need to avoid over the counter drugs, eat nutritious and well-balanced diet, avoid high sodium diet (salt), do regular exercises and the need for renewal of national health insurance card before it expires. I educated her on the importance of review and follow ups for continuity of care after discharge. I explained to her about her medications, dosages, route of administration as well as side effects to patient and her family. I gave them the opportunity to ask questions which were answered clearly. She was discharged to continue with the following drugs;

Tablet Nifedipine 20mg bd x 30 days

Tablet Bendroflumethiazide 2.5g daily x 30 days

Tablet Aspirin 75mg daily x 30 days

Paracetamol 1g x 5 days

After settlement of the hospital bill that were not covered by the National Health Insurance Scheme (NHIS), I helped them to pack their belongings. Mrs. A.Z, her children, husband and other relatives thanked the staff present and other patients at the ward and bid them goodbye. I escorted them to the hospital gate, said goodbye to them and came back to the ward. I removed her bed linen and disinfected the bed and cupboard. All care rendered to her was documented in the nurse's note. She was also discharged in the admission and discharge book and in the daily ward state.

#### **4.2 Preparation of Patient and Family for Discharge/Rehabilitation**

Preparation towards discharge and rehabilitation was established on the admission day (18/08/23) until the day of discharge (21/08/23). The aim was to enable her to take active role in her care of speedy

recovery and also to give her an insight to her condition. My patient and relatives were made to understand that with the continuous care, her condition will improve and will be discharge home, patient and family were also reassured that Patient will return home fully recovered to reduce anxiety. Emphasis was made on the need to visit the hospital immediately with any illness that occurs to avoid complications. During ward rounds on the 21/08/23 patient was examined and discharged. Patient and relatives were educated to have enough rest and to avoid stressful activities. On the day of discharge, Patient and relatives were helped to pack their belongings reminded them on the review dates. Patient and her family were educated on the following;

1. Patient was educated on the importance of well-balanced diet in the Maintenance of good health
2. She was encouraged to continue taking low sodium diet, fruits and adequate fluids to prevent constipation and also limit the intake of fatty foods.
3. Patient was educated on the importance of exercise.
4. She was encouraged to do exercises which she can tolerate in order to improve on her health status. A passive exercise example walking was also encouraged
5. Patient was encouraged to have enough rest and sleep after the day's activities. The Importance of rest and sleep was explained to her.
6. She was educated on the need for stress management in reducing hypertension.
7. . She was advised to prevent stressful situations and share problems with her husband and children.
8. She was advised to contact someone she trusts for advice when she encounters any problem rather than keeping it to herself.
9. My patient and her family were educated to maintain proper personal and environmental

Cleanliness.

10. She was advised to bath twice daily, wash clothes frequently, proper disposal of Refuse, weeding around their compound and also avoid stagnant waters around their house.

11. Mrs. A.Z was advised to continue her medication as prescribed to prevent relapse of the disease condition. She went home with the following drugs;

Tablet Nifedipine 20mg bd x 30 days

Tablet Bendroflumethiazide 2.5g daily x 30 days

Tablet Aspirin 75mg daily x 30 days

Paracetamol 1g x 5 days

The side effects of the drugs were explained to her. She was informed to come for review on 4<sup>th</sup> September, 2023. She was informed to come to the hospital when symptoms occur. Patient and relatives were again advised on the need to avoid counter medication. They were educated on the National Health Insurance Scheme and its benefit and they were encouraged to continue using it as their source of care in the hospital.

#### **4.3 Follow Ups /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 also aims at assessing the use of available resources at home as well as in the community that could be used to solve actual and potential health problems and also helps to follow patient's progress after discharge.

#### **4.3.1 First Home Visit (Monday 21/08/23)**

My first home visit was on 21<sup>st</sup> August, 2023 when patient was still on admission. The main purpose was to familiarize myself with patient's home environment and assess the health related factors and ways of solving them. The environment of the house was not tidy. The house is a bungalow located near a road and it has three single rooms. Each room had a single window located at the back of the room and a single door in front. The rooms were not spacious and properly ventilated. They had a toilet facility which was well cleaned and tidy. I encouraged them to give patient all the support she would require when discharged, her sleep pattern, nutritional status, and personal hygiene. I reassured them of patient improvement in condition and them of seeing her very soon. I informed them of my next visit, which was going to be after patient's discharge. I thanked them for their hospitality and asked permission to leave.

#### **4.3.2 Second Home Visit (Tuesday 28/08/23)**

My second home visit was paid on 28<sup>th</sup> August, 2023 at 9:00am. Everyone was happy to see me, they warmly welcomed me and offered me a seat. The main aim was to assess the state of patient health at home, remind her of her review date and also to know how the family is responding to what they were educated on during the first home visit. I congratulated them for the good work done. I made mention of introducing a nurse from Suyani Regional Hospital, who would be taking over from me after termination of care. We interacted for a while and I finally had to leave. I thanked them for their company and they thanked me for keeping to my promise by visiting. I went to arrange with a nurse at the Suyani Regional Hospital about continuity of care.

#### **4.3.3 Day of Review/Follow Up (Monday 4<sup>th</sup> September, 2020).**

At 10:20am on 4<sup>th</sup> September, 2023, I met Patient and husband at the hospital gate of Suyani

Regional Hospital and warmly welcomed them. Her hospital card was taken to the record department and details were sent through digital means after which vital signs were checked at the Nurses station at the outpatient department and were recorded as: temperature 36.4°C, Pulse, 78 beat per minute, Respiration 19cpm, Oxygen saturation 96% and Blood pressure 115/72mmHg. Patient was directed to nurse's room number two to meet the doctor on duty. During consultation with the doctor, patient did not mention any new complaint and an education was given to her on the need to maintain good personal and environmental hygiene, the need to take in well balanced meals and healthy drinking water and also prompt an immediate report to the facility when not feeling well. After seeing the doctor, I accompanied them to the hospital gate and bid them good bye.

#### **4.3.4 Third Home Visit (Tuesday 13<sup>th</sup> September, 2023)**

On 13th September, 2023, I paid patient/family a visit with the aim of checking up on them and their health status and also terminating care. I got to the house and met patient at the entrance, where I went in with her. I greeted and I was offered a seat. I congratulated them for the good work done. I thanked them and assured them of calling and visiting from time to time to check up on them. They also thanked me. I introduced them to a nurse who stays around. There was no community nurse around so I handed patient over to the from Suyani Regional Hospital, called Y.P who lives about one mile away from them who also assured me of doing her best to continue care. I asked for permission to leave and permission was granted for me to leave.

## 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).After patient has been assessed, problems identified, diagnosis made, care plan formulated and implemented, he nurse judges the success of these steps by way of examining patient's response and comparing them with the expected outcomes stated.

The result determines whether or not expected goals were achieved and if the process should be terminated or revisited.

#### **5.1 Statement of Evaluation.**

Evaluation is the final phase of the nursing process. It is the process of assessing and comparing the outcome of nursing orders and intervention against previously stated goals and objectives. During the admission and hospitalization of Mrs. A.Z some problems were identified, goals were set and interventions employed to solve them. The outcomes of the goals set for the problems identified are below:

##### **1. Patient's chest pain was relieved within 24hours on 21/08/23 at 7:30am**

On 19/08/23, at 7:30am, Patient complains of chest pains. A nursing diagnosis of acute chest pain related to inflammatory process of the disease condition. An objective was set to help patient chest pain relieve to normal within 24hours.

The following nursing interventions were carried out; Patient was reassured that she is in competent hands of professional health workers to allay anxiety, Patient level of pain was assessed using a scale of 1-10 and rated 2, Patient was made comfortable by placing patient in a semi fowlers position, Tight clothing was removed from patient neck, chest and waist to aid in breathing, Tablet paracetamol 1g was served.

On 21/08/23 at 7:30am evaluation was made for the objective set to relieve patient of chest pains Goal fully met as nurse assessed patient level of pain and realizing it has reduced by a scale of 1 (using a pain scale of 1-10) and patient reported relieve of chest pain during breathing without the use of accessory muscles.

### **2. Patient was relieved of headache on 21/08/23 at 8:30am**

On 19/082023 at 7:40am, Patient complained of headache and a nursing diagnosis of impaired comfort (headache) related to increase cerebral vascular pressure was formulated and an objective was set to relieve patient from headache throughout the period of hospitalization. The following nursing interventions were carried out; Reassuring patient and family, Paracetamol 1gm and antihypertensive nifedipine 20mg was administered, cold compress was applied to patient head to relieve her from pain, Patient was educated to have enough rest, A quiet environment was ensured by reducing noise at the ward to promote rest and sleep. All care rendered was documented.

On 21<sup>st</sup> AUGUST, 2023 at 8:30am, the goal set to relieve patient of headache was evaluated and goal was fully met as patient verbalized the absence of headache and nurse observed patient is comfortable in bed.

### **3. Patient was relieved of dizziness on 21/08/23 at 7:50am**

On 18/08/23 at 7:50am, patient complained of dizziness. A nursing diagnosis of risk for injury as evidenced by dizziness was formulated and an objective set up to relieve patient of dizziness throughout the period of hospitalization. The following interventions were carried out; patient reassured that she will be able to carry out activities of daily living without assistance, Side rails of bed raised to prevent patient from falling, complete bed rest ensured by restricting visitors during sleep and rest hours, Injurious objects like needles removed from patient's reach, vital signs especially blood pressure were monitored 4 hourly and recorded, patient was informed to call for assistance from the nurses when needed, patient was educated to sit up in bed for 5 minutes before standing up.

On 21/08/2023 at 7:50am, evaluation was done on dizziness and patient verbalized absence of dizziness and I also observed that patient showed no sign of injuries which shows that therefore goal set on 18/08/23 to relieve her from dizziness on the first day was fully met.

#### **4. Patient resumes her normal sleeping pattern on 21/08/23 at 7:30am**

On 20/08/23 at 8:00am, patient complained of difficulty in sleeping (insomnia). A nursing diagnosis of insomnia related to unfamiliar hospital environment. An objective was set to relieve patient of insomnia within 24 hours. The following nursing interventions were carried out, Patient/family reassured, The environment was made quiet by minimizing noise at the ward and restricting visitors, Proper circulation of air was ensured to promote sleep, Patient was educated to take warm bath before going to bed and patient also educated to empty her bladder before going to bed.

On 21<sup>th</sup> August 2020, at 8:00am, evaluation was done on insomnia and patient verbalized having uninterrupted sleep for 8 hours, Goal set to relieve patient of insomnia was fully met.

#### **5. Patient regained her normal nutritional pattern within 48 hours on 21/08/23 at 8:00am.**

On 21/08/2023, at 8:00am of admission. A nursing diagnosis of altered nutrition pattern (less than body requirement related to loss of appetite) was formulated. An objective was set to help patient regain her normal nutritional pattern within 48 hours.

Nursing interventions implemented includes: Patient was reassured that the necessary measures would be rendered to improve appetite. Patient's mouth was cleaned every morning and evening. This was done to keep the mouth clean and to stimulate appetite. Patient was assisted to feed to provide energy and nutrients. Bed pans were removed from patient sight before meals to prevent loss of appetite. Relatives were encouraged to serve food attractively and in bits.

On 21/08/23 at 8:00am evaluation was done on the objective set to help patient regain normal nutritional pattern. Goal was fully met as; nurse observed patient eat more than half of meal served and Patient verbalized regain of appetite.

**6. Patient resumed her normal bowel movement within 24 hours on 22/08/23 at 9:00am.**

On 21/08/23 at 9:00am, Patient complained of irregular and difficulty in emptying her bowel. A nursing diagnosis of impaired bowel elimination (constipation) was drawn and an objective was set to relieve patient of constipation within 24 hours and the following nursing interventions were carried out; Patient/family reassured that everything possible would be done to help her move her bowels, Sips of water served at regular intervals and appropriate fruits like water melon, Patient served with roughage diet and educated on the importance of roughages in diet, Patient encouraged to do passive exercise like walking around, Patient educated to empty her bowel whenever she feels the urge to prevent constipation. She had already performed her personal hygiene without assistance.

On 21/08/23 at 9:00am Evaluation was done on constipation and the objectives set on 21/08/20 at 9:00am to relieve patient of constipation was fully met as she verbalized that she emptied her bowel that morning with less difficulty and that her condition has improved.

## **5.2 Amendment of the Nursing Care Plan for Partially Met or Unmet Outcome Criteria.**

Despite the numerous problems identified, all goals set for patient were fully achieved through the co-operation of patient. Hence no amendments were made.

## **5.3 Termination of Care**

Termination of care is the ending of the nurse -patient relationship that existed between patient and nurse during rendering of care (Kamitsuri, 2017). Patient and family were made to understand that patient's hospitalization was temporal since she will be discharged to go home after her condition had improved. The preparation for discharge started on the day of admission until the day of discharge.

My interaction with Mrs. A.Z started from 18<sup>th</sup> August, 2023 at the Females Medical Ward. The interaction was smooth as patient's improvement began on admission through to discharge on 22<sup>nd</sup> August, 2023 with good nursing and medical care.

On 13/09/2023, I made my last home visit to patient. I visited patient on the said date at 9:50am with a nurse called Y.P. who works at Suyani Regional Hospital. The purpose of the visit was to know how my patient was doing and terminate the care that was rendered to patient as I explained to her that care rendered to her will be terminated after she has been discharged. We were welcomed and offered a seat. I introduced nurse Y.P. to them that she will visit them very often to check on them. Mrs. A.Z looked cheerful, active and healthy. I asked about her drugs and I found out that she had been taking her medications. Patient condition had improved and no complaints

were presented. I emphasized on the health education and stressed on the need to avoid selfmedication and also to report promptly when sick. Patient's children and husband also promised to take good care of her to prevent complications. Patient and family were educated again on the need to take low sodium diet, avoid stress, drinking alcohol in moderation and also eat low fatty diet.

Finally, I handed patient over to nurse Y.P. She promised to take good care of her to prevent any complication. They thanked me for the care rendered and I also thanked them for their maximum Cooperation. We bid them goodbye and left.

## CHAPTER SIX

### SUMMARY AND CONCLUSION

#### 6.0 Introduction

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

#### 6.1 Summary

Patient a 45-year-old farmer from Adomako junction in Sunyani was admitted to the Females Medical Ward of Sunyani Regional Hospital on 18<sup>th</sup> of August 2023 at 7:30am. She complained of headache, dizziness, loss of appetite and many more. She was diagnosed of hypertension with blood pressure of 150/100mmHg. She was put on the following treatment;

- 1) Intravenous hydralazine 5mg stat, should be given slowly.
- 2) Tablet Nifedipine 20mg bd x 30
- 3) Tablet Aspirin 75mg daily x 30
- 4) Tablet Bendroflumethiazide 2.5g daily x 30
- 5) Tablet Paracetamol 1g td for 5 days orally

Routine care such as personal hygiene, assisted bed bath, monitoring of vital signs and drug administration were monitored to ensure that patient recovers successfully without complications. Nursing problems were identified, nursing diagnoses were formulated, and objectives set, nursing orders carried out and goals fully met within the expected time. She spent four days in the hospital.

Patient and family were given comprehensive care and education on hypertension such as predisposing factors. She was also educated on the signs and symptoms and possible complications of the condition and the need to seek medical treatment when she notices them. With effective medical and nursing management, patient recovered within four days without complications. The following diagnostic investigations/tests were carried out on Patient

- 1) Full Blood Count
- 2) Malaria parasite Test
- 3) Blood urea and creatinine
- 4) Kidney Function Test

Mrs. A.Z's blood pressure when admitted was 150/100mmHg but during her discharge, it was 130/90mmHg, which indicated that she was given the right treatment and it was effective. She was discharged on 21<sup>st</sup> August, 2023. And she came for review on 4<sup>th</sup> September, 2023. Three home visits were made. First home visit was made on 21<sup>st</sup> August, 2023, second on 28<sup>th</sup> August, 2023 and the third on 13<sup>th</sup> September, 2023. One during admission and two after patient was discharged.

## **6.2 Conclusion**

The patient and family care study has help me improve my knowledge and skills as a student nurse in planning care for patient and their families and efficient nursing care delivery for hospitalized patients. The care rendered to Mrs. A.Z and her family has really helped me to gain a great knowledge on hypertension.

It has also offered me a great opportunity to know how to nurse individuals with hypertension. It has also helped me to practice my skills acquired in the classroom practically. It has strengthened my relationship with patients, families and the members of health team. The study has helped the

patient/family comprehend and gain insight in the condition and improved upon their health status through the practice and health education received throughout their interaction with me. A copy of the care study will also be kept in the school library to help student gain knowledge on how to nurse hospitalized patients with this condition, broaden their knowledge. I therefore encourage a continual writing of patient/family care study by all final year student nurses before being awarded a certificate as professional nurses because of the benefits they will derive from it, which includes formulating proper nursing care plan for patients and broaden their knowledge in the condition they choose for their study.

## APPENDIX

**Table 8: Vital signs check for Mrs. A.Z From Admission till Discharge**

<b>Date</b>	<b>Time</b>	<b>Temperature (<sup>0</sup>C)</b>	<b>Pulse (bpm)</b>	<b>Respiration (cpm)</b>	<b>Oxygen Saturation</b>	<b>Blood pressure (mmHg)</b>
18/08/23	7:30am	37.0	82	21	92	140/100
	10:00am	36.8	84	21	93	150/90
	2:00pm		89	23	93	
	6:00 pm	36.7	88	22	94	140/90
	10:00 pm	36.8	81	20	95	140/90
19/09/23	7:30am	36.2	80	20	96	140/100
	10:00am	35.6	80	20	95	140/90
	2:00pm	36.2	77	20	92	140/90
	6:00pm	35.6	72	22	94	130/100
	10:00pm	36.3	81	20	94	130/100
20/09/23	7:30am	36.2	96	19	95	140/80
	10:00am	35.6	88	21	97	130/90
	2:00pm	36.8	91	22	96	130/90
	6:00pm	35.6	88	20	94	130/90
	10:00pm	35.5	93	22	98	130/90
21/09/23	08:00am	36.1	92	21	98	130/90

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