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

**A PATIENT AND FAMILY CARE STUDY (A NURSING PROCESS APPROACH)**

**ON A PATIENT WITH**

**HYPERTENTION**

**BY**

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**A PATIENT AND FAMILY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA INPARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF LICENSE TO PRACTICE AS A**

**PROFESSIONAL REGISTERED GENERAL NURSE**

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## PREFACE

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

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

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

## ACKNOWLEDGEMENT

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

My next gratitude goes to my patient, Mrs. D.A and her family members for their absolute co-operation. I thank them for all the information they provided towards the progress of this study. I am also grateful to the medical doctors and the entire staff nurses of the Female Medical Ward at St. John of God Hospital Duayaw Nkwanta especially, the ward in charge.

Furthermore, my special thanks go to Mr. Eric Obeng for his time and energy spent in supervising me throughout this study and the entire teaching and non-teaching staffs of Holy Family Nursing And Midwifery Training College, Berekum.

My profound thanks to the Principal of the Holy Family Nursing and midwifery Training College-Berekum, Ms. Monica Nkrumah, for being my source of guidance and motivation during this study.

My sincere appreciation to my parents for their emotional, spiritual and their physical support throughout this study and also my class mates RGN 24 Class may the good lord bless everyone.

Finally, I am very grateful to all the publishers and authors whose books I used as a source of reference during the course of my study without forgetting Dwomo Printing Press at Berekum.

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

## INTRODUCTION

Patient and family care study is a report of comprehensive nursing care rendered to patient and their family from the day of admission, discharge and subsequent follow ups visits in other to help them meet their health needs. For confidentiality purposes, the name of my patient and her family would be replaced by their initials.

Presented is a report of care study written on Mrs. D.A, a 60 years old woman diagnosed of hypertension, who was admitted to the Female Medical Ward at St John of God Hospital , Dauyaw Nkwanta on the 1st September, 2023, with the history of headache, dizziness and general body weakness. Patient spent five days at the females ward but was detained at the Emergency Ward for 24 hours. Patient was discharged on the 5$^{th}$ September, 2023 after which, several home visits were embarked.

She was managed under the following medications;

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

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

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

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

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

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

Chapter one deals with assessment of Mrs. D.A and her family.

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

Chapter three comprises the planning phase of the nursing process.

Chapter four tackles the actual implementation of the care plan.

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

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

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# CHAPTER ONE

# ASSESEMENT OF PATIENT AND FAMILY

## 1.0 **Introduction**.

Assessment is a systematic collection of data to determine the patient's health status and any actual or potential health problems (Smeltzer, Bare, Hinkle, & Cheever, 2014). In the nursing process, assessment involves the gathering of information about the health status of the patient/client, analysis and synthesis of the data and the making of a clinical nursing judgment (Weller, 2014). It is an essential key needed in the nursing process in other to render holistic care to patient and their relatives. In this study, assessment was conducted based on the following methods; interview, physical examination, observations (using senses such as; the eye, nose, skin, ears etc.), Laboratory results and x-ray reports. Also, sources of information for this study was patient and the relatives as well as patient's folder etc. Assessment consists of the following sub headings; patient's particulars, Patient and family medical history, patient and family socio- economic history, patient developmental history, patient obstetric history, patient lifestyles and hobbies, patient past medical history, patient present medical history. It also consists of admission of patient, patient and family concept of the illness, literature review of the medical or surgical condition and finally, validation of data.

## 1.1 Patient's Particulars

Patient is a person who is ill or is undergoing treatment for a health care problem and registered with a general practitioner. (Weller, 2014). Particulars refers to details or information about a person or an event (Walter, 2013). For confidentiality purpose, in this study, the patient's full name is denoted by her initials as far as D.A.

Mrs. D.A is an 60-year-old woman born on 24th July 1964 at Bechem in the Ahafo region of Ghana. Mrs. D.A currently lives at Dua-yaw Nkwanta

also in the Ahafo region. She weighed 80kilogram with height 5 feet on admission. Mrs. D.A is the third born of the twelve children of her parents. She has nine children with Mr. A.B, of which five are males and four are females. Mrs D.A is a Ghanaian and an Akan by ethnicity hence, she speaks Twi. She is fair in complexion. She has a smooth skin, medium sizes

head, a round nose and white teeth in good alignment. Patient has no physical impairment and has no tribal mark on her face. Patient's house number is **DN 457** Duayaw Nkwanta. Mrs. D.A is a Christian and worship with The church of Pentecost at Dua-Yaw Nkwanta. Her next of kin is her daughter A.R.

**1.2 Patient and Family's Medical History**

According to Mrs. D.A, both her grandparents and parents had passed away. She continued by saying, among her eleven siblings, she has lost four remaining seven. She attributed the causes of their deaths to no cause. According to Mrs. D.A, her husband died 4 years ago as a result of hypertension and ended by saying her third born died at her seventh month and the cause of her death was hyperthermia. She was then reassured and the conversation continued. According to Mrs .D.A, there are no congenital abnormality in their family neither do they have any hereditary diseases like diabetes, hypertension, asthma nor any mental illness in their family except herself who is suffering from hypertension. She confirmed that once in the blue moon, some members in the family do suffer from the ailment of malaria, diarrhoea, headache and generalised body pains which they treat with over the counter medications (pharmaceutical medications). She

added that when the needs arises too, they combine their treatment with herbal medication. Mrs. D.A. said, she has been going for check-ups and reviews at ST. John of God hospital due to her known condition (hypertension). According to the patient, there are no known allergies in their family.

**1.3 Patient and Family Socio-Economic History**

Socio-economic history captures sources of support, coping styles, strengths, and fears. (Bickley, 2009). Mrs. D.A said, the relationship that exists between their family members is cordial and much cohering. She said, there is unity among family members hence they all work in peace and harmony together as one people. According to Mrs. D.A, none of her children has ever been educated hence does no white-collar jobs. Mrs. D.A, in terms of financial needs, each member joins hands to solve the problem out. Patient said, some members partake in religious activities but due to her age, she has isolated herself from religious activities. However, she always ensures that she prays every day at home. Patient said, her source of money for medical care is from her next of kin (daughter). She said, National Health Insurance Scheme (NHIS) also plays a vital role in the reduction of her medical cost. From Mrs. D.A, her parents' occupation was farming at Bomaa of which they cultivate cocoa. She continued by saying, the risks involved in the farming activities was bites from harmful animals such as; mosquitos, snakes etc. this was because, they sleep in the farm during the harvesting seasons. Mrs. D.A was not able to give an estimated value of capital received or earned by the family since she was not working. However, in terms of financial status, her family is in the middle class. This means, they are neither poor nor rich. According to patient, it is a taboo in their ethnic group for a woman to commit adultery once Married.

### 1.4 Patient's Developmental History

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

Maturation is the process of becoming completely developed mentally or emotionally (Walter, 2013). Growth is the progressive development of a living thing, especially the process by which the body reaches its complete physical development (Weller, 2014).

According to Mrs. D.A, she was told by her mother that she went through a normal pregnancy for nine successful months without any abnormality or disorder and got assisted in delivery by Traditional Birth Attendants through Spontaneous Vagina Delivery (S.V.D) without any complications. My patient was breastfed up to period of 8 months before complementary food such as porridge. She added that her infancy stage (0-2 years), she sat without support at her 6th months, started walking, talking and running at her 10th months, she was not able to tell as to whether immunized against childhood diseases. She said at her childhood stage (3-8 years), she started speaking their local dialect, running an errand and begun practising personal hygiene such; bathing twice daily, brushing the teeth etc. Puberty refers to a stage in people's lives when they develop from childhood into an adulthood because of changes in their body that make them able to have children (Walter, 2013). According to Mrs. D.A, she had her menarche (first menstrual period) at the age of 17 years and had her breast started developing. She then started growing pubic hairs around her genital region as well as under her armpit. Her hips begun broadening. Mrs. D.A. started practising good personal and environmental hygiene such as washing of clothing and utensils, bathing twice daily and does cooking by herself. She added that their house is well swept whenever dirty to improve upon their health. My patient explained to me that her relationship among her fellow adolescents was not all that close especially, men. Her

reason was, she was cautioned by her relatives not to get closer to men if not, she would get pregnant. Mrs. D.A actually did not give any career plans of hers. According to her, she has never been engaged in any occupation after she married. Her reason was, in their tradition, their husbands does not permit them to suffer rather they are to fulfil all duties to the wife. According to my patient, she got married at the age of 25 years to Mr A.B who is a Ghanaian. She enjoyed best and found happiness in her marriage and was blessed with children. Mrs. D.A. lost her husband for 4 years ago due to hypertension. She said, currently, as she is in her widowhood state now, she is not experiencing any problem simply because, all her needs are provided by her sons. Based on my patient's age and other symptoms she exhibited, she is in her menopausal age. Erikson's theory of psychosocial development describes the human life cycle as a series of eight ego developmental stages from birth to death.

Upon my constant conversation with my patient in the study, I realized that she falls under the 8$^{th}$ stage of Erik- Erickson Psychosocial developmental theory which is **Ego, Integrity versus Despair**. According to Erik- Erickson, at this stage, the late adulthood reflects back on the life they have lived and come out with either a sense of fulfillment(successful) from a life lived or a sense of regret and despair over a life misspent. According to Mrs. D.A., she is feeling satisfaction in life in the sense that, she has raised nine children and has a good relationship with them all. Furthermore, she feels so proud of her years educating young children and being around her young grandchildren. She concluded by saying, as she faces the end of her life, she feels a sense of being complete and is able to look back and face what is ahead with a sense of wisdom and peace. This is what Erickson referred to as ego integrity. I was told by Mrs. D.A. that she did not have the opportunity to be educated due to hardship in their family at that time.

### 1.5 Patient's Obstetric History

Obstetric is a field of study concentrated on pregnancy, childbirth and the postpartum period (Roth, 2018). According to Mrs. D.A, she gave birth to 9 children and all her deliveries were spontaneous vagina deliveries assisted by Traditional Birth Attendant at home without complications. Mrs. D.A. told me she had her menarche (first menstrual period) at age 17 with a normal flow. According to her, she had never used contraceptives since her lifetime.

### 1.6 Patient's Lifestyles and Hobbies.

Lifestyle is the pattern of daily living that an individual develops (Weller, 2014).

Hobby is a regular activity done for enjoyment, typically during one's leisure time, not professionally and not for pay (Stebbins, 2015).

Mrs. D.A. normally goes to bed around 9:00 pm and wakes exactly, 5:00am at dawn to start morning prayers. She performs oral hygiene twice daily with a soft brush and tooth paste, at times uses chewing stick. She takes a warm bath twice daily. My patient performs no special assignment during the week days. During weekends, she normally attends naming ceremonies, funerals and at times do visits close relatives around. She experiences no difficulty in eating except when she is sick. She always wears decent dress when she is going to church. She walks a little bit slower and assumes a slightly forward -bent position when walking. My patient does not use alcohol, tobacco, coffee and uses no illicit drugs such as; cocaine, tramadol etc. and recreational drugs. She empties her bowel at least once daily and empties her bladder more frequently especially when she takes in more fluids. Mrs. D.A. rarely buys food outsides but does all her cooking by herself. She said Mrs. A.R (daughter) is their source of housekeeping. She takes three square meals per day with no snacks. My patient's favorites dish is plain rice with an egg stew, fufu and light soup with cow meat and ampesie with garden eggs stew with

sardine. Mrs. D.A. said that, they experience no difficulty in feeding just that, at times they eat late and it as a result of her grandchildren. She has no disturbed sleeping pattern hence uses no special remedies for sleeping. She said, a times she sleeps in the afternoon and sleeps well at night too. My patient has no known allergies to food and drugs. Singing Pentecost team songs and watching television are her favorite's hobbies. She does not engage herself in any form of exercise. She has no abnormal psychological disorders such; Schizophrenia, post-traumatic stress disorder, bipolar disorders etc. She is mentally sound and alert. According to Mrs. D.A, her 3 grandchildren are her major source of stressors. They always make her talk much. Her perception is, when they grow up such behaviour will be halted since she always try her best advising them. She normally sleeps when she becomes stressed up and at times, does watch movies on television. Her mode of communication is by verbal means and speaks at a lower tone. She likes telling the truth, educating and helping young ones. Her dislikes are prostitution, stealing, fighting and maltreating children. She is much sociable and does not think or cares about herself alone but rather for all. Sincerely, my personal impressions about Mrs. D.A. is so amazing and loving. This is because, she opened up whole heartedly discussing her personal issues with me in the study and always wish best for the youth.

**1.7 Patient's Past Medical History**

According to Mrs. D.A, she was told she did not experience any childhood illness such as; tetanus, whopping cough, measles, poliomyelitis diphtheria etc. However, she added that, once in the blue moon, she does experiences mild headache, abdominal pains and malaria which is treated with over the counter drugs and herbal preparations. She has no known allergies to animals, drugs, foods, insects etc. My patient has never been involved in an accident before. She said, she had an incisional wound as a result of cut from knife several years ago and the source of

treatment was hot water therapy at home. Mrs. D.A. first hospitalization occurred last three months ago. Her reason for hospitalization was headache and generalized bodily pains which ended up with the diagnosis hypertension. Currently, she is on the following antihypertensive medications: tablet Amlodipine and tablet Atenolol. She has not developed any complications per her condition simply because, she is on antihypertensive medications which she always takes as prescribed. Her access to health care is much easier due to support from relatives and with the help of National Health Insurance Scheme (NHIS) which reduces her medical bills. She attends her medical checkups currently at ST. John of God Hospital.,Duayaw Nwanta.

**1.8 Patient's Present Medical History**

According to patient's next of kin, (Mrs. A.R), Mrs. D.A. is a known hypertensive patient as said earlier. He added that she was doing well until she returned from a two- day naming ceremony from Bomaa on 16th August, 2023. In the morning, she started complaining of headache, dizziness and generalized bodily pains. Mrs. D.A. taught her complaints could subside but rather, kept on aggravating. According to Mrs. R.A. her mother left her antihypertensive medications in the house and went for the ceremony. This means she defaulted from her drugs. Due to its severity, she quickly took a car and rushed her to St. John of God Hospital where she was detained at the Emergency ward for treatment at 8:30 am. With references to her vital signs, physical assessment and complaints, she was finally diagnosed of hypertension by Doctor Asiedu Stephene.

**1.9 Admission Of Patient**

Admission of a patient into the hospital ward is a change of environment with its attendant problems (Gyang & Darko, 2010).

Patient was admitted into the Females ward through the Accident and Emergency Unit at St. John of God Hospital, Duayaw Nkwanta accompanied by a staff nurse, two student nurses and a relative in a wheel chair in a conscious but weak state on 1st September, 2023. at 8:30am with the diagnosis of hypertension. Patient's complains were; headache, generalized bodily weakness and dizziness. I welcomed patient and the relative and they were reassured of competent nursing care. I made a cross-check to confirm whether patient was truly admitted into the females ward with the said diagnosis. Patient's full name was mentioned to ensure if she was the right person. Cardiac bed was prepared to make patient comfortable. I made a brief introduction of myself and staffs to patient and the relative. Patient's vital signs were checked and recorded as:

| | |
|---|---|
| Temperature | 36.6 Degree Celsius($^{O}$C) |
| Pulse | 67 beats per minutes (bpm) |
| Respiration | 20 cycles per minutes (cpm) |
| Blood pressure | 160/90 millimeters of mercury (mmHg) |

Tab Amlodipine 5mg was administered when she was recorded high Blood pressure.

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

Mrs. D.A was to be managed under the following medications;

1. Intramuscular (IM) Diclofenac Stat (st)
2. Tab Amlodipine 5mg daily x 60days
3. Tab Atenolol 50mg daily x 60 days
4. Tablet Paracetamol 1g tid x 7
5. Suppositories Diclofenac 100 daily 5/7

The following Laboratory Investigation were ordered;

Full blood count (FBC) for, RBC,WBC,HBC etc.

1.Malaria Test

2.Urinalysis (Urine R/C)

3.Random Blood sugar (RBS) was checked and recorded as; 5.9 mmol/1

Intramuscular diclofenac, Tablet Atenolol 50 mg daily and Tablet Amlodipine 5mg daily was rightly administered and well documented. Patient was changed into new clothing, reassured of competent nursing care and made more comfortable in bed by ensuring bed free from creases and cramps. Relatives were entreated to participate in the health care delivery in other to achieve patient's early recovery. I also made them aware hospitalization was temporal home for them. Hence, there would be a need for the continuation of care after discharge especially, with regards to her nutrition, lifestyle and pharmacological managements.

Patient's details such as, name, sex, age, address, diagnosis, occupation etc. were entered into the admission and discharge (A&D) book as well as, the daily ward state. Patient's admission notes was then written.

I introduced myself to patient and her relative that, I am a final year student nurse of Holy Family Nursing and Midwifery Training College ,Berekum, who wished to use them for my care study in which a report would be written after the study. I explained to them that, the care study is a requirement by the Nursing and Midwifery Council (NMC) of Ghana before Diploma Certificate would be awarded. They were assured of confidentiality. I ended by saying, they could choose to withdraw from the study whenever they wished to do so. Patient and her relative were glad to hear and consented to my request and I thanked them. I explained to the ward in - charge a and she gave me the go ahead to continue my study with Mrs D.A .She was chosen for my care study because patients and relative lacked detailed knowledge about their condition therefore,

I decided to take Mrs. D.A for my study in other to educate them more about hypertension since it is known as a silent killer. Patient's relative was encouraged to bring food to patient but was cautioned to avoid food containing fat such as ; meat, sardine, fried rice etc. and also her personal items such as; clothing, mosquito net, bowl, toilet roll, spoon, plastic, items for mouth care etc.

**1.10 Patient's and Family Concept Of Illness**

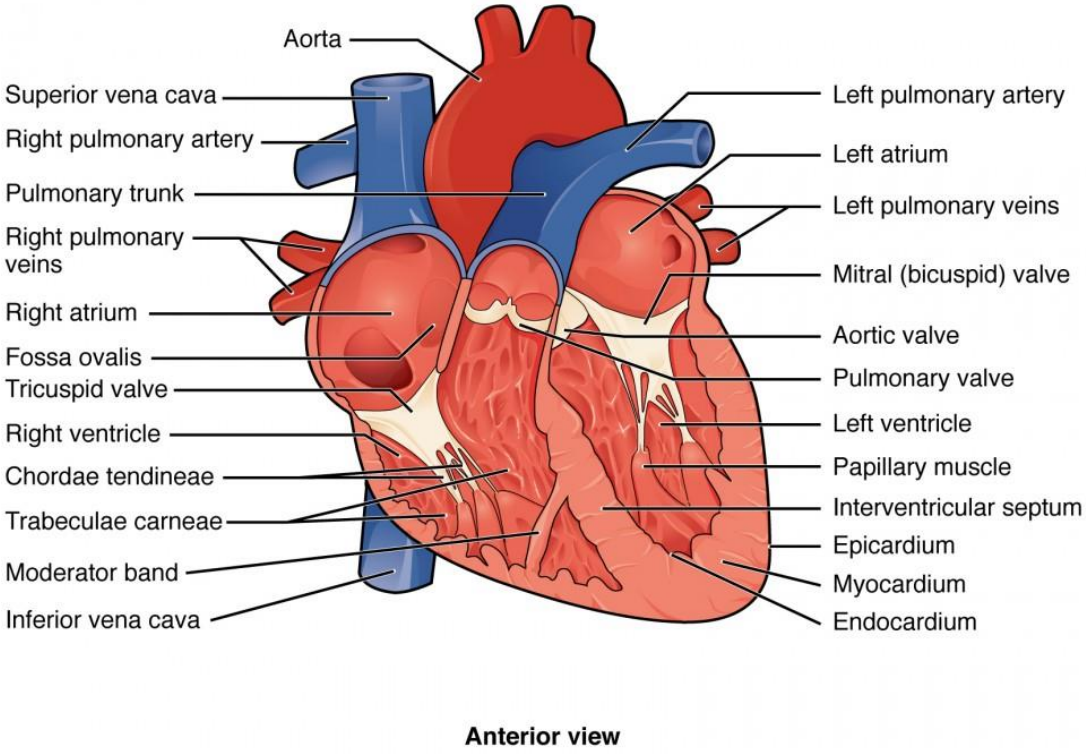
According to patient and the relative, the illness was not as a result of any spiritual influence. However, when they were examined on some risks factors and major signs and symptoms of the condition, Mrs. D.A said they do not have adequate information on hypertension and that was their reason of admission for treatment. Patient and the relative expressed a little bit fear concerning the illness. They believe the is not condition curable? because, since the past years, patient had been on antihypertensive medications yet still the condition still exists

## 1.11 LITERATURE REVIEW ON HYPERTENSION

### Basic Anatomy and Physiology of the heart and blood vessels.

The heart is a four-chambered hollow muscular organ normally about the size of a fist. It lies within the thorax in the mediastinal space that separates the right and left pleural cavities. The heart is composed of three layers: a thin inner lining, the endocardium; a layer of muscle, the myocardium; and an outer layer, the epicardium. The heart is covered by a fibro serous sac called the pericardium. This sac consists of two layers: the inside (visceral) layer of the pericardium (part of the epicardium) and the outer (parietal) layer. A small amount of pericardial fluid (approximately 10 to 15 mL) lubricates the space between the pericardial layers (pericardial space) and prevents friction between the surfaces as the heart contracts. The heart is divided vertically by the septum. The interatrial septum creates a right and left atrium, and the interventricular septum creates a right and left ventricle. The thickness of the wall of each chamber is different. The atrial myocardium is thinner than that of the ventricles, and the left ventricular wall is two or three times thicker than the right ventricular wall. The thickness of the left ventricle is necessary to produce the force needed to pump the blood into the systemic circulation. The four valves of the heart serve to keep blood flowing in a forward direction. The cusps of the mitral and tricuspid valves are attached to thin strands of fibrous tissue termed chordae tendinea . Chordae are anchored in the papillary muscles of the ventricles. This support system prevents the eversion of the leaflets into the atria during ventricular contraction. The pulmonic and aortic valves (also known as semilunar valves) prevent blood from regurgitating into the ventricles at the end of each ventricular contraction (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

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




Source: (Smeltzer, Bare, Hinkle, & Cheever, 2014).

**Blood Supply to Myocardium.**

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

coronary veins parallel the coronary arteries. Most of the blood from the coronary system drains into the coronary sinus (a large channel), which empties into the right atrium near the entrance of the inferior vena cava.

**Vascular System Blood Vessels.**

The three major types of blood vessels in the vascular system are the arteries, veins, and capillaries. Arteries, except for the pulmonary artery, carry oxygenated blood away from the heart. Veins, except for the pulmonary veins, carry deoxygenated blood toward the heart. Small branches of arteries and veins are arterioles and venules, respectively. Blood circulates from the left side of the heart into arteries, arterioles, capillaries, venules, and veins, and then back to the right side of the heart. Arteries and Arterioles. The arterial system differs from the venous system by the amount and type of tissue that make up arterial walls. The large arteries have thick walls composed mainly of elastic tissue. This elastic property cushions the impact of the pressure created by ventricular contraction and provides recoil that propels blood forward into the circulation. Large arteries also contain some smooth muscle. Examples of large arteries are the aorta and the pulmonary artery. Arterioles have relatively little elastic tissue and more smooth muscle. Arterioles serve as the major control of arterial BP and distribution of blood flow. They respond readily to local conditions such as low oxygen (O2) and increasing levels of carbon dioxide (CO2) by dilating or constricting. The innermost lining of the arteries is the endothelium. The endothelium serves to maintain hemostasis, promote blood flow, and, under normal conditions, inhibit blood coagulation. When the endothelial surface is disrupted (e.g., rupture of an atherosclerotic plaque), the coagulation cascade is initiated and results in the formation of a fibrin clot (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

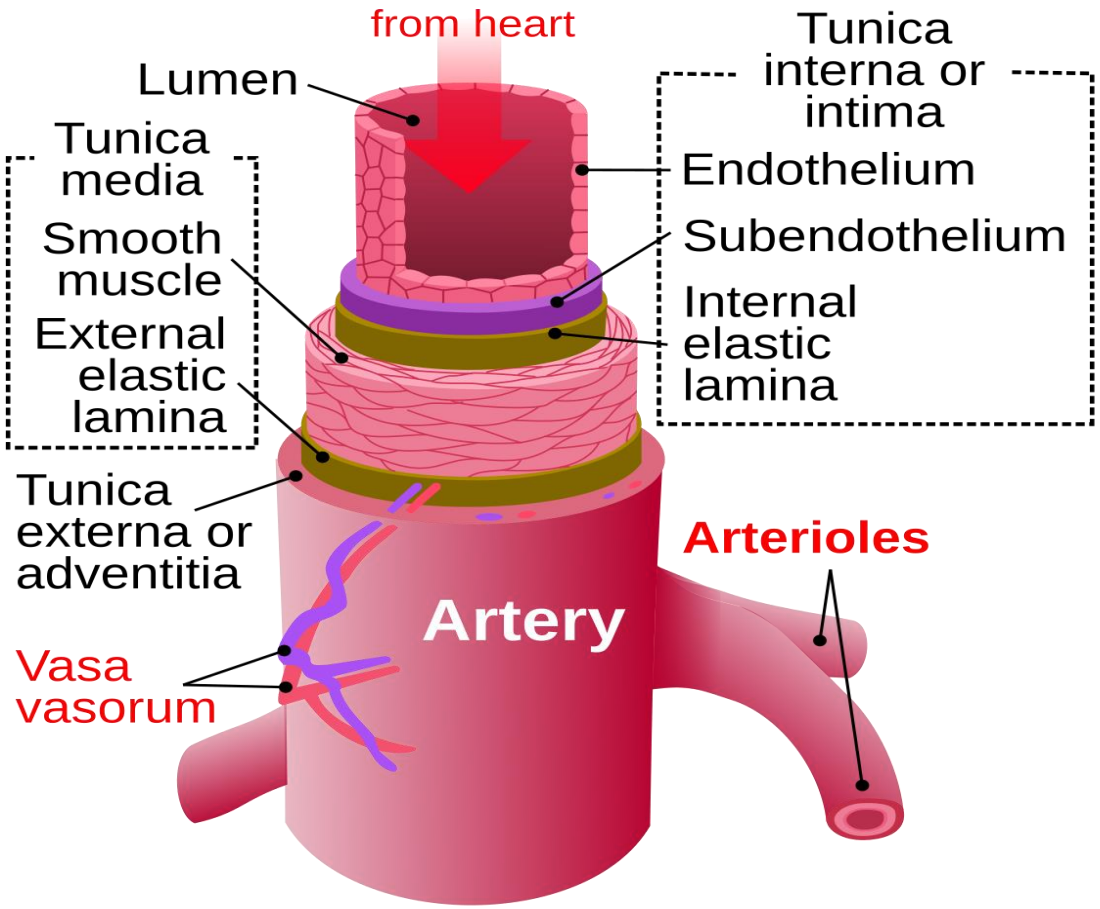



Figure 1.1: Anatomy of the Artery

**Capillaries.**

The thin capillary wall is made up of endothelial cells, with no elastic or muscle tissue. The exchange of cellular nutrients and metabolic end products takes place through these thin-walled

vessels. Capillaries connect the arterioles and venules.

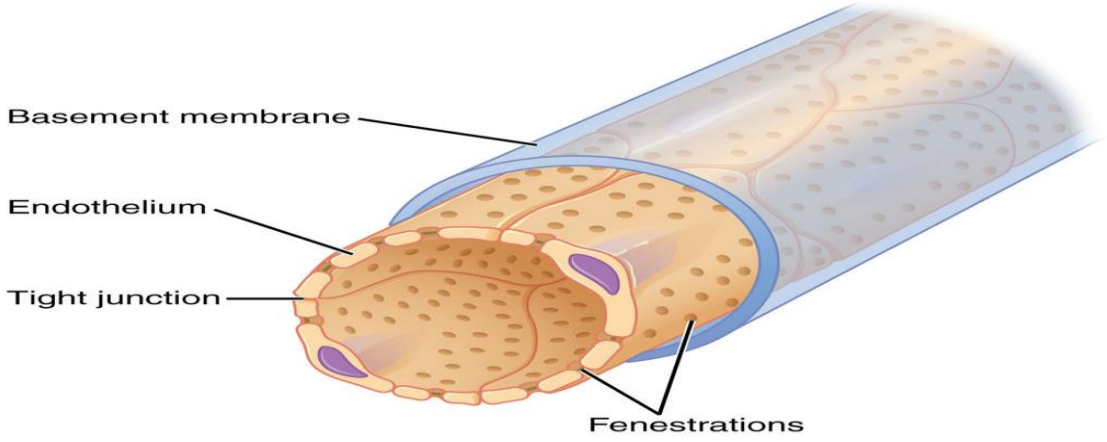



Figure 1.2: Anatomy of the Capillary

**Veins and Venules**

Veins are large-diameter, thin-walled vessels that return blood to the right atrium. The venous system is a low-pressure, high-volume system. The larger veins contain semilunar valves at intervals to maintain the blood flow toward the heart and to prevent backward flow. The amount of blood in the venous system is affected by a number of factors, including arterial flow, compression of veins by skeletal muscles, alterations in thoracic and abdominal pressures, and right atrial pressure. The largest veins are the superior vena cava, which returns blood to the heart from the head, neck, and arms, and the inferior vena cava, which returns blood to the heart from the lower part of the body. These large-diameter vessels are affected by the pressure in the right side of the heart. Elevated right atrial pressure can cause distended neck veins or liver engorgement as a result of resistance to blood flow. Venules are relatively small vessels made up of a small amount of muscle and connective tissue. Venules collect blood from the capillary beds and channel it to the larger veins (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

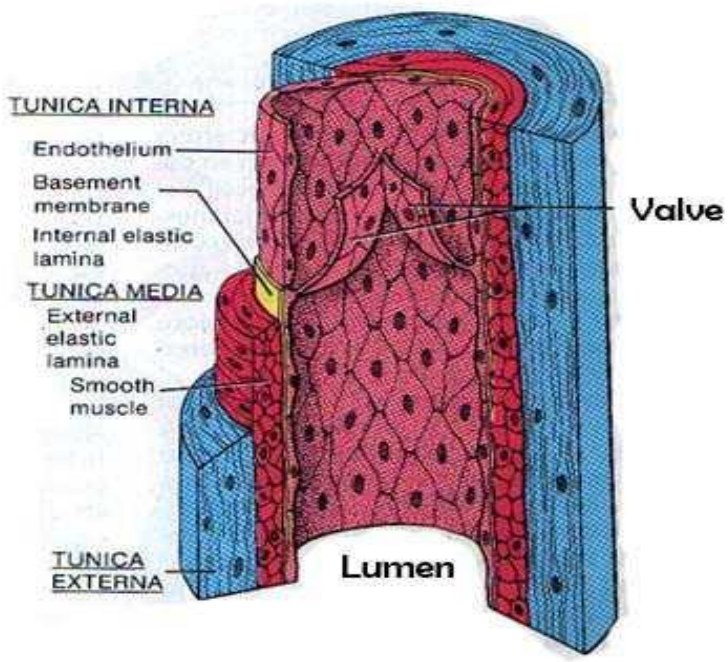



Figure 1.3: Anatomy of the Vein.

**Definition of hypertension**

**Hypertension** is defined as a persistent systolic BP (SBP) of 140 mm Hg or more, diastolic BP DBP) of 90 mm Hg or more, or current use of antihypertensive medication (Smeltzer, Bare, Hinkle, & Cheever, 2014).

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

**Prehypertension** is defined as SBP of 120 to 139 mm Hg or DBP of 80 to 89 mmHg (Smeltzer, Bare, Hinkle, & Cheever, 2014).

**Incidence of hypertension**

About 31% of the adults in the United States have hypertension, and the prevalence increases significantly as people get older or have other cardiovascular risk factors. The prevalence also varies by ethnicity, with African Americans having the highest prevalence at approximately 37% (Smeltzer, Bare, Hinkle, & Cheever, 2014).

**Types of hypertension**

Hypertension can be classified as either **primary** or **secondary**. Primary Hypertension. Primary (essential or idiopathic) hypertension is elevated BP without an identified cause, and it accounts for 90% to 95% of all cases of hypertension. Primary hypertension is the major focus of this chapter because of its prevalence and impact on health. Although the exact cause of primary hypertension is unknown. However, there are several contributing or risks factors as follows (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

1. **Age:** systolic blood pressure rises progressively with increasing age.
2. **Alcohol:** Excessive alcohol intake is strongly associated with hypertension.
3. **Tobacco use:** smoking tobacco greatly increases risks of cardiovascular disease since it contains nicotinic substances that increases vasoconstriction.
4. **Obesity:** weight gain increases the risks for the accumulation of atheroma (fats) inside blood vessels which does increases blood pressure accordingly.

5. **Gender:** Hypertension is more prevalent in men in young adulthood and early at middle age (<55 years of age). After age 64, hypertension is more prevalent in women.

6. **Excessive dietary sodium intake:** Increasing excessive intake of sodium increases the risks for hypertension since sodium absorbs water from interstitial space into vascular compartment thus, increasing blood pressure leading to hypertension.
7. **Family history:** History of a close blood relative (parents or siblings) with hypertension is associated with an increase risks for developing hypertension since it runs through blood.
8. **Diabetes mellitus:** Hypertension is more common in patients with diabetes
9. **Sedentary lifestyle:** Regular physical activity can help control weight and reduce cardiovascular risks.
10. **Elevated serum lipids:** Increase levels of cholesterol and triglycerides are primary risks factors in atherosclerosis. Hyperlipidemia is more in people with hypertension
11. **Race (ethnicity):** Incidence of hypertension is two times higher in African Americans than in whites (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

**Secondary Hypertension**

Secondary hypertension is elevated BP with a specific cause that often can be identified and corrected. This type of hypertension accounts for 5% to 10% of hypertension in adults. Secondary hypertension should be suspected in people who suddenly develop high BP, especially if it is severe. Clinical findings that suggest secondary hypertension relate to the underlying cause. For example, an abdominal bruit heard over the renal arteries may indicate renal disease. Treatment of secondary hypertension is aimed at removing or treating the underlying cause. Secondary hypertension is a contributing factor to hypertensive crisis (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

**Causes of secondary hypertension.**

According to Lewis (2014). The causes of secondary hypertension are as follows;

1. Endocrine disorder
2. Drug-related
3. Neurologic disorders
4. Pregnancy-induced hypertension
5. Renal disease
6. Liver cirrhosis
7. Diabetes mellitus

**Other forms of hypertension**

1. **Hypertensive emergency:** a situation in which blood pressure is severely elevated and there is evidence of actual or probable target organ damage.
2. **Hypertensive urgency:** a situation in which blood pressure is severely elevated but there is no evidence of target organ damage.
3. **Isolated systolic hypertension:** a condition mostly commonly seen in the elderly in which the systolic pressure is greater than 140 mm Hg and the diastolic pressure is within normal limits (less than 90 mm Hg).
4. **Rebound hypertension:** blood pressure that is controlled with medication and that becomes uncontrolled (abnormally high) with the abrupt discontinuation of medication.
5. **Malignant hypertension:** It is a severe form of hypertension. Malignant hypertension progresses rapidly and results in necrosis of the small arteries of the heart, kidneys, brain

and eyes (target organ). Dysfunction of the organ ensues and without medical treatment the course of malignant hypertension is rapidly fatal. Most persons do not survive longer than two years. This condition is seen most often in black men under the age of 40. Patient may experience headache, seizures, papilloedema and retinal haemorrhage (Smeltzer, Bare, Hinkle, & Cheever, 2014).

## PATHOPHYSIOLOGY OF HYPERTENSION

Blood pressure is the product of cardiac output multiplied by peripheral resistance. Cardiac output is the product of the heart rate multiplied by the stroke volume. In normal circulation, pressure is transferred from the heart muscle to the blood each time the heart contracts, and then pressure is exerted by the blood as it flows through the blood vessels. Hypertension can result from an increase in cardiac output, an increase in peripheral resistance (constriction of the blood vessels), or both. Although no precise cause can be identified for most cases of hypertension, it is understood that hypertension is a multifactorial condition. Because hypertension is a sign, it is most likely to have many causes, just as fever has many causes. For hypertension to occur there must be a change in one or more factors affecting peripheral resistance or cardiac output (Smeltzer, Bare, Hinkle, & Cheever, 2014). For instance: in renal ischemia due to renal disease like nephritis, stenosis of renal artery or polycystic disease, the kidneys release the enzyme renin. In the blood stream renin acts upon a plasma protein to produce angiotensin I. The angiotensin I is then converted to angiotensin II, by another enzyme called angiotensin converting enzyme. The angiotensin II (a potent vasoconstrictor) causes widespread peripheral resistance. This leads to elevation of blood pressure. The angiotensin II also increases the secretion of aldosterone by the adrenal cortex leading to sodium and water retention. As a result, there is increase in cardiac output leading to increasing blood pressure (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

**STAGES OF HYPERTENSION**

According to (Lewis, Dirksen, Heitkemper, & Bucher, 2014)**.**

**Stage 1 (Mild):**

I. Systolic pressure: from 140 mmHg to 159 mmHg

II. Diastolic pressure: 90 mmHg to 99mmHg.

**Stage 2 (Moderate)**:

I. Systolic pressure: from 160 mmHg to 179 mmHg

II. Diastolic pressure: 100 mmHg to 109mmHg.

**Stage 3 (Severe):**

I. Systolic pressure: from 180 mmHg to 209 mmHg

II. Diastolic pressure: 110 mmHg to 119mmHg.

**Stage 4 (hypertensive crisis):**

I. Systolic pressure: from 210 mmHg or more

II. Diastolic pressure: 120 mmHg or more

**Clinical manifestations of hypertension**

1. Occipital Headache
2. Blood pressure above 140/90 mmHg
3. Palpitations
4. Fatigue

5. Angina
6. Dyspnoea
7. Nausea
8. Confusion
9. Lightheadedness
10. Vertigo
11. Blurred vision (Dizziness)
12. Convulsion
13. Transient blindness
14. Stupor
15. Coma (Smeltzer, Bare, Hinkle, & Cheever, 2014).

**Diagnostic Investigations**

1. Health history and physical examination.
2. **Full blood count** to detect the amount of RBC, WBC, HB
3. **Urinalysis** to detect an amount proteins, pus, glucose, bacteria and blood presents in urine.
4. **Blood chemistry to** detect levels of blood K+ , Na+, creatinine, urea and high density lipoprotein (HDL)
5. **Elevation of blood urea, nitrogen and creatinine levels** is suggestive of renal damage.
6. **Electrocardiography (ECG)** to detect cardiac dysfunction or cardiac conduction system.
7. **Chest x ray (** To show cardiomegaly)
8. **Echocardiography** ( to detect left ventricular hypertrophy)

9. **Fastening blood sugar (FBS)** to determine blood glucose level (Smeltzer, Bare, Hinkle, & Cheever, 2014).

**Nursing managements of hypertension**

**Psychological Care.**

1. Explain all procedures to patients in other to get relieved of anxiety.
2. Reassure patient of competent nursing care.
3. Diversional therapy such as watching of television and engaging patient in a conversation.
4. Allow patient to express fears and anxiety
5. Allow patient to ask questions about her condition.

**Observation and monitoring**

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

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

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

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

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

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

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

**Nutrition**

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

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

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

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

4. Limit eating canned foods and other processed foods.

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

**Patient Education**

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

2. Educate patient concerning the causes/predisposing factors, signs and symptoms and the management of hypertension.

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

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

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

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

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

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

10. Lose weight if overweight.

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

**Protection from injury**

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

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

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

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

**Pharmacological management of hypertension**

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

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

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

4. Aldosterone Receptors Blockers: competitive inhibitors of aldosterone binding.

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

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

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

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

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

i. It inhibits calcium ion influx across membrane.

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

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

10. Vasodilators (Hydralazine): It helps in acting directly on smooth muscles of blood vessels to decrease peripherals resistance by dilatation of blood vessels (Lewis, Dirksen, Heitkemper, & Bucher, 2014).

**Complications of hypertension**

According to Smeltzer, Bare, Hinkle, & Cheever, (2014). the complications of hypertension are;

1. Left ventricular hypertrophy

2. Myocardial infarction
3. Heart failure
4. Cerebrovascular accident (CVA), (stroke), or brain attack)
5. Renal insufficiency and failure
6. Retinal hemorrhage
7. Ischemic Heart Disease

## 1.12 VALIDATION OF DATA

Validation is the extent to which a measure, indicator, or a method of data collection possesses the quality of being sound or true as far as it can be judged (Weller, 2014). During my home visits, the information received from Mrs. D.A and the relative such as, the location, number of rooms of the house and the type of materials made of the building were true. Also, some clinical manifestations exhibited by Mrs. D.A were found in textbooks, internet, journals etc. Finally, some laboratory investigations carried out on Mrs. D.A as well as, some of her pharmacological management were truly found in literature review such as; textbooks, internet etc. Based on the facts highlighted concerning the data collected from Mrs. D.A, this renders my care study valid.

# CHAPTER TWO

# ANALYSIS OF DATA

## 2.0 INTRODUCTION

Analysis of data is the process of systematically applying statistical or logical techniques to describe and illustrate, condense, recap, and evaluate data (Weller, 2014). It is the second phase of the nursing process. Analysis of data helps the health care worker to compare the data extracted from patient to that of the standard.

## 2.1 COMPARISON OF DATA WITH STANDARDS.

The following data will be compared with standards;

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

## 2.1 DIGNOSTICS TESTS OR INVESTIGATIONS

**2.2** Test/ investigations refers to an examination or analysis of the composition of a substance by the use of chemical reagents, and/or to determine the presence or absence of a substance (Weller, 2014).

The following diagnostic tests were carried on Mrs. D.A,

1. Full Blood Count (FBC): To detect the level of white blood cells (WBC), red blood cells (RBC), Haemoglobin (HGB) present in Mrs. D.A blood.

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

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

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

**Table 2.1: Comparison of Diagnostic Tests carried on D.A with Standards.**

| **Diagnostic Investigations in the literature review** | **Diagnostic Investigations carried on Mrs. D.A** |
|---|---|
| 1. Health history and physical examination | 1. Health history was taken and physical examination was conducted on Mrs. D.A |
| 2. Full blood count to detect the amount of RBC, WBC, HB present in blood. | 2. Full blood count was investigated on Mrs. D.A |
| 3. Urinalysis to detect an amount proteins, pus, glucose, bacteria and blood presents in urine. | 3. Urinalysis was done on Mrs. D.A |
| 4. Blood chemistry to detect levels of blood K+, Na+, creatinine, urea and high density lipoprotein (HDL). | 4. Blood chemistry was not done on Mrs. D.A |

| | |
|---|---|
| 5. Blood urea, nitrogen and creatinine levels. | 5. Blood Urea Nitrogen and Creatinine was not tested on Mrs. D.A |
| 6. Electrocardiography (ECG) to detect cardiac dysfunction or cardiac conduction system. | 6. Electrocardiography was not conducted on Mrs. D.A |
| 7.Chest x-ray to detect cardiomegaly | 7. Chest x ray was not conducted on Mrs. D.A. |
| 8. Echocardiography (to detect left ventricular hypertrophy). | 8. Echocardiography was not done on Mrs. D.A. |
| 9. Random blood sugar (FBS) to determine blood glucose level. | 9. Random blood sugar level was tested on Mrs. D.A |

With references to the table above 1.0 blood chemistry, Echocardiography, Chest x-ray, Blood Urea Nitrogen and electrocardiography was not conducted on Mrs. D.A simply because diagnoses were arrived and confirmed by, health history and physical examination, Urinalysis, full blood count and random blood sugar.

**Table 2.2: Diagnostic Investigations/Tests conducted on Mrs. D.A Compared with Standards.**

| Date | Specimen | Investigation | Results | Normal Values | Interpretation | Remarks |
|---|---|---|---|---|---|---|
| 02/09/2023 | Blood | Random blood sugar | 5.9mmol/L | 5.6mmol/L-11.1mmol/L | Mrs. D.A is not diabetic. | No treatment was given since the RBS was within normal range. |
| | | Malaria | Negative | Negative | Mrs. D.A is not having malaria. | No treatment was given to Mrs. D.A**.** |
| | | White blood cell count | 9.3x10^3/^y | (4.5x10^9-11.0x10^9 | White blood cell is within normal range. | No treatment was given to Mrs. D.A. |
| | | Red blood cell count | 4.01x10^6/^4 | Females: 4.1 x1012/L-5.1 x1012/L | Red blood cell is within normal range | No treatment was given. |
| | | Haemoglobin level estimation | 12.7g/Dl | 12.3 g/dL -15.3g/Dl | The Haemoglobin is within normal range. | No treatment given since level was within normal range. |

**Diagnostic Investigations/Tests conducted on Mrs. D.A Compared with Standards Continues.**

| Date | Specimen | Investigation | Results | Normal Values | Interpretation | Remarks |
|---|---|---|---|---|---|---|
| 02/09/2023 | Urine | Appearance | Clear | Clear | Urine appears clearer | No treatment was given was Mrs. D.A. |
| | | Colour | Amber | Amber | Urine was amber in colour | No treatment was given was Mrs. D.A. |
| | | Leucocyte | Negative | Negative | No leucocyte present | No treatment was given was Mrs. D.A. |
| | | Urobilinogen | 0.7 | 0.5-1 | Was within normal range | No treatment was given was Mrs. D.A. |
| | | Nitrate | Negative | Negative | No nitrate present | No treatment was given was Mrs. D.A. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Protein | Negative | Negative | Protein was absent | No treatment was given was Mrs. D.A. |
| | | PH | 7.0 | 4.5-8.0 | PH was within normal range | No treatment was given was Mrs. D.A. |
| | | Blood | Negative | Negative | Blood was absent | No treatment given |
| | | Bilirubin | Negative | Negative | Bilirubin was absent | No treatment given |
| | | Specific gravity | 1.005 | 1.005-1.025 | Was within normal range | No treatment given |
| | | Ketones | Negative | Negative | Ketones was absent | No treatment given |

### 2.1.2 CAUSES OR RISKS FACTORS

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

### 2.1.3 CLINICAL MANIFESTATIONS

**TABLE 2.3 CLINICAL MANIFESTATIONS EXHIBITED BY MRS. D.A COMPARED TO LITERATURE.**

| CLINICAL MANIFESTATIONS STATED IN LITERATURE REVIEW | CLINICAL MANIFESTATIONS EXHIBITED BY MRS. D.A. |
|---|---|
| 1. Occipital headache | 1. Patient experienced headache. |
| 2. Blood pressure above 140/90 mmHg | 2. Mrs. D. A's blood pressure was 160/90 mmHg |
| 3. Palpitations | 3. Patient did not complain of palpitation |
| 4. Fatigue | 4.Patient experienced fatigue |
| 5. Angina | 5.Patient did not complain of pain |
| 6. Dyspnea | 6. Patient was not dyspneic |
| 7. Nausea | 7.Patient did not report |
| 8. Confusion | 8. Patient never exhibited |

| | |
|---|---|
| 9. Lightheadedness | 9. Patient experienced lightheadedness |
| 10. Vertigo | 10. There was vertigo |
| 11. Blurred vision(dizziness) | 11. Patient experienced blurred vision (dizziness) |
| 12. Convulsion | 12. Patient did not experienced convulsion |
| 13. Transient blindness | 13. Transient blindness was absent |
| 14. Stupor | 14. Mrs. D.A experienced no stupor |
| 15. Coma | 15. Coma was absent |

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

### 2.1.4 TREATMENTS GIVEN TO MRS. D.A.

**The following treatments were used in the management of Mrs. D.A.**

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

**TABLE 2.4: TREATMENTS GIVEN TO MRS. D.A COMPARED TO LITERATURE REVIEW.**

| TREATMENTS OUTLINED IN LITERATURE REVIEW | TREATMENTS PRESCRIBED TO MRS. D.A |
|---|---|
| 1. Thiazide Diuretics (Indapamide, hydrochlorothiazide, Chlorthalidone). | Thiazide Diuretics was not prescribed to patient. |
| 2. Loop Diuretics (furosemide, bumetamide, torsemide). | Loop Diuretics was not prescribed to patient. |
| 3. Potassium- sparing diuretics (amiloride, Spironolactone triamterene): | Potassium- sparing diuretics was not prescribed to patient. |
| 4. Aldosterone Receptors Blockers | Aldosterone Receptors Blockers was not prescribed to Mrs. D.A. |
| 5. Beta Blockers (Atenolol, propranolol, nadolol, timolol). | Tab Atenolol 50 mg daily x 60 days was prescribed and administered. |
| 6. Alpha- Blockers (Doxazosin, prazosin hydrochloride): | Alpha-Blockers was not prescribed to patient. |
| 7. Angiotensin-Converting Enzyme Inhibitors (Captopril, enalapril, benazepril). | Angiotensin-Converting Enzyme Inhibitors was not prescribed to my patient. |
| 8. Angiotensin II Receptors Blockers (Losartan, Valsartan): | Angiotensin II Receptors Blockers was not prescribed to Mrs. D.A. |
| 9. Calcium Channels Blockers (Amlodipine, felodipine,isradipin,nicardipine,nifedpine,nisoldipine): | Tab Amlodipine 5mg daily x 60days was prescribed to Mrs. D.A. |

| | |
|---|---|
| 10. Vasodilators (Hydralazine): | Vasodilators was not prescribed to Mrs. D.A. |

Aside Tab Amlodipine 5mg daily x 60 days and Tab Atenolol 50mg daily x 60 days that were administered as an antihypertensive medications, the following medications were also prescribed and administered as a supportive treatment to get Mrs. D.A. relieved of her symptoms.

1. Intramuscular (IM) Diclofenac as a Stat (ST) dose.
2. Tablet Paracetamol 1g tid x 7
3. Suppositories Diclofenac 100mg 5/7.
4. Syrup Simple Linctus 15mls x 7 days
5. Syrup Lactulose 10mls bd x 5 days.

**TABLE 2.5: PHARMACOLOGY OF DRUGS ADMINISTERED TO MRS. D.A.**

| **Date** | **Name of drug** | **Classification of drug.** | **Standard(Literature) Dosage and Route of Administration** | **Dosage and route of administration for Mrs. D.A** | **Desired effect** | **Actual effect of the drug observed.** | **Side effects and remarks** |
|---|---|---|---|---|---|---|---|
| 02/09/2023 | Tab Amlodipine | Antihypertensive (Calcium Channels Blockers). | Dosage-5 to a maximum dose 10mg once per day.<br><br>**Route**- Orally. | Dosage- 5mg daily x 60 days.<br><br>**Route**- Orally | i. It inhibits calcium ion influx across membrane.<br><br>ii. It also has a vasodilation effects on coronary arteries and peripherals arteriole.<br><br>iii. It helps in decreasing cardiac load and energy consumption. | Mrs. D.A. blood pressure reduced from 160/90mmHg to 140/84mm | Headache,<br><br>nausea,<br><br>fatigue,<br><br>dizziness,<br><br>and abdominal pains<br><br>No side effect was encountered. |

**TABLE 2.6: PHARMACOLOGY OF DRUGS ADMINISTERED TO MRS. D.A.**

| **Date** | **Name of drug** | **Classification of drug.** | **Standard(Literature) Dosage and Route of Administration** | **Dosage and route of administration for madam D.A.** | **Desired effect** | **Actual effect of the drug observed.** | **Side effects and remarks.** |
|---|---|---|---|---|---|---|---|
| 02/09/2023 | Tab<br>Atenolol | Antihypertensive Beta Blockers | Dosage- 25mg to a maximum dose of 100mg once daily.<br><br>**Route**- Orally | Dosage- 50mg daily x 60 days,<br><br>**Route**- Orally | Helps in blocking the sympathetic nervous system. | Madam D.A's blood pressure reduced from 160/90 to 140/84 mmHg | Indigestion, dizziness, dry mouth, confusion,<br><br>Mrs. D.A experienced no side effects |

**TABLE 2.7: PHARMACOLOGY OF DRUGS ADMINISTERED TO MRS.. D.A.**

| **Date** | **Name of drug** | **Classification of drug.** | **Standard(Literature) Dosage and Route of Administration** | **Dosage and route of administration for Mrs. D.A.** | **Desired effect** | **Actual effect of the drug observed** | **Side effects and remarks.** |
|---|---|---|---|---|---|---|---|
| 02/09/2023 | Tab Paracetamol<br><br>(Acetaminophen) | Analgesics and Antipyretic effects. | Dosage- 325mg to a maximum dose of 4mg daily that is qid when the needs emerges.<br><br>**Route**- Orally, rectal, Intravenous | Dosage- Tablet Paracetamol 1g Tid x 7<br><br>**Route**- Orally | Helps in the reduction of pain thresh hold and also helps in temperature reduction. | Mrs. D.A had a reduction of pain and slightly reduction of temperature. | Skin rashes, dizziness, urticarial, nephrotoxicity, Hepatotoxicity when there is an over dose of drug.<br><br>Patient experienced no side effects. |

**TABLE 2.8: PHARMACOLOGY OF DRUGS ADMINISTERED TO MRS. D.A.**

| **Date** | **Name of drug** | **Classification of drug.** | **Standard (Literature) Dosage and Route of Administration.** | **Dosage and route of administration for Mrs. D.A.** | **Desired effect** | **Actual effect of the drug observed.** | **Side effects And remarks.** |
|---|---|---|---|---|---|---|---|
| 02/09/2023 | Intramuscular (IM) Diclofenac Start (ST) | Non-steroidal anti-inflammatory drugs (NSAIDs) | Dosage 75 -150 mg/day in divided doses 50 mg twice a day or three times a day, or 75 mg twice a day.<br><br>**Route**: Orally, Intramuscular, Intravenous | Dosage- 75 mg stats<br><br>**Route**- Intramuscular(I. M) | Indicated for management of mild- to- moderate pain and moderate-to- severe pain. | Patient had a reduction of the headache | Headache, nausea, pruritus, diarrhea, constipation, dizziness.<br><br>No side effects observed. |

**TABLE 2.9: PHARMACOLOGY OF DRUGS ADMINISTERED TO MRS. D.A.**

| **Date** | **Name of drug** | **Classification of drug.** | **Standard (Literature) Dosage and Route of Administration** | **Dosage and route of administration for Mrs. D.A.** | **Desired effect** | **Actual effect of the drug observed.** | **Side effects and remarks.** |
|---|---|---|---|---|---|---|---|
| 02/09/2023 | Suppositories Diclofenac | Non-steroidal anti-inflammatory drugs (NSAIDs) | 100mg up to a maximum dosage of 150 mg bd<br><br>**Route**- Orally, Intramuscular, Rectum, Tropical | Dosage- 100mg was administered<br><br>**Route**- Rectum | Indicated to relieve pain, swelling(inflammation) and joint stiffness | Patient's general body pains and weakness was relieved | Headache, loss of appetite, constipation, dizziness.<br><br>No side effects observed. |

**TABLE 2.10: PHARMACOLOGY OF DRUGS ADMINISTERED TO MRS. D.A**

| **Date** | **Name of drug** | **Classification of drug.** | **Standard (Literature) Dosage and Route of Administration** | **Dosage and route of administration for Mrs. D.A.** | **Desired effect** | **Actual effect of the drug observed.** | **Side effects and remarks.** |
|---|---|---|---|---|---|---|---|
| 03/09/2023 | Syrup Simple Linctus | Expectorant | Dosage- 15mls qid x 7 days.<br><br>**Route**: Orally | Dosage- 15mls of syrup Simple Linctus x 7 days was administered<br><br>**Route-** Orally. | To release patient from cough | Mrs. D.A's cough subsided | Nausea, vomiting, diarrhoea.<br><br>None of these were observed by Mrs. D.A |

**TABLE 2.1.1: PHARMACOLOGY OF DRUG ADMINISTERED TO MRS. D.A**

| **Date** | **Name of drug** | **Classification of drug.** | **Standard (Literature) Dosage and Route of Administration** | **Dosage and route of administration for Mrs. D.A.** | **Desired effect** | **Actual effect of the drug observed.** | **Side effects and remarks.** |
|---|---|---|---|---|---|---|---|
| 02/09/2023 | Syrup Lactulose | Stool Softener | 10mls to a maximum dose of 30mls when necessary.<br><br>**Route**- Orally | 10mls b.d x 5 days<br><br>**Route**- Orally | Helps in the emptying the bowels with ease. | Patient was able to pass out stools without straining | Anal irritation, flatulence, abdominal cramps and belching.<br><br>Mrs. D.A exhibited no side effect to the drug. |

### 2.1.5 COMPLICATIONS DEVELOPED ON ADMISSION

Complication is an extra medical problem that makes it more difficult to treat an existing illness (Walter, 2013). Mrs. D.A. developed no complications on admission to the above under listed complications stated in the literature review. This was because she was admitted on time.

## 2.2 PATIENT AND FAMILY'S STRENGTH

Strength refers to the ability to do things that need lot of physical or mental effort (Walter, 2013). The following strengths were observed in patient and family during their period of hospitalization

1.(02/09/2023), Mrs.D.A, was able to state the degree of the headache.

2. (02/09/2023), Mrs. D.A could perform some simple daily activities such as mouth care, feeding with an assistant.

3. (03/09/2023), Mrs. D.A could describe the frequency of the cough.

4. (03/09/2023,) Mrs. D.A and her family were able to identify at most a risk factor and a symptom of hypertension

5.(04/09/2023), Mrs. D.A could sleep for 3 hours at night and an hour at the day time.

6. (04/09/2023), Mrs. D.A could understand education on measures to prevent constipation.

7. (04/09/2023), Mrs. D.A and her family were able to follow medical regimen even though they were anxious

## 2.3 PATIENT'S AND FAMILY HEALTH PROBLEMS

Problem is a situation, person, or thing that needs to be dealt with or solved (Walter, 2013).

1. Madam D.A. experienced headache, on admission (02/09/2023).

2. Mrs. D.A could not perform any daily activities, on admission (02/09/2023).

3. Mrs. D.A experienced coughing (03/09/2023).

4. Mrs. D.A and her family had insufficient knowledge on her medical condition (03/09/2023).

5. Mrs. D.A experienced difficulty in sleeping (04/09/2023).

6. Mrs. D.A could not empty her bowels freely (04/09/2023).

7. Mrs. D.A and her family were anxious (05/09/2023).

## 2.4 NURSING DIAGNOSIS.

Diagnosis is a judgment about what a particular illness or problem is, made after examining it (Walter, 2013).

1. 02/09/2023, Acute pain (headache) related to increased cerebral vascular pressure as evidenced by patient showing guarding behavior.

2. 02/09/2023, Activity intolerance related to general body weakness as evidenced by patient getting tired easily.

3. 03/09/2023, impaired comfort related to irritation of the airway as evidenced by ineffective breathing pattern.

4. 03/079/2023, knowledge deficit related to the technical nature on the risk's factors, clinical manifestations and the management of hypertension as evidenced by patient's inability to answer simple questions.

5. 04/09/2023, disturbed sleeping pattern (insomnia) related to coughing as evidenced by patient found being awake and not able to sleep as at 12:00am.

6. 04/09/2023, Constipation related to inadequate intake of fiber diet and fluid as evidenced by patient not passing stools for two days.

7. 05/09203, anxiety related to an unknown outcome of the illness as evidenced by patient being restless.

# CHAPTER THREE

# PLANNING FOR PATIENT AND FAMILY CARE

## 3.0 Introduction

Planning is the process in which the nurse and patient together consider the goals to achieve in meeting the patient's identified or potential problems in daily life and produce an individual care plan (Weller, 2014). Planning is the third phase in the nursing process which involves a deliberative and a systematic process which involves decision making and solving patient's health problem.

## 3.1 Objectives and Outcome Criteria for Patient and Family Care.

Objective refers to something that you plan to do or achieve (Walter, 2013).

1. Mrs. D.A would be relieved of headache within 6 hours as evidenced by;

a. Patient verbalizing she has been relieved of the headache.

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

2. Mrs. D.A would be able to perform activities of daily living within 72 hours as evidenced by;

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

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

3. Mrs. D.A would be relieved of cough within 24 hours as evidenced by;

a. Patient verbalizing she has been relieved of cough.

b. The nurse observing patient experienced no cough.

4. Mrs. D.A and her family would have sufficient knowledge on hypertension throughout their period of hospitalization as evidenced by;

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

b. The nurse observing patient and family being able to answer questions posed to them on hypertension correctly.

5. Mrs. D.A's disturbed sleeping pattern would be restored within 24 hours as evidenced by;

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

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

6. Mrs. D.A would get relieved of constipation within 48 hours as evidenced by;

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

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

7. Mrs. D.A's anxiety level would be lessened within 12 hours as evidenced by;

a. Patient verbalizing she is feeling less anxious.

b. The nurse observing patient had good facial expression and freely communicating with other patients.

**Table 3.1: Nursing Care Plan for Mrs. D.A and the Family.**

| Date and Time | Nursing Diagnosis | Objectives and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 02/09/2023<br><br>11:00 am | Acute pain (headache) related to increased vascular pressure as evidenced by patient showing guarding behaviour. | Mrs. D.A would be relieved of headache within 6 hours as evidenced by;<br><br>a. Patient verbalizing she has been relieved of pain.<br><br>b. The nurse recording patient's pain level using numerical rating scale. | 1. Reassure patient of competent nursing care that her pain will get relief sooner.<br>2.Assess patient's pain level using numeric rating scale from (0-10)<br><br>3. Monitor and check patient's vital signs regularly especially blood pressure every 30 minutes for 1 hour,<br><br>4. Put patient into a comfortable position | 1. Mrs. D.A was reassured of competent nursing care.<br><br>2. Mrs. D. A's pain level was assess using numerical rating scale.<br><br>3.patient's vital signs especially blood pressure was checked and monitored every 30 minutes for 1 hour.<br><br>4.Patient was kept into a comfortable position that | 03/09/2023<br><br>5:00pm | Goal fully met as patient verbalized, she has been relieved of pain and nurse recorded patient's pain level of 0 using numerical rating scale. | A. P |

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| | | | that relieves her pain.<br><br>5. Employ diversional therapies such as; watching television and interacting with patient to reduce stress.<br><br>6. Ensure adequate bed rest for patient to induce maximum sleep.<br><br>7. Administer prescribed analgesics and antihypertensive medications. | relieves her pain.<br><br>5.Diversional therapies; such as watching television and interacting with patient was done.<br><br>6. Adequate bed rest was ensured to induce maximum sleep.<br><br>7. Prescribed analgesics (acetaminophen) and antihypertensive(amlodipine) medications were rightly administered and documented. | | | |

**Table 3.2: Nursing Care Plan for Mrs. D.A The Family.**

| Date and Time | Nursing Diagnosis | Objective and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 02/09/2023 11:30 am | Activity intolerance related to general body weakness **as evidenced by patient being not able to perform daily activity.** | Mrs. D.A would be able to perform activities of daily living within 72 hours as evidenced by;<br><br>a. Patient verbalizing she was able to do daily activities such as; bathing, mouth care without assistance.<br><br>b. The nurse observes patient performing daily activities of living without any assistant. | 1. Reassure patient and family that measures would be put in place to help patient perform activity of daily living.<br><br>2. Assess patient's level of physical activity and mobility.<br><br>3. Assist patient to increase activity with active range of motion exercises in bed, increasing to sitting and | 1. Mrs. D.A and the family were reassured of measures that would be kept in place to enable her perform daily activities such as exercise , assisted Bathing and eating.<br><br>2. Patient's level of physical activity and mobility was assessed such as assisted her on walking, eating and bathing.<br><br>3. Active range of motion exercise such as; sitting and standing was assisted in bed. | 05/09/2023<br><br>11:30am | Goal fully met as patient verbalized she has been relieved of activity intolerance and nurse observed patient performed daily activities of living such as; mouth care, feeding and bathing without any assistant. | **A.P** |

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

**Table 3.3: Nursing Care Plan for Mrs. D.A and the Family.**

| Date and Time | Nursing Diagnosis | Objective and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 03/09/20<br><br>23<br><br>6:30am | impaired body comfort (cough) related to irritation of the airway as evidenced by ineffective breathing pattern. | Mrs. D.A would be relieved of cough within 24 hours as evidenced by;<br><br>a. Patient verbalizing she has been relieved of cough.<br><br>b. The nurse observing patient experiences no cough. | 1. Put patient into a semi-fowlers position and encourage patient to perform deep breathing exercise and coughing exercise to help expand the lungs in a well-ventilated area.<br><br>2. Assess patients respiratory pattern including; the rate, rhythms and the depth to assess for respiratory distress.<br><br>3. Encourage patient to cover the mouth when coughing to help reduce the spread of infections. | 1. Mrs. D.A was kept in the semi- fowler's position to help expand the lungs to aid in easy breathing such blowing of balloon and deep breathing.<br><br>2. Patient's respiratory pattern such as; the rate, rhythm and depth were assessed for respiratory distress.<br><br>3. Patient was educated on covering the mouth when coughing to help reduced the spread of infections. | 04/09/20<br><br>23<br><br>6:30am | Goal partially met as patient verbalized, she stills coughs and nurse observed patient coughing intermittently. | A.P |

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|---|---|---|---|---|---|---|---|
| | | | 4. Encourage patient on the intake of copious fluids to help liquefy mucus for easy expectoration.<br><br>5. Administer prescribed expectorants. | 4. Patient was encouraged to take in adequate fluids.<br><br>5. Prescribed Syrup Simple Linctus 15mls tds was rightly administered and documented. | | | |

**Table 3.8: Nursing Care Plan For The Unmet Goals.**

| Date and Time | Nursing Diagnosis | Objective and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 05/09/2023 6:30am | Impaired body comfort (cough) related to irritation of the airway as evidenced by ineffective breathing pattern. | Mrs. D.A would be relieved of cough within 24 hours as evidenced by;<br><br>a. Patient verbalizing she has been relieved of cough.<br><br>b. The nurse observing patient experiences no cough. | 1. Put patient into a semi-fowlers position to expand lungs for easily breathing.<br><br>2. Educate patient on deep breathing and coughing exercise.<br><br>3. Assess patients respiratory pattern including; the rate, rhythms and the depth to assess for respiratory distress.<br><br>4. Educate patient to cover the mouth with a clean handkerchief when coughing. | 1. Patient was put in a semi-fowlers position to expand lungs for easily breathing.<br><br>2. Patient was educated on deep breathing and cough exercises.<br><br>3. Patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress.<br><br>4. Patient was educated to cover the mouth with a clean handkerchief when coughing. | 06/09/2023 6:30am | Goal fully met as patient verbalized she had been relieved of cough totally and nurse observed patient experienced no cough. | A.P |

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

**Table 3.7: Nursing Care Plan for Mrs.D. A**

| Date and Time | Nursing Diagnosis | Objective and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 04/09/2023 8:33 am | Anxiety related to an unknown outcome of illness (hypertension) as evidenced by patient' being restlessness | Mrs. D.A's anxiety relieved of anxiety within 12 hours as evidenced by;<br><br>a. Patient verbalizing she is feeling less anxious.<br><br>b. The nurse observing patient had good facial expression and freely communicating with other patients. | 1. Reassure Mrs. D.A and family they are in the hands of competent medical team and effective nursing care will be rendered to help relieve fears causing anxiety.<br><br>2. Assess patient's level of anxiety to plan appropriate nursing interventions.<br><br>3. Educate Mrs.D.A on the disease condition including risks factors, clinical manifestations and management of hypertension. | 1. Mrs.D.A and her family were reassured of competent nursing care in other to relieve them from fears causing anxiety.<br><br>2. Patient's level of anxiety was assessed to help plan appropriate nursing interventions.<br><br>3. Mrs. D.A was educated on the risks factors, clinical manifestations and managements to hypertension. | 04/09/2023<br><br>8:33pm | Goal fully met as patient and family verbalized they are feeling less anxious and nurse observed patient and family had good facial expression and freely communicating with other patients. | A.A |

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|---|---|---|---|---|---|---|---|
| | | | 4. Explain all procedures and interventions to patient to help her cooperate with the medical team.<br><br>5. Encourage Mrs. D.A to verbalize her feelings, fears and concern and provide answers in a clear and simple language.<br><br>6. Orientate Mrs. D.A and the family to the ward, equipment and daily routine at the ward. | 4. All nursing procedures and interventions were explained to Mrs.D.A to help gained her cooperation.<br><br>5. Patient was encouraged to verbalize her fears and feelings and clear and simple language was used.<br><br>6. Mrs. D.A and her family was oriented to the ward, equipment and daily routine at ward in other to reduce their level of anxiety. | | | |

**Table 3.5: Nursing Care Plan for Mrs. D.A and the Family.**

| Date and Time | Nursing Diagnosis | Objective and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 04/09/2023<br><br>6:35 am | Impaired sleeping pattern (insomnia) related to coughing as evidenced by patient's found being awake and not able to sleep as at 12am | Mrs. D.A's disturbed sleeping pattern would be restored within 24 hours as evidenced by;<br><br>a. Patient verbalizing she had a good sleep last night.<br><br>b. The nurse observing patient had a maximum sleep of 2 hours at day time and 6 hours at night time. | 1. Put patient into a semi-fowlers position to expand lungs for easily breathing.<br><br>2. Educate patient on deep breathing and coughing exercises.<br><br>3. Keep away noxious and irritational substances away from patient.<br><br>4. Educate patient to cover the mouth with a | 1. Patient was put in a semi-fowlers position to expand lungs for easily breathing.<br><br>2. Patient was educated on deep breathing and cough exercises such as blowing of balloon.<br><br>3. Noxious and irritational substances was kept away from patient's environment examples medication like morphine and codeine.<br><br>4. Patient was educated to cover the mouth whenever | 05/09/2023<br><br>6:35am | Goals fully met as patient verbalized she had a good sleep last night and nurse observed patient had a maximum sleep of 2 hours at day time and 6 hours at night time. | A.P |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | clean handkerchief when coughing.<br><br>5. Encourage patient on the need to take in adequate fluid to loosen mucus.<br><br>6 Administer prescribed expectorant.<br><br>7. Give warm bath.<br><br>8. Serve warm beverages like milo.<br><br>9. Administer prescribed sedatives | coughing.<br><br>5. Patient was encouraged to take in adequate fluids to help loosen mucus and also clear the airway.<br><br>.6. Prescribed expectorant Simple Syrup Linctus 15mls tds was administered.<br>7. Patient was given warm bath.<br>8. Patient was served with warm beverage like milo.<br><br>9. Prescribed sedatives were administered. | | | |

**Table 3.6: Nursing Care Plan for Mrs. D.A and the Family.**

| Date and Time | Nursing Diagnosis | Objective and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 04/09/2023<br><br>2:43 pm | Alteration in bowel movement (constipation) related to inadequate intake of fibre diet and fluid as evidenced by patient not passing stools for 2 days. | Mrs. D.A would get relieved of constipation within 48 hours as evidenced by;<br><br>a. Patient verbalizing she has been relieved of difficulty emptying her bowels.<br><br>b. The nurse observing patient passing normal stools twice daily without straining | 1. Serve patient with a balanced diet containing adequate fibre, fresh fruits, vegetables and grains.<br><br>2. Encourage patient adequate intake of fluids.<br><br>3. Assist patient to perform passive exercise in bed.<br><br>4. Educate patient to empty her bowls regularly to avoid postponing faeces. | 1. A well balanced diet containing adequate fibre, fresh fruits, vegetables and grains were served. Such as, oranges and water mangoes and water million.<br><br>2. Patient was educated on the need to take in adequate fluids.<br><br>3. Patient was assisted to perform passive exercise in bed.<br><br>4. Mrs. D.A was encouraged to empty her bowl regularly in other to avoid postponing faeces. | 06/09/2023<br><br>2:43pm | Goals fully met as patient verbalized, she has been relieved of difficulty emptying her bowels and nurse observed patient passed stools twice daily without straining. | A.P |

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|---|---|---|---|---|---|---|---|
| | | | 5. Provide privacy for patient when emptying her bowls.<br><br>6. Administer prescribed syrup Lactulose. | 5. Privacy was ensured so as patient could feel the edge to empty her bowls freely<br><br>6. Prescribed Syrup Lactulose was rightly administered. | | | |

**Table 3.4: Nursing Care Plan for Mrs. D.A and the Family.**

| Date and Time | Nursing Diagnosis | Objective and Outcome Criteria | Nursing Orders | Nursing Interventions | Date and Time | Evaluation | Sign |
|---|---|---|---|---|---|---|---|
| 03/09/20<br>23<br>2:10 pm | Knowledge deficit related to insufficient knowledge on the risk's factors, clinical manifestations and the management of hypertension as evidenced by patient's inability to answer simple questions on the illness. | Mrs. D.A and her family will have sufficient knowledge on hypertension throughout their period of hospitalization as evidenced by;<br><br>a. Patient and the family been able to enumerate at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension.<br><br>b. The nurse observing patient and family being able to answer questions correctly. | 1. Provide noise free environment for the education and ask patient the language she understands.<br><br>2. Explain all procedures to patient to gain her attention and cooperation.<br><br>3. Assess Mrs. D. A's knowledge concerning | 1. Noise free environment on the education of hypertension were ensured using language patient understand (Twi).<br><br>2. All procedures were clearly explained to patient and her family.<br><br>3. Patient and family's knowledge concerning the diagnosis, risks | 06/09/20<br>23<br>2:10pm | Goals fully met as patient and the family been able to enumerate at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension and nurse observed patient and family utilizing the knowledge gained on hypertension into practice and answering questions | A.P |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | the diagnosis, risks factors, clinical manifestations and the management for hypertension.<br>4. Explain to patient and family the risks factors, clinical manifestations and the management of hypertension<br><br>5. Encourage patient and family to ask questions to clarify any misconceptions about hypertension. | factors and clinical manifestations on hypertension was assessed asking respective questions.<br>4. The risks factors, clinical manifestations and management of hypertension was explained to patient and the family.<br><br>5. Patient and her family were encouraged to ask questions in other to clarify any misconceptions with regards to hypertension. | | on hypertension. | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 6. Allow patient and family to verbalize knowledge gained on hypertension.<br><br>7. Answer patient and family's questions in a simple and clear language tactfully | 6. Mrs. D.A and her family tried answering a lot of questions that were asked on hypertension.<br><br>7. A clear language was used in answering Mrs. D.A and her family tactfully. | | | |

# 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, 2013). The nurse assumes responsibility for the implementation and coordinates the activities of all those involved in implementation, including the patient and family, other members of the nursing team, and other members of the health care team, so that the schedule of activities facilitates the patient's recovery (Smeltzer, Bare, Hinkle, & Cheever, 2014). This chapter gives a vivid account of the nursing care that was rendered to the patient and family from the day of admission until discharge based on the health problems identified. It also deals with follow up visits/home visits to ensure continuity of care.

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

### 4.1.1 First Day of Admission: 1st September, 2023.

Patient was admitted into the Females ward through the Accident and Emergency Unit at St. John of God Hospital accompanied by a staff nurse, two student nurses and a relative in a wheel chair in a conscious but weak state on 1st September, 2023, at 8:30am, with the diagnosis of hypertension. Patient's complaints were; headache, generalized bodily weakness and dizziness. I welcomed patient and the relative and they were reassured of competent nursing care. I made a cross-check to confirm whether patients were truly admitted into the females ward with the said diagnosis. Patient's full name was mentioned to ensure if she was the right person. Cardiac bed was prepared to make patient comfortable in bed. I made a brief introduction of myself and staffs

to patient and the relative. Patient's vital signs were checked and recorded at 10:30 am as on the appendix.

At 11:00 am ,Mrs.D.A complained of headache. A nursing diagnosis of acute pain (headache) related to increase in cerebral vascular pressure as evidenced by patient guarding behaviour was made. An objective was set to help relieve her of headache within 6 hours. The following nursing interventions were implemented; patient was reassured of competent nursing care to relieved pain, Patient level of pain was assessed using numerical rating scale of 0-10. Mrs. D.A scored 7 on the scale denoting her pain intensity. Patient was put in a comfortable position of choice that relieves her pain. Vital signs especially, blood pressure was checked and recorded for every 30 minutes for 1 hour, diversional therapy such as; watching television was employed. This was purposefully done to divert patient's attention from the headache. Adequate bed rest was ensured to help reduced Mrs. D.A's blood pressure. Prescribed analgesics and antihypertensive medications such as; Tablet Atenolol 50mg daily, Tablet Amlodipine 5mg daily and Tablet Paracetamol 1gram tds and Suppositories Diclofenac 100mg daily were rightly administered and documented as 10:00 am medications.

At 11: 30am, I realized that, patient could not perform any daily activities by self. Quickly, a nursing diagnosis of activity intolerance related to general bodily weakness as evidenced by patient being not able to perform daily activities. A goal was set to help relieve Mrs. D.A from activity intolerance within 72 hours. Implementation was done to help achieve the set objective, the following interventions were; Mrs. D.A and her family members were reassured that measures would be kept in place to help patient perform activities of daily living by self. Patient's level of physical activities and mobility were assessed. Range of motion exercise in bed were performed to enable Mrs. D.A sit and perform some activities in bed by herself. Vital signs

were checked and recorded every 4 hourlies. Mrs. D.A was assisted in mouth care, feeding and bed bath. At 2:00 pm, patient's vital signs especially, blood pressure were checked and documented as shown in the appendix.

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

At 6:00 pm, patient's prescribed medications such as; Tab Paracetamol 1gram was administered and rightly documented. I monitored the side effects of medications administered until we handed over to the night staffs at 8:00 pm. Patient's 10:00pm vital signs were checked and recorded as shown in the appendix. All rendered care were documented.

**4.1.2 Second Day of Admission: 2nd September, 2023.**

Mrs. D.A woke up from bed at 5:30 am on the second day of admission. I greeted Mrs. D.A and she responded. Patient was asked about her health and she replied saying, her headache had subsided. Patient's side lockers were cleaned and her bed linen was changed and prepared her with a comfortable bed. Throughout our interaction, patient had several episodes of cough. According to patient, the cough started at dawn. She was encouraged to cover her mouth with an hanker chief whenever coughing.

Patient's vital signs checked and documented at 6:00 am as shown in the appendix.

Patient was assisted in mouth care after which she took in porridge as her breakfast.

At 6:30am, a nursing diagnoses of impaired body comfort (cough) related to irritation of the airway as evidenced by restlessness, aprehension was formulated. An objective was set to relieve

Mrs. D.A from cough within 24 hours. The following nursing interventions were carried out; Mrs. D.A was kept in the semi- fowler's position to help expand the lungs to aid in easy breathing, patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress, patient was educated to cover the mouth whenever coughing to help reduced the spread of infections to others. Mrs. D.A was also encouraged to take in adequate fluids to help moisten and loosen mucus. Ward rounds started at 8:20 am where patient was reviewed by Dr. A. After the review, Mrs. D.A's treatments were ordered to be continued and Syrup Simple Linctus 15mls tds x 7 was prescribed. At 10:00 am, patient vital signs was checked and recorded as shown in the appendix.

Patients due medications were administered and documented at 10:00am.

At 5:00am an evaluation of the objective set on 2nd September, 2023 at 11:00am to relieve patient from headache within 6 hours was done and goal was fully met as patient verbalized she has been relieved of pain and nurse recorded patient's pain level of 0 using numerical rating scale. At 12:45 pm, Mrs. D.A was assisted to take rice ball and palm nut soup as her lunch.

At 2:00 pm, Mrs. D.A's vital signs especially blood pressure was checked as shown in the appendix. At 2:05 pm, I realised that the management of hypertension does not only rely on drugs but lifestyle and dietary modifications also play a major role in its management. Hence, I decided there would be a need to make an enquiry from patient and the family if they have sufficient knowledge concerning the risks factors, clinical manifestations and the prevention of hypertension. According to patient and the relative, all what they knew concerning hypertension was moderate intake of salt in patient's diet.

At 2:10 pm, a nursing diagnoses of knowledge deficit related to insufficient information on the risks factors, clinical manifestations and the management of hypertension as evidenced by patient's inability to answer simple questions about her illness was formulated. An objective to increase their knowledge on the illness throughout their period of hospitalization was made. The following nursing interventions were implemented; noise free environment was ensured. All procedures were clearly explained to patient and her family. Patient and family's knowledge concerning the diagnosis, risks factors and clinical manifestations on hypertension were assessed. Education was given on the causes, risks factors and management. Patient and her family were encouraged to ask questions in order to clarify any misconceptions with regards to hypertension. Mrs. D.A and her family tried answering a lot of questions that were asked on hypertension. A clear language (Twi) was used in answering Mrs. D.A and her family tactfully. At 4:25pm patient went to the wash room to empty her bowls after which she bathed. Mrs. D.A took in ampesie and cabbage stew as her supper at 5:15pm. At 6:00 pm, patient's vital signs was checked and recorded as shown in the appendix. Tablet Paracetamol 1gram tds and Syrup Simple Linctus 15mls were administered and documented. Patient's 10:00pm vital signs were checked and recorded as shown in the appendix. Patient slept at 10:20 pm.

### 4.1.3 Third Day of Admission: 3rd September, 2023.

On the third day of admission, I met Mrs. D.A already awaken in bed at 6:10am. Patient was greeted and was asked about her health. She replied by saying, she was not able to sleep well last night due to the cough she experienced. Patient was able to perform mouth care on her own. Patient's vital signs at 6:00am were checked and documented as shown in the appendix.

Mrs. D.A took in porridge and masa as her breakfast. Due to patient's complaint of insomnia, a nursing diagnosis of disturbed sleeping pattern related to cough was formulated. At 6:35am, an

objectives was set to relieved Mrs. D.A from difficulty in sleeping within 12hours. The following nursing interventions were carried out; patient was put in a semi-fowlers position to expand lungs for easily breathing, patient was educated on deep breathing and coughing exercises, noxious and irritational substances were kept away from patient's environment, patient was educated to cover the mouth whenever coughing, patient was encouraged to take in adequate fluids to help loosen mucus. Prescribed expectorant Simple Syrup Linctus 15mls tds was administered and documented, warm bath was given, warm beverage like milo was served and prescribed sedatives were administered.

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

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

At 2:43 pm, Mrs. D.A reported to me that, she had visited the toilet twice since morning but she always strains with difficulty before passing small amount of stools. Syrup Lactulose 10mls bd x 5 days was prescribed for patient.

At 2:43 pm, a nursing diagnosis of alteration in bowel movement (constipation) related to inadequate intake of fibre and fluid was formulated. An objective was set to help patient relieve of constipation within 48 hours. The following nursing interventions were carried out: a well-balanced diet containing adequate fibre, fresh fruits, vegetables and grains were served, patient was educated on the need to take in adequate fluids. Patient was assisted to perform passive exercise in bed, Mrs. D.A was encouraged to empty her bowl regularly. Prescribed Syrup Lactulose 10mls bd x 5 days was administered and documented at 2:50 pm. At 5:13 pm, patient

took her bath after which she ate fufu and light soup as supper. At 6:00 pm, patient's vital signs were checked and documented as shown in the appendix. Prescribed medications such as; Syrup Simple Linctus 15mls tds x 5 days and Tablet Paracetamol I gram tds x 7 days were administered and documented at 6:00pm. Patient 10:00pm vital signs were checked and recorded as shown in the appendix. Mrs. D.A Slept at 10:00pm right after the vital signs.

### 4.1.4 Fourth Day of Admission: 4th September, 2023.

On the fourth day of admission, patient woke up from bed at 6:00am. I greeted patient and she responded. Patient was asked about her health and she replied by saying, she slept well. Patient performed mouth care on her own without any assistance after taken her bath. Patient's bed side an lockers was cleaned with an antiseptic solution and her bed linen was changed after which I prepared a comfortable bed. Patient's vital signs at 6:00 am were checked and recorded as shown in the appendix.

On 4th September, 2023 at 6:30am an evaluation of the objective set on 3rd September, 2023 to relieve Mrs. D.A from cough within 24 hours was made and goal partially met as patient verbalized she still coughs and nurse observed patient coughing intermittently.

On 4th September, 2023 at 6:35am, an evaluation of the objective set on 3rd September, 2023 to relieved Mrs. D.A from difficulty in sleeping was evaluated and goals fully met as patient verbalized she had a good sleep last night and nurse observed patient had a maximum sleep of 2 hours at day time and 6 hours at night time.

At 7:19 am, patient took her bath after which she took in rice porridge with little sugar. At 8:20 am, Mrs. D.A was reviewed by ward doctor and her treatments were continued. After the review, Mrs. D.A made an enquiry from me that when would she be discharged? According to

patient, she does not know how the illness would end with her. This is because, the disease condition has been with her for several years yet still no solution. At 8:33 am, a nursing diagnose of anxiety related to an unknown outcome of illness was made. A goal was set within 12 hours to relieved patient and family from anxiety. The following nursing interventions were carried out successfully. Mrs. D.A and her family were reassured of competent nursing care in other to relieved them from fears causing anxiety, patient's level of anxiety was assessed to help plan appropriate nursing interventions, Mrs. D.A and her family were educated on the risks factors, clinical manifestations and managements to hypertension, all nursing procedures and interventions were explained to Mrs. D.A and her family to help gained their cooperation, patient was encouraged to verbalize her fears and feelings and clear and simple language such as Twi was used. Mrs. D.A and her family were oriented to the ward, equipment and daily routine at ward in other to reduce their level of anxiety.

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

Prescribed medications were administered and documented at 10:00am.

At 1:45pm, Mrs.D.A took in Tuozaafi with ayoyo soup. At 2:00 pm, patient's vital signs were checked and documented as shown in the appendix.

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

Prescribed medications were administered and documented at 6:00pm.

On the same day ( 4$^{th}$ September, 2023) at 8:33pm, an evaluation of the objective set on 3rd September, 2023 to relieved Mrs. D.A and the family from anxiety was evaluated and goal fully

met as; patient and family verbalized they are feeling less anxious and nurse observed patient and family had good facial expression and freely communicating with other patients.

### 4.1.5 Fifth Day of Admission/ Day of Discharge: 5th September, 2023.

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

Patient ate all the porridge and koose that was bought. At 8:30 am, patient was reviewed by the ward doctor and no new health complaints were raised by both patient and the relative.

The Doctor explained to patient and her relative that, they might have a possible discharge after 2:00 pm when there are no new complaints and when her vitals especially, blood pressure is within normal range.

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

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

the negative effects of defaulting medications since she had ever done same before. Patient and her family were encouraged to renew their National Health Insurance Scheme card whenever it expires since it helps in the reduction of medical bills. At 2:00 pm, patient's vital signs were checked and documented as shown in the appendix.

On the day of discharge(06/09/2023) at 2:10pm, an evaluation of the objective set on 3rd September, 2023 to increase Mrs. D.A and the family's knowledge on hypertension throughout their period of hospitalization was evaluated and goal fully met as patient and the family been able to enumerate at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension and nurse observed patient and family utilizing the knowledge gained on hypertension into practice and answering questions on hypertension correctly.

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

On 5$^{th}$ September, 2023 at 2:43pm, an evaluation of the objective set on 4th September, 2023 to relieve Mrs. D.A from difficulty in emptying her bowels was evaluated and goal fully met as patient verbalized she has been relieved of difficulty emptying her bowels and nurse observed patient passed stools twice daily without straining

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

Preparation of patient and family for discharge started from the day of admission when I informed Mrs. D.A and her family that the hospital was not going to be their permanent living environment but they would be discharged home soon. On 6th September, 2023 at 2:30 pm, patient and relative were informed about their discharge. I explained to patient and the relative that there would be the need to continue treatments and subsequent follow ups. I informed them about the review date which was on 30th September, 2023. Since medical bills had already been settled earlier on, I helped in packing patient's and her family belongings. Patient and her family were educated on the risks factors, clinical manifestations and the management of hypertension. Patient and her family were once again educated on the need to continue proper personal hygiene and proper environmental sanitation as well. Patient was educated to sleep under insecticide treated net so as to prevent the occurrence of malaria. Mrs. D.A was educated on the need to avoid smoking, alcohol intake, low sodium in diet, avoidance of saturated fatty diets, embarking on reviews, reporting to the health facility whenever symptoms emerges, avoidance of over the counter medications, reduction of stress, involvement in passive exercise and reduction of weight to prevent obesity. Patient and her family were also educated on how to take her medications at home. Patient and the family were also educated on the side effects of the medications. Mrs. D.A was educated on the negative effects of defaulting medications since she had ever done it before..

Patient and her family were encouraged to renew their National Health Insurance Scheme card whenever it expires since it helps in the reduction of medical bills. The date for the review, was re-echoed to patient and her relative. Patient's bed side lockers were disinfected and her bed was carbolized. This was performed to reduce the risks of transferring infection from one patient to the other. Patient's date of discharge was entered into the Admission and the Discharge book as

well as the daily ward state. I intentionally quizzed patient and her relative on the date for the review as well as questions concerning the managements of hypertension. Mrs. D.A and her family did their best by answering most of the questions that were posed to them. I congratulated them for their effort. Mrs. D.A and her family gave their appreciation to the entire staffs for the holistic care rendered to them. I accompanied patient and her relative to the hospital entrance at 3:17pm. I stopped a taxi and they bored after which I returned to the ward.

### 4.3.0 Follow Up/Home Visits/Continuity of Care

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

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

### 4.3.1 First Home Visit (8th September, 2023).

My first home visit was made on 8th September, 2023 . The visit was made in Dua-yaw Nkwanta near 58 junction in the Ahafo Region of Ghana . I called patient's daughter (R.A) when I alighted and he took me to the house. Mrs. R.A warmly welcomed me and I was offered a seat. The main reason for my visit was to identify if there was any contributing factor to Mrs. D.A's

disease and also to verify as to whether the information received from patient and the relative were indeed valid. Mrs. R.A took me around all the four corners of the house and later sent me into patient's room. The following observations were made; the house is in two apartments. One apartment had 6 rooms and the other one had 5 rooms. The front view for both lane was painted violet and the lateral view painted with yellow. The house was roofed with aluminium sheets. The compound was neat. The house had one kitchen, two bath rooms and two toilet facilities which were neat. The house had a good electrical connection system and their source of water was from the bore-hole. I educated Mrs. R.A that the water should either be purified by the addition of chlorine or boiled before domestic usage. There was a waste bin which was not covered with a lid. Hence, I educated him on the need to always cover the bin in other to prevent the spread of infections. I asked for the room where patient lives and her daughter sent me over there. Upon entering, it was identified that, patient was not using insecticide mosquito net. Mrs. R.A. was educated to tie mosquito net for the mother to prevent the occurrence of malaria. Furthermore, her windows were covered with rubbers hence the ventilation within the surrounding was poor. Therefore, I educated him to always remove the rubber so as to promote good ventilation in the room. Again, I saw a little boy with a wound on the right lower limb. Therefore, I educated the mother to send the child to the nearest health care centre for treatment in order to help the wound to heal. Also, a pregnant woman was asked to always embark on anti-natal care for regular check-ups. I made an enquiry from the daughter concerning her mother's nutritional lifestyle. According to the daughter, since patient is the one who does her own cooking, she eats whatever she likes. she said, patient mostly uses canned foods, eggs and meat when cooking and mostly eats at night. I explained to the daughter that since she is the one

who does her own cooking, then there would be the need to educate her directly when I embark on my next visit. I thanked Mrs R.A for his cooperation and left the house at 11:14am.

### 4.3.2 Second Home Visits (11th September, 2023).

My second home visit was embarked on 11th September, 2023 . The purpose for this visit was to assess patient's health status and also offer more education to patient on her illness as well as verifying if she abides by the medical regimen as prescribed. I arrived at patient's house at 8:45am. Mrs. D.A and her family were very glad to see me. They offered me a seat and warmly welcomed me once again. I asked about her health and she replied saying, since the day of discharge she has not encountered any health complaints again. I carried along with me the following equipment, blood pressure apparatus and thermometer. Truly, she was clinically stable as an evidenced by her vital signs recording;

| | |
|---|---|
| Temperature | $36.5^0$C |
| Pulse | 75 beats per minutes |
| Respiration | 18 cycles per minutes |
| Blood Pressure | 130/70 mmHg |

I inspected patient's antihypertensive medications and realised that, she was taking them as prescribed. I congratulated patient to continue to take her medications without defaulting. Patient and her family were given the following education; avoidance of fat foods like meat, eggs, lard, canned foods such as; sardine, corner beef margarine etc. Patient was also educated to use soya beans oil and sunflower oil when cooking, minimizing sodium intake, reduction of stress to have adequate rest, involving herself in passive exercises, avoidance of alcohol and smoking, taking

her medications as prescribed, attending to medical reviews regularly and reporting to the hospital whenever experiencing any symptoms that are unusual. Mrs. D.A was also educated to sleep under treated insecticide mosquito net and remove rubbers covered on her windows to promote adequate and good ventilation and also left there around 10:00am.

### 4.3.3 Day of Review/ Follow up (12th September, 2023).

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

| | |
|---|---|
| Temperature | $36.2^0$C |
| Pulse | 73 beats per minutes |
| Respiration | 17 cycles per minutes |
| Blood Pressure | 130/80 mmHg |

Patient was accompanied to the consulting room and reviewed by Dr. Asiedu Stephene, On review patient gave no complaints. She was advised on the need to take medications as prescribed without defaulting and encouraged patient to report to the hospital whenever she was not feeling well and avoid the usage of over the counter drugs. After the review, I escorted patient to the hospital entrance where she bored a taxi and left.

### 4.3.4 Third Home Visit (18th September, 2023).

On 18th September, 2023, I embarked on my last home visit in other to terminate the care. I reached patient's house at 10:15am. The entire family were much excited to see me once again. I carried along with me the following vital signs equipment, blood pressure apparatus and thermometer. I checked her vital signs and the readings were as follows;

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

Since the patient was clinically well and had no complaint, I humbly handed Mrs. D.A to a Registered General Nurse whose house was nearer to patient's own to continue the care. I educated Mrs. D.A on the need to take her medications as prescribed even though she was taking them accordingly when I inspected. Patient's daughter was encouraged to monitor her mother's medications so as she would not default. The entire family especially Mrs. D.A, was educated to report to the hospital whenever experiencing any symptoms that are unusual. Also, the entire family were educated on the need to stop the usage of over the counter drugs. All the education given to patient on the day of admission till discharge were restated. I finally thanked the entire family especially, Mrs. D.A for their cooperation throughout the entire study. They looked a bit sad when they heard the termination of my care with them. I encouraged them by saying, my time for School was at hand therefore I had to go and continue with my studies in order to learn more to render holistic care to others whenever the needs emerge. Within a moment, the entire family put on a smiling facial expression and also expressed their profound gratitude to me for been with them from day one till now. Mrs. D.A encouraged me to study harder and continue to remain in my humble state. I thanked her and the entire family and left the house at 1:40pm.

# CHAPTER FIVE

# EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

## 5.0 Inroduction

Evaluation refers to the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process (Smeltzer, Bare, Hinkle, & Cheever, 2014). The chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of the care rendered to patient and family.

## 5.1.0 Statement of Evaluation

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

### 1.1.1 Mrs. D.A was Relieved of Headache .

On the day of admission (1st September, 2023) at 11:00am Mrs. D.A complained of headache. A nursing diagnosis was formulated as, acute pain (headache) related to increase in cerebral vascular pressure. An objective was set to relieve patient from headache within 6hours. The following nursing interventions were carried out to meet the objective set; Mrs. D.A was reassured of competent nursing care that measures would be kept in place to relieve her from headache, madam D.A's pain level was assess using numerical rating scale and she chose 7 denoting her pain intensity, patient was kept into a comfortable position that relieves her pain, patient's vital signs especially blood pressure was checked and monitored every 30 minutes for 1

hour, diversional therapies was employed to reduce Mrs. D.A from stress. Adequate bed rest was ensured to induce maximum sleep. Prescribed analgesics such as; tablet Paracetamol 1 gram tds was administered and documented.

On 2nd September, 2023 at 11:00am an evaluation of the objective set on 1st September, 2023 to relieved patient of headache within 6 hours was done and goal was fully met as evidenced by patient verbalized she had been relieved of headache and nurse recorded patient's pain level of 0 using numerical rating scale.

**5.1.2 Mrs. D.A was able to perform daily activities of living within 72 hours (4th September, 2023).**

On the day of admission on the 1st September 2023 ) at 11:30am Mrs. D.A complained of general body weakness. A nursing diagnosis was formulated as; activity intolerance related to general body weakness. An objective was set to help patient perform activities on her own within 72 hours. The following nursing interventions were carried out to meet the objective set; Mrs, D.A and the family were reassured of measures that would be put in place to enable her perform daily activities, patient's level of physical activity and mobility was assessed, active range of motion exercise such as; sitting and standing was done, Mrs, D.A's vital signs was checked and recorded, she was assisted with daily activities such as; bed bath, mouth care, feeding etc. Mrs. D.A was taught on energy conservation techniques such as; pushing rather than pulling, sliding rather than lifting and sitting whilst performing tasks.

On 4th September, 2023 at 11:30am an evaluation of the objective set on 1st September, 2023 to help patient perform activities on her own within 72 hours was done and goal was fully met as

patient verbalized she has been able to perform daily activities with ease and nurse observed patient performing daily activities of living such as; mouth care, feeding and bathing without any assistant.

**5.1.3 Mrs. D.A was partially relieved of cough .**

On the second day of admission (2nd September, 2023 ) at 6:30am, Mrs. D.A experienced coughing. A nursing diagnosis was formulated as; altered body comfort (cough) related to irritation of the airway. An objective was set to help patient relieved of coughing within 24 hours. The following nursing interventions were carried out to meet the objective set; Mrs .D.A was put in the semi- fowler's position to help expand the lungs to aid in easy breathing, her respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress, Mrs. D.A was taught on deep breathing exercise, and was educated on covering the mouth when coughing to help reduced the spread of infections. Also, patient was encouraged to take in adequate fluids to help loosen mucus, prescribed expectorant such as, Simple Linctus syrup 15mls was administered.

On 3rd September, 2019 at 6:30am, an evaluation of the goal set on 2nd September, 20 to help patient relieve of cough within 24 hours was made and was goal partially met as patient was still coughing and nurse observed patient having an intermittent cough. Therefore, the nursing care was amended and reinforced for another 24 hours.

### 5.1.4 Mrs. D.A and the Family gained sufficient knowledge on Hypertension throughout their period of hospitalization.

On the second day of admission 2nd September, 203 at 2:05pm upon my constant interaction with patient and the relative, I realised that they lacked sufficient knowledge concerning the risks factors, clinical manifestations and management of hypertension. A nursing diagnose of knowledge deficit related to insufficient information on the risks factors, clinical manifestations and the management of hypertension was formulated to help increase patient and the family's knowledge on hypertension at 2:10pm. The following nursing interventions were carried out to help meet the objective set; noise free environment on the education of hypertension was ensured, all procedures were clearly explained to patient and her family, patient and family's knowledge concerning the diagnosis, risks factors and clinical manifestations on hypertension was assessed, patient and her family were encouraged to ask questions in other to clarify any misconceptions with regards to hypertension, Mrs. D.A and her family tried answering a lot of questions that were asked on hypertension, a clear and simple language was used in answering Mrs. D.A and her family tactfully.

On the day of discharge(5th/09/23) at 2:10pm, an evaluation of the objective set on 2nd September, 2023 to help increase patient and the family's knowledge on the risks factors, clinical manifestations and the management of hypertension throughout their period of hospitalization was made and goal fully met as patient and the family enumerated at least 5 predisposing factors, 5 clinical manifestations and 5 dietary managements to hypertension and nurse observed patient and family utilized the knowledge gained on hypertension into practice and answering questions on hypertension correctly.

### 5.1.5 Mrs. D.A's disturbed sleeping pattern was restored .

On the third day of admission 3rd September, 2023 at 6:35am, patient complained of difficulty in sleeping. At 6:35am a nursing diagnosis was formulated as, altered sleeping pattern related to cough. An objective was set within 24 hours to help relieve patient from difficulty in sleeping. The following nursing interventions were carried out to help meet the objective set. Mrs. D.A was kept in the semi- fowler's position to help expand the lungs to aid in easy breathing, patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress. Also, patient was suctioned. Patient was educated on covering the mouth when coughing to help reduced the spread of infections, patient was encouraged to take in adequate fluids. Prescribed Syrup Simple Linctus 15mls tds was rightly administered and documented, patient was given warm bath, patient was served with warm beverage like milo and prescribed sedatives were administered.

On 4$^{th}$ September, 2023 at 6:35am, an evaluation of the objective set on 3rd September, 2023 to relieve Mrs. D.A from difficulty in sleeping was evaluated and goals fully met as patient verbalized she had a good sleep last night and nurse observed patient had a maximum sleep of 2 hours at day time and 6 hours at night time.

### 5.1.6 Mrs. D.A was relieved of constipation within 48 hours .

On the third day of admission, 3rd September, 2023 at 2:43 pm patient gave complaint of straining when emptying bowel. At 2:43 pm, a nursing diagnosis was formulated as; alteration in bowel movement (constipation) related to inadequate intake of fibre and fluid. An objective was set to help relieve patient from constipation within 48 hours. The following nursing interventions were carried out to help meet the objective set; a well-balanced diet containing adequate fiber,

fresh fruits, vegetables and grains were served, patient was educated on the need to take in adequate fluids, patient was assisted to perform passive exercise in bed, Mrs. D.A was encouraged to empty her bowl regularly in other to avoid postponing faeces, privacy was ensured so as patient could feel the edge to empty her bowls freely. Prescribed Syrup Lactulose 10mls was administered and documented.

On 5th September, 2023 at 2:43pm, an evaluation of the objective set on 3rd September, 2023 to relieve Mrs. D.A from difficulty in emptying her bowels was evaluated and goals was fully met as patient verbalized she had been relieved of difficulty emptying her bowels and nurse observed patient passed stools twice daily without straining.

**5.1.7 Mrs. D.A and her family were relieved of Anxiety within 12 hours 4th September, 2023).**

On the fourth day of admission, 4th September, 2023 at 8:33am, I realised that Mrs. D.A and the family were anxious. A nursing diagnosis was formulated as; Anxiety related to an unknown outcome of medical condition at 8:33am. An objective was set to help relieved Mrs. D.A and the family from anxiety within 12 hours. The following nursing interventions were carried out; Mrs. D.A and her family were reassured of competent nursing care in other to relieve them from fears causing anxiety, patient and family level of anxiety were assessed to help plan appropriate nursing interventions, Mrs. D.A and the family were educated on the risks factors, clinical manifestations and managements of hypertension. All nursing procedures and interventions were clearly explained to patient and the family to help gained their cooperation. Patient and family were encouraged to verbalize their fears and feelings. Also, clear and simple language was used throughout our conversation. Mrs. D.A and her family were oriented to the ward, equipment and daily routine at ward in other to reduce their level of anxiety.

On the same day (4th September, 2023) at 8:33pm, an evaluation of the objective set to relieve Mrs. D.A and the family from anxiety was fully met as patient and family verbalized, they felt less anxious and nurse observed patient and family had good facial expression and freely communicating with other patients.

**5.2 Amendment of Care Rendered to Mrs. D.A**

On 3rd September, 2023 at 6:30am, an evaluation of the goal set on 2nd September, 2023 to help patient relieved of cough within 24 hours was made and goal was partially met as patient verbalized, she was still coughing and nurse observed patient having an intermittent cough. Therefore, the nursing care was amended and reinforced for another 24 hours. The following nursing interventions were reinforced and carried out; patient was put in a semi-fowlers position to expand lungs for easily breathing, patient was educated on deep breathing and cough exercises, patient's respiratory pattern such as; the rate, rhythm and depth was assessed for respiratory distress, patient was educated to cover the mouth with a clean handkerchief when coughing, patient was encouraged to take in adequate fluid to loosen mucus, patient was suctioned, adequate bed rest was ensured, a well-balanced diet was served, patient's relative was educated to wash patient's handkerchief and dried under sun in other to reduce the number of microorganisms, prescribed Syrup Simple Linctus 15mls tds was administered and documented.

On 4thth September, 2023 at 6:30am, the amendment made on 3rd September, 2023 was evaluated and goal was fully met as patient verbalized she had been relieved of cough totally and nurse observed patient experienced no cough.

## 5.3 Termination of Care

Patient and Family's care ended on the 3rd October, 2023 which was the very day I embarked on my last home visit. This ended the interaction between the health team and Mrs. D.A and her family. The preparation for termination of care started on the day of admission through discharge, review to the third home visit. On that day, I educated patient and the family with regards to the risk's factors, clinical manifestations, lifestyle and dietary modifications without forgetting the pharmacological managements prescribed for patient. I congratulated the entire family for the care they rendered to Mrs. D.A in one way or the other. I also expressed my profound gratitude to the entire family especially, Mrs. D.A for their marvellous co-operation rendered to me throughout the study. Patient was clinically well and had no complaint therefore she was handed over to a Registered General nurse whose house was nearer to patient's own to continue the care. They were informed that, now that Mrs. D. A's health had been restored, the care for her has officially ended. I informed them of my desire to visit them unofficially whenever I had the opportunity. They were happy and noted that they would miss my care and would strictly adhere to all instructions given to them. I informed them of my leaving and looked a bit unhappy but I encouraged them by saying, my time to School was due therefore I had to go and continue with my studies in other to learn more to render holistic care to others whenever the needs emerge. Within a moment, the entire family put on a smiling facial expression since they were prepared psychologically from the day of admission till date. I bade them a good bye and left the house at 1:40 pm

# CHAPTER SIX

# SUMMARY AND CONCLUSION

## 6.0 Introduction

Summary is a comprehensive and usually brief abstract, recapitulation, or compendium of previously stated facts or statements. Conclusion is something that you decide when you have thought about all the information connected with the situation (Weller, 2014).

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.

## SUMMARY 6.1

Summary is a brief statement of the main points of something (Chester & Murray, 2010).

Patient was admitted into the females ward through the Accident and Emergency Unit at St. John of God Hospital, Duayaw Nkwanta accompanied by a staff nurse, two student nurses and a relative in a wheel chair in a conscious but weak state on 1st September, 2023 at 10:30am with the diagnosis of hypertension. Patient gave the following complains on admission, headache, dizziness and general bodily weakness. Patient's vital were checked and recorded as; Temperature- $36.6^0$C, Pulse- 99bpm, Respiration- 23cpm and Blood Pressure 180/120mmHg. Patient was educated on the risk's factors, clinical manifestations and both pharmacological and non-pharmacological management of hypertension. Aside the education, Mrs. D.A were assisted in maintaining good personal hygiene, nutrition and passive exercises. The following medications were used in the management of patient throughout her period of hospitalization;

The following Laboratory Investigation were ordered;

Full blood count (FBC) for, RBC,WBC,HBC etc.

1.Malaria Test

2.Urinalysis (Urine R/C)

3.Random Blood sugar (RBS) was checked and recorded as; 5.9 mmol/1

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

Patient was discharged on her fifth day of admission on the 5th September, 2023. Patient came for a review on the 12th September, 2023. Upon assessment, patient looked very healthy as evidenced by her vital signs within normal range with no new complaints and she was complying with her medications as prescribed without defaulting. Three home visits were made in this study. The first home visit was made on 8th September, 2023 , second home visit was made on 11th September, 2023 and the third visit was embarked on 18th September, 2023 purposefully to terminate patient's care. The care was terminated on 18th September, 2023.

## 6.2 Conclusion/Recommendation

Conclusion is the final part of something. Recommendation is a suggestion that something is good or suitable for a particular purpose or job (Walter, 2013).

The study has equipped me with knowledge on how to care for a patient as an individual. Through this study, I have been able to put into practice actual and holistic nursing care as has been learnt theoretically. The study provided a therapeutic environment for nursing patient as an individual and has promoted a good nurse-patient (family) relationship as well as broadened my knowledge on hypertension, its risks factors, clinical manifestations as well as its management. It has also helped me to practice my skills acquired in the classroom theoretically. It has deepened my relationship with patients, families and the people in a given community as a whole. The study also provided the platform for the patient and family to receive individualized care. Based on the testimonies given by patients who receive individualized nursing at hospitals, it prompts most of the community members to seek medical help at the various hospitals. This helps to redeem the image of the hospital and the staff nurses as a whole. Also this patient and family care study also helps to change the community's wrong perceptions about staff nurses and also improve the people's attendance to the hospital.

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

## BIBLIOGRAPHY


Bickley, L. P. (2009). In *Bates' guide to phsical examination&history taking* (10 ed.). Philadelphia: Walters Kluver Health/Williams&Wilkins.

Chester, W., & Murray, J. (2010, August 1). *Oxford English Dictionary Online*. (J. Simpson, E. Weiner, Editors, & Oxford Univerty Press) Retrieved October 3, 2019, from Oxforddictionaries.com

Chobanian, A., Bakris, G., Blank, H., & Cushman, W. (2003, May 14). *The Seventh Report of the Joint National Committee on Prevention*. Retrieved September 14, 2019, from https://www.ncbi.nlm.nih.gov.com

Gulani, K. (2017). *A Textbook of Community Health Nursing*. (S. S. Roshani Tuitui, Editor) Retrieved 09 13, 2019, fr



Bickley, L. P. (2009). In *Bates' guide to phsical examination&history taking* (10 ed.). Philadelphia: Walters Kluver Health/Williams&Wilkins.

Chester, W., & Murray, J. (2010, August 1). *Oxford English Dictionary Online*. (J. Simpson, E. Weiner, Editors, & Oxford Univerty Press) Retrieved October 3, 2019, from Oxforddictionaries.com

Chobanian, A., Bakris, G., Blank, H., & Cushman, W. (2003, May 14). *The Seventh Report of the Joint National Committee on Prevention*. Retrieved September 14, 2019, from https://www.ncbi.nlm.nih.gov.com



Gulani, K. (2017). *A Textbook of Community Health Nursing*. (S. S. Roshani Tuitui, Editor) Retrieved 09 13, 2019, from Home-visiting: www.slideshare.net

Gyang, R., & Darko, V. (2010). Standard Procedure Manual For Nurses In Ghana. In M. Twum (Ed.), *Nursing Procedure* (Vol. I). Accra, Ghana: Health Sector Programme-DANIDA. Retrieved September 14, 2019

Lewis, S. L., Dirksen, S. R., Heitkemper, M. M., & Bucher, L. (2014). In C. D. Rogers, & J. Wiley (Eds.), *Medical- Surgical NursingAssesement&Management of Clinical Problems* (9th ed.). Philadelphia-Ohio, United State. Retrieved August 3, 2019, from http//www.bookaid.org

McLeod, S. (2018, 4). *Erick-Erickson's psychosocial stages*. Retrieved from https//www.simplypsychology.org/Erik-Erickson.html

Roth, J. (2018, February 14). *Pregnancy and Birth*. Retrieved September 13, 2019, from The history of child bearing: www.ourbodiessourselves.org.org

Sid, I. (2018, March 11). *Pears Foundation*. Retrieved from What is Development?: www.sid-Israel.org

Smeltzer, S. C., Bare, B. C., Hinkle, J. L., & Cheever, K. H. (2014). In *Brunner&Suddarth's Textbook of Medical- Surgical Nursing.* Philadelphia: Wolters Kluwer Health/Lippincott Williams& Wiilkins.

Stebbins, R. (2015). *A Perspective for Our Time*. Retrieved september 14, 2019, from Serious Leisure: http://en.m.wikipedia.org/wiki/Hobby.com

Tuitui, R., & Suwal, S. (2017). *A Textbook of Community Health Nursing*. Retrieved September 13, 2019, from shijuvarghesepg/home visiting: www.slideshare.net

Walter, E. (2013). In C. Mclntosh (Ed.), *Cambridge Advanced Learner's Dictionary* (4th ed.). Cambridge, America: Cambridge University Press. Retrieved September 14, 2019

Weller, B. (2014). In *Bailliere's nurses dictionary for nurses and healthcare workers* (25 ed.). London: Elsevier Health Sciences.

om Home-visiting: www.slideshare.net

Gyang, R., & Darko, V. (2010). Standard Procedure Manual For Nurses In Ghana. In M. Twum (Ed.), *Nursing Procedure* (Vol. I). Accra, Ghana: Health Sector Programme-DANIDA. Retrieved September 14, 2019

Lewis, S. L., Dirksen, S. R., Heitkemper, M. M., & Bucher, L. (2014). In C. D. Rogers, & J. Wiley (Eds.), *Medical- Surgical NursingAssesement&Management of Clinical Problems* (9th ed.). Philadelphia-Ohio, United State. Retrieved August 3, 2019, from http//www.bookaid.org

McLeod, S. (2018, 4). *Erick-Er* frohttps//www.simplypsychology.org/Erik-Erickson.html

## APPENDIX

**Table 6.1: Vital Signs for Mrs. D.A**

| Date | Time | Temperature ($0^0$C) | Pulse (Bpm) | Respiration (Cpm) | Blood Pressure (mmHg) |
|---|---|---|---|---|---|
| 01/09/23 | 10:30am | 36.6 | 67 | 20 | 160/90 |
| | 2:00am | 36.3 | 78 | 21 | 140/84 |
| | 6:00pm | 35.8 | 67 | 19 | 130/80 |
| | 10:00pm | 36.1 | 70 | 20 | 136/80 |
| 02/09/23 | 6:00am | 36.0 | 74 | 17 | 140/80 |
| | 10:00am | 36.5 | 70 | 20 | 130/70 |
| | 2:00pm | 36.1 | 80 | 21 | 120/70 |
| | 6:00pm | 36.0 | 74 | 17 | 140/80 |
| | 10:00pm | 36.3 | 77 | 19 | 140/70 |
| 03/09/23 | 6:00am | 36.5 | 82 | 22 | 110/70 |
| | 10:am | 37.0 | 73 | 19 | 130/80 |
| | 2:00pm | 36.6 | 78 | 20 | 120/80 |
| | 6:00pm | 36.5 | 83 | 21 | 130/80 |
| | 10:00pm | 36.4 | 80 | 20 | 130/70 |
| 04/09/23 | 6:00am | 36.8 | 80 | 22 | 136/80 |
| | 10:00am | 37.0 | 86 | 25 | 130/80 |
| | 2:00pm | 36.2 | 77 | 20 | 130/70 |
| | 6:00pm | 36.4 | 81 | 19 | 130/80 |
| | 10:pm | 36.2 | 80 | 20 | 130/70 |
| 05/09/23 | 6:00am | 36.2 | 83 | 18 | 130/80 |
| | 10:00am | 36.0 | 80 | 19 | 130/80 |
| | 2:00pm | 36.0 | 80 | 20 | 120/84 |
| | 2:30pm | 36.2 | 78 | 19 | 120/80 |

## SIGNATORIES

1. **The Student Nurse Holy Family Nursing and Midwifery Training College, Berekum.**

Name: Master Addo Philip

Signature: .....

Date: 7th June, 2024

2. Nurse In-Charge of Female Medical ward at St John of God Hospital.

Name: Miss. Nora Donkor

Signature: .....

Date: 11/06/2024

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3. The Supervisor, Holy Family Nursing and Midwifery Training College, Berekum.

Name: Mr. Eric Obeng

Signature: .....

Date: 10/06/2024

4. The Principal, Holy Family Nursing and Midwifery Training College, Berekum.

Name: Monica Nkrumah

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