HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

PATIENT/FAMILY CARE STUDY ON HYPERTENSION

BY

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A PATIENT/FAMILY CENTERED CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILLMENT TOWARDS THE AWARD OF A LICENSE TO PRACTISE AS A PROFESSIONAL REGISTERED GENERAL NURSE

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PREFACE

Centuries ago, the nursing profession was just caring for the sick. From the day the profession started, it has undergone many changes throughout the years. Starting from the patient centered approach to a more complicated form of care which includes: the family and the community as a whole. Nursing became a profession when Florence Nightingale, in the nineteenth century provided and set a pattern which has become the basis of educating nurses today.

Nursing care has moved from the physical care of patients to a more complex approach which includes the psychological, spiritual and intellectual needs as well as that of their family as a whole (Nursing process). To achieve ultimate goal, the nursing process requires the cooperation of the family, the patient and the community. Also, education is given to help prevent the disease

and to help them to know their right. pertaining to their care. The patient and family care study entails rendering holistic care to the patient and family starting from the day of admission till discharge. Individualized nursing care is the area of interest in the study.

The nursing process is a deliberate problem-solving approach for meeting a person's health care and nursing needs. It consists of a sequence of steps in the following order; assessment, diagnosis, objective/outcome criteria, planning, implementation, and evaluation.

The patient/family care study also offers the student nurse the opportunity to put into practice the knowledge acquired at school in giving effective nursing care to client with reference to the client's condition. In addition to the above, the patient/family care study enables the student to acquire more knowledge about the causes, signs and symptoms, diagnosis and treatment given to patients with specific conditions using the nursing process. The confidentiality of the patient/family was ensured by the use of patient/family members initials instead of full names. The patient/family care study is a requirement for the award of the license to practice as a Registered General Nurse by the Nursing and Midwifery Council of Ghana. The comprehensive

care rendered was made possible by the employment of skills and knowledge in such disciplines as psychology, anatomy and physiology of the human system, public health nursing, medical nursing, surgical nursing, pharmacology and nutrition and dietetics.

ACKNOWLEDGEMENT

I deem it expedient to express my profound gratitude to the Almighty God for giving me the strength, knowledge and understanding to write this care study.

My sincere gratitude goes to Mr. S.A.O. and his family especially F.S (patient's wife) for their cooperation and provision of all the necessary information for this study. This care study would not have been successful without the directions and constructive criticism of my supervisor, who equipped me with the knowledge and guidelines whilst writing this care study and all the tutors of Holy Family Nursing and midwifery Training college-Berekum, for their support and the pieces of advice they gave me throughout this study. I am also grateful to the medical doctors and the staff nurses of the General Ward at Municipal Hospital, Goaso especially Mr. Adu Sarfo Felix and Mr. Agyei Enock who assisted me in the care of my patient. I would like to extend my appreciation to my wonderful brother and his wife Mr. and Mrs. Saasor Daniel and all my sisters, my friends and roommates who tried their best in providing me with the needed support, finance and materials for this care study. My appreciation goes to my friends and colleagues who have motivated me throughout the writing of this care study. Lastly, I am very grateful to all the publishers and authors whose books I used during the course of my Study.

May God bless you all.

INTRODUCTION

This patient and family care study was conducted on Mr. S.A.O. a 41-year-old, who was admitted to the male general ward of Municipal Hospital Goaso, on the 25th of November, 2021. He was diagnosed with Hypertension. On the day of admission, patient complained of headache and dizziness. During the period of hospitalization, patient and family were nursed for five (5) days. The script gives a sum total of all activities rendered to maintain and achieve a high level of wellbeing for client and family. The reader is introduced to the concept of nursing process being used effectively to provide good nursing care to the client and his family with particular reference to Mr. S.A.O. at the time of discharge, his condition had improved tremendously without any complication. Patient was used for the study because I wanted to know more about the condition, it cause, treatment, prevention and its complications and the knowledge gained will help me in the practice of nursing.

The report of the study is outlined in six chapters namely;

1. Assessment of patient/family.

2. Analysis of data.

3. Planning for patient and family care.

4. Implementation of patient and family care plan.

5. Evaluation of the care rendered to patient and family.

6. Summary and conclusion.

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CHAPTER ONE

ASSESSMENT OF PATIENT/FAMILY

1.0 Introduction

Assessment is the systematic collection of data to determine the patient health status and any actual or potential health problems (Hinkle & Cheever, 2014). Assessment is the first phase of the nursing process. It includes collection of data from the patient/family about their health status, hence enabling the nurse to render quality health care to the patient through interviews, medical records, laboratory investigations and examinations. It covers the patient's particulars, family medical/surgical history, family social/economic history, patient's developmental history, patient's concept of illness, patient's lifestyle and hobbies and patient's past and present medical/surgical history. This begins from the day of admission and ends after termination of care. Data was collected from the patient, relatives, health personnel, laboratory investigations and textbooks from which analysis was made to identify patient's problems in order to plan and implement care for the patient. The methods used in assessment include; observation and interview with patient and family.

These methods were used to obtain data from patient and family. The main purpose of assessment was to help identify objective and subjective data which is of importance to the health of my patient as well as the family.

1.1 Patient's Particulars

Particulars refer to a detailed information or facts about a person. It is usually of an individual personal detail such as name, address, sex, age, date of birth and among others (Merriam

Webster's College Theasaurus,2014). Mr. S.A.O. is the name of my patient. He is the first born of his parents and was born on 13th September,1980 at Gambia number1 to Mr. O.A and Mrs. G.A. He is 41years of age. Mr. S.A.O currently lives in a house with house numberABK-14 at Kasapin alone and hails from Gambia a small town near Bediako in the Ahafo Region of Ghana. He is married to Mrs..F S; he said all his family members including himself are Christians. Mr. S.A.O said he worships with the Assemblies of God Ghana, Kasapin branch. Miss D A is the name his younger sister and the next of kin. D.A does not live in the same house with her brother but lives in Mim. According to patient, he attended school primary at M/D primary school at Mim. He has three (3) children, (2 males and 1 female). Mr. S.A.O is dark in complexion,1.07meters tall and weighs 89 kilograms. He speaks Twi and English languages and has no physical impairment.

1.2 Patient / Family's Medical History

Health history is a series of questions used to provide an overview of the patient's current health status. Attention is focused on the impact of psychosocial, ethic, and cultural background on a person' health. Information is also obtained on both paternal and maternal sides of family (Hinkle & Cheever, 2014). According to patient, there are no known hereditary diseases such as asthma, diabetes mellitus, mental illness or hypertension in the family. He also said that, there are no chronic and infectious conditions like cancer, tuberculosis, epilepsy and leprosy in the family. However, he said sometimes the family members do experience minor ailments like common cold, headache and diarrhea, which they treat by using over the counter

drugs, and usually go to the hospital when symptoms persist for long period. I used this opportunity to educate them on the avoidance of over the counter drugs but rather seek early medical aid at the hospital anytime they fall sick. In the course of our conversation, Mr. S.A.O stated that at the age of twenty, he lost his grandfather and at age thirty-five, he also lost his grandmother after he fell sick for a long time. Mr. S. A. O. father died of stroke three years ago. Mr. S.A. O. said the rest of his family are all alive and healthy. Patient further stated that the only hospitalization he had was when he was newly diagnosed of hypertension, but was hospitalized for five days and discharged. The source of their medical treatment is orthodox. There is no known allergy in the family.

1.3 Patient's/Family Socio-Economic History

Socio-economic history captures sources of support, coping styles, strengths, and fears or any measures which attempts to classify individuals, families, or households in terms of indicators such as occupation, income, and education (Scott & Marshall, 2015). The patient Mr. S.A.O works in a forestry Ministry and the breadwinner of his family. He is not supported by any body as his Job is able to help feed the family and also provide all the needs of his three children. Due to the nature of his work I realized that patient may be prone to occupational hazards like cuts, stress, musculoskeletal pains and animal bites which he confirmed. According to patient, he earns moderately two thousand and fifty cedi each month His income is used for the up keep of the family and family health needs when insurance does not cover because patient and family are all registered members of the national health insurance scheme and also paying of his children school fees. According to Mr. S.A.O, he is the head of his

family and as such associates well with all his family members. He said in instances of family disputes and misunderstandings, he settles them amicably and upon my observation during visiting hours, I realized that there was a cordial and peaceful coexisting relationship amongst he and his family members. I also interacted with some of the family members like his wife and some of his siblings who confirmed what he said. Patient is a Christian who worships with the Assemblies of God Church of Ghana, Kasapin branch but does not play any role in the church. Patient was unable to throw more light on some cultural practices, norms, values and taboos. However**,** has been told it is a taboo to go to the farm on Fridays. He added that when one goes contrary to the set rules and regulations in the community, sanctions are applied.

1.4 Patient's Developmental History

Growth refers to measurable changes which shows an increase in size, physique and body composition, and various systems of the body (Merriam Webster's College Thesaurus, 2014). Development is a process that creates growth, progress, positive changes or the addition of physical economic, environmental, social and demographic component (Webster, 2018). Maturation is an increase in competence and adoptability, or the process whereby behavior is modified as a result of growth and development of physical structures (Shivangi, 2018). According to patient, he is the first born among four children. His mother experienced normal pregnancy for a period of nine months and did not experience any disease during that period. She did not attend antenatal, but had spontaneous vaginal delivery at the Pentecost health

center at Kasapin, in 1980. He added that he did not know whether his birth was at term or preterm since he never took the chance to ask his parents. Patient said his mother informed him that he was immunized against the Vaccine preventable diseases such as (diphtheria, tetanus, whooping cough, measles, poliomyelitis and yellow fever) and upon observation, the Bacille Calmette Guarine (BCG)scar was found on his right arm and this confirmed what patient said. Though, he never developed any complications throughout his development, however, he said he thinks that the presence of the immunization was why he did not suffer from measles when he was at the age of five (5). From patient, he went through the average normal developmental milestone and child's developmental characteristics. Mr. S.A.O., said according to his mother, at about seven months, he was sitting and crawling and could walk at ten months, by one year, he could eat all meals prepared at home, as a result was weaned at two years. Patient added that he was not exclusively breastfed and that his mother said he started drinking water and taking in porridge at 4 months old.

From my patient, he reached puberty when he was at the age of fifteen (15) and experienced all the features and changes during puberty like, pubic hair growth, deepening of voice etc. without any abnormalities.

Mr. S.A.O. said he did not engage in any relationship during his adolescence period until he met and married his wife at the age of twenty-eight years (28). He said he went to school and learnt very hard to become who he is today due to the fact that his parents were a bit well to do. Patient said he had the zeal to go to school and was interested in becoming a Lawyer but

due to the fact he did not properly pass his WASCE examination he could not achieve that dream.

In Erik Erikson's psychosocial theory (1950), he suggested that there are eight stages that one goes through from birth to death and failure to go through one stage successfully can result in a reduced ability to complete further stages and therefore an unhealthier personality and a sense of self.

Below show the stages one goes through from birth to death according to Erikson;

1.Trust vs mistrust(0-1year)

2.Autonomy vs shame and doubt (2-3years)

3.Initiative vs guilt(3-5years)

4.Industry vs inferiority(6-11years)

5.Identity vs role confusion(12-18years)

6.Intimacy vs Isolation(19-40years)

7.Generativity vs stagnation(40-65years)

8.Integrity vs despair(65years-death)

Patient does not fall within the eighth stage thus integrity versus despair (65years to death) of Erik Erikson's psychosocial theory Even though patient does not fall within this stage but has developed a sense of integrity since he has been able to achieve most of his goal without regrets. Mr. S O A is calm, humble, and respectful and treats all people equally

1.5 Patient's Lifestyle and Hobbies

Lifestyle is defined as the pattern of a daily living that an individual develops (Weller, 2014). Mr. S.A.O. wakes up about 4:30am, prays and cares for his mouth, baths and prepare to go the office if he other important this to do at work site. According to him, he does almost everything for himself.

He usually takes his breakfast at 7:30am and takes his lunch around 12:00pm. On days he does not go to the office, he goes to chat with his friends, neighbors or family. Patient does not take alcohol, tobacco and other illegal drugs because of his religious beliefs and I encouraged him to keep on with that because medically, it can have negative implications on his health., Patient hardly goes to the office on Fridays and Saturday days since these days were always not effective at work. He often takes a three-square meal daily but at times takes two meals daily with fufu and light soup as his favorite food. He is not allergic to any food, drug or animal. Mr. S.A.O. says he moves his bowels at least twice daily but at no specific time, and finds no difficulty in eating, grooming, dressing and walking. Mr. S.A.O. is very sociable, kind and has good communication skills which makes it easier for an effective and interactive communication to be achieved and as such impresses everyone at his first contact, he continued that, He does not keep people's mistakes and flaws to himself when he is offended but verbalizes them to ensure unity and harmony. Patient said he attends social functions like weddings, funerals, church activities, naming ceremonies, festivals and community events occasionally. He likes chatting with his family and also listening to the radio whenever it is time for news especially 6am, 12pm and 6pm as well as watching television. He said he always takes the radio to the work place to listen to new. Mr. S.A.O is the head of his family and associates well with his family members and neighbors. He likes hardworking people and encourages them but really hates lazy people. Patient also added that he likes banku and okro soup so much. Patient on daily basis uses his own motor bike to work and anywhere he wants to go as well. Patient said his

work always is challenging one but he is always motivated by his wife and children as well as going out some of the time his friends to release stress. He said he also likes to spend a lot of time with his family. My view and impression about patient is that he is a sociable person and a family man.

1.6 Patient's Past Medical History.

Past medical history is a narrative or record of past events and circumstances that are or may be relevant to a patient's current state of health (Merriam Webster, 2019). According to Mr. S.A.O. he had his first admission 2 years ago in the year 2019, at Municipal Hospital, Goaso, where he was admitted with hypertension and spent five days at the hospital. There were no complications because of the competency of staffs and medical doctors. He added that sometimes he visits the community health center at Kasapin at or Mim health center both in the Ahafo Region of Ghana whenever he experiences minor ailments like headache, general body weakness and fever but he sometimes buys and treats with over the counter drugs like paracetamol, diclofenac etc. or drugs collected from the hospital like analgesics such as paracetamol, aspirin and antihypertensive drugs like nifedipine, lisinopril, amlodipine etc. Mr. S.A.O. said he goes for regular checkups and always complies to his treatment regimen to prevent complications. He has never undergone any surgery, and has no physical deformity. He also said that his mother told him that, he had no ailment like measles, when he was about the age of (5) five because of the immunization at early age. Patient is not allergic to any drug, animal or insect. Patient also said that he has never incurred any road traffic accident in his lifetime.

1.7 Patient's Present Medical History

History of present illness is a complete, clear, and chronologic account of the problems prompting the patient to seek care (Merriam Webster, 2019). According to patient, he started experiencing headaches, blurred vision and dizziness a week before he came to the hospital and confessed that his anti-hypertensive drugs were completely finished. On 25/11/2021, patient

decided to come for a checkup and was told by the attending doctor that his blood pressure was elevated and needed to be admitted and monitored carefully to prevent further complications. His vital signs were checked and recorded at the outpatients' department as:

Temperature -36.3◦C.

Pulse -99 bpm.

Respiration -22cpm.

Blood pressure -200/120mmHg.

He was told to rest for 15minutes to help us know whether there will be a reduction or persistent increase in his blood pressure. He was later assessed by the doctor on duty, doctor A M who realized that there was a persistent increase in his blood pressure. Doctor A M made us re-check his blood pressure again and there was no reduction, doctor A M then informed patient that he needed to be admitted and monitored to prevent further complications. He was then admitted to the males' unit of the general ward and was put on the following medications:

1.Hydralazine hydrochloride 5mg over 10mins as stat dose the 15mg in a crystalloid solution.

2.Tablet Amlodipine 10mg once dailyx60days

3.Tablet Lisinopril 5mg once daily x60days

4.Tablet soluble aspirin 300 mg dailyx30days

1.8 Admission of patient

Admission is defined as an entry into a place (Merriam Webster's College Thesaurus,2014). On 25/11/2021 at 11:00 am, Mr. S.A.O. was brought to the general male's ward of Municipal Hospital Goaso per ambulation, from the out- patients' department accompanied by a colleague student nurse.

On arrival, myself together with a staff nurse on duty welcomed the patient and gave him a comfortable seat at the patients' waiting area. His folder was collected from the student nurse who brought him in. I introduced myself and other staff on duty to Mr. S.A.O, took his folder and mentioned his name, he responded and this confirmed that I was admitting the right patient. Mr. S.A.O.'s particulars were documented into the admission and discharge book as well as the daily ward state. Patient is a known hypertensive. He complained of headache and dizziness on admission. He was reassured that he is in the hands of competent staff and everything possible would be done to restore him to normal health.

His vital signs were checked and recorded as;

Temperature - 36.5 ^{o}C

Pulse -95bpm

Respiration -24cpm

Blood Pressure - 200/120mmHg

Mr. S.A.O. was made to rest comfortably in an already prepared simple unoccupied admission bed in the males' ward with bed number M-9. Nurses' notes were also written. He was put on the following drugs;

1. Hydralazine hydrochloride(intravenous)5mg over 10 minutes then 15mg in a crystalloid solution.

2. Tablet Lisinopril once daily 5mg x 60 days

3. Tablet Amlodipine 10mg once daily x 60 days

4. Tablet soluble aspirin 75mg once daily x 30 days

These drugs were obtained from the pharmacy and the prescribed stat dose was served. Diagnostic investigations requested for my patient were;

1.Full blood count.

2.Blood sample for malaria parasites.

3. Urinalysis

Later in the day, patient called his wife and some of his family members and told them that he has been admitted. When his wife, children and other few family members came, some of them were orientated to all parts of the unit and around such as the nurses' station, relatives hostel, kitchen, dry lines, bathroom, toilet, both males and females' unit of the general ward, the children's ward as well as the pharmacy and the laboratory. Patient and family were introduced to the staff and other patients present. He and his family were also informed about the daily ward routines such as serving of medications, ward rounds, schedules and visiting hours. Devices to be used on the ward during their stay was also mentioned to them like sphygmomanometer, thermometers, oxygen cylinders, suction machines etc. patient and family were told not to hesitate to call on any staff when there was a problem. Later, I told the ward in-charge of my intention to use the patient and the family for my care study and I was given the permission.

I introduced myself to the patient and family that, I am a student nurse of Holy Family Nursing and Midwifery Training College, Berekum, conducting a study at the hospital and as part of my training, it is a requirement in the Nursing and Midwifery council for all final year students to take a patient each, nurse him or her from the time of admission till time of discharge. I further made them aware that, the study will help me identify some possible risk

factors in their home environment which might have triggered the onset of the condition. I then

made it known to them my intention to use Mr. S.A.O. as the patient for my study, and I will need their co-operation and all the necessary information that will help me render individualized care to the patient towards recovery. The patient and family accepted and promised their cooperation and readiness to give me any information needed for my study. They were told that, they would be discharged home once the patient's condition is stable and that they were not going to be on the ward forever. They were also informed that, as part of my care, I would visit their home whiles he was on admission and after he has been discharged. I decided to use the patient for my care study because the condition was of much interest to me and I wanted to know more about hypertension.

1.9 The Patient/Family Concept about her Illness.

Patient's concepts of illness can be as an abstracts or generic idea generalized from one's illness or condition (Merriam Webster's College Thesaurus, 2014). During interaction with patient, he said he does not know the exact cause of the illness but believes it is not spiritual and that diseases can affect any person at any time. He also said that, he was not afraid but believes that with the competency of the staff and the best care that will be rendered throughout his hospitalization will help restore his health to normal. He also believes that as far as medical interventions have begun, he would regain his normal health by the end of hospitalization.

1.10 Literature Review on Hypertension.

Review Anatomy and Physiology of The Cardiovascular System (The Heart).

According to Waugh and Grant (2014), the heart lies in the thoracic cavity in the media-sternum. It lies oblique, a little more to the left than the right, and present a base above and apex below. The apex is about 9cm to the left of the midline at the 5th intercostal space, i.e. a little below the nipple and slightly nearer the midline. The heart is roughly cone-shape hollow muscular organ. It is about 10cm long and about the size of the owner's fist. It weighs about 225g in women and about 310g in men. The main function of the heart is to pump blood to the body parts

Position of The Heart

According to Waugh and Grant (2014), the heart lies in the thoracic cavity in the mediastinum (spaces between the lungs). It lies obliquely, a little more to the left than the right, and presents a base above and an apex below. The apex is about 9cm to the left of the midline at the level of the 5^{th} intercostal space, i.e. a little below the nipple and slightly nearer the midline.

Structure of The Heart

The Heart Wall

According to Waugh and Grant (2014), the heart wall is composed of three layers of tissues, pericardium, myocardium and endocardium. The pericardium which is the outermost layer is made up of two sacs; the outer sac and the inner layer. It protects the heart. The myocardium, which is the middle layer, is also composed of specialized muscles found only in the heart. It is not under voluntary control but striated, like skeletal muscles. The sheet arrangement of the myocardium enables the atria and ventricles to contract in a coordinated and efficient manner. The endocardium, the (innermost layer) lines the chambers and valves of the heart. It is a thin, smooth, glistening membrane that permits smooth flow of blood inside the heart.

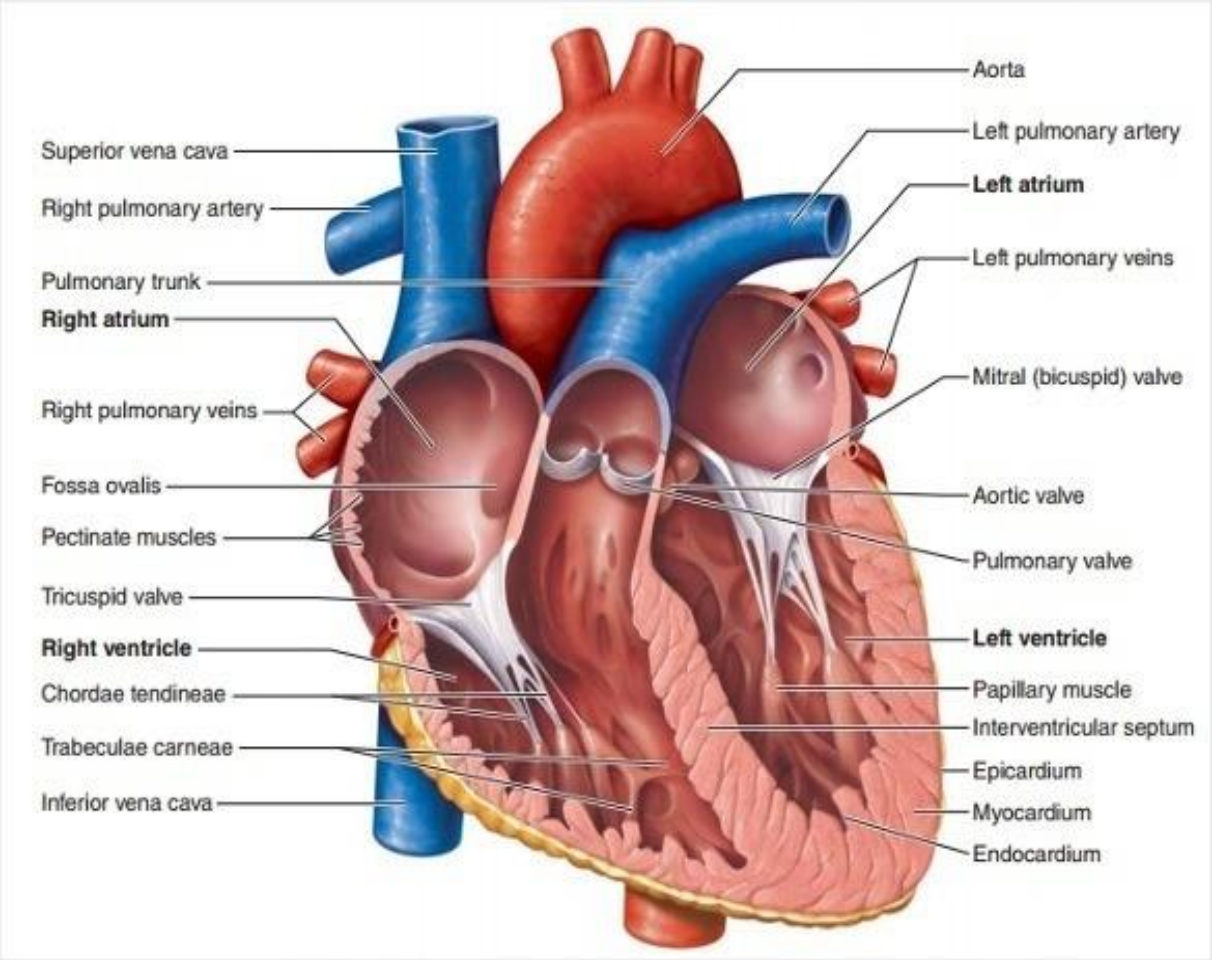

Figure 1: Diagram of the Heart.

Blood Pressure

Blood pressure is the force or pressure that the blood exerts on the wall of the blood vessels.

Systemic arterial blood pressure maintains the essential flow of blood into and out of the organs of the body. Waugh and Grant, (2014).

Keeping blood pressure within normal limits is very important. If it becomes too high, blood vessels can be damaged, causing clots or bleeding from sites of blood vessel rupture. If it falls too low, then blood flow through the tissue beds may be adequate. This is particularly dangerous for such essential organs as the heart, brain or kidneys. (Hinkle and Cheever, 2014)

Systolic and Diastolic Blood Pressure

When the left ventricle contracts and pushes blood into the aorta, the pressure produced within the arterial system is called *Systolic blood pressure.* In adults, it is 120 mmHg.

When complete cardiac diastole occurs and the heart is resting following the ejection of blood, the pressure within the arteries is much lower and is called *diastolic blood pressure*. In an adult, this is about 80mmHg. The difference between systolic and diastolic blood pressure is the pulse pressure.

Arterial blood pressure is measured with a sphygmomanometer and is usually expressed with the systolic blood pressure written above the diastolic pressure.

BP= 120/80mmHg

Factors Determining Blood Pressure

According to Waugh and Grant (2014), blood pressure is determined by cardiac output and

peripheral resistance. Change in either of these parameters tends to alter systemic blood pressure,

although the body's compensatory mechanisms usually adjust for any significant change. Blood

pressure=Cardiac output x peripheral resistance. Cardiac output is determined by the stroke volume and the heart rate. An increase in stroke volume increases systolic pressure more than it does diastolic pressure

Peripheral resistance is also determined by constriction and dilatation of the arterioles. When elastic tissue in the tunica media is replaced by inelastic fibrous tissue as part of the ageing process, blood pressure rises.

Auto regulation: When systemic blood pressure falls and rises constantly, according to the level of activity and body positions, etc. the organs of the body are capable of adjusting blood flow

and blood pressure in their own local vessels. This is called auto regulation, and protects the tissues against swings in systemic pressure.

Control of Blood Pressure

1. Blood pressure is controlled in two ways; Short term control, on a moment-to-moment basis,

2. which mainly involves the baroreceptor reflex, chemoreceptors and circulating hormones.

3. Long-term control, which involves regulation of blood volume by the kidneys and the renin-angiotensin-aldosterone system.

Definition

According to Hinkle and Cheever (2014), hypertension is a systolic blood pressure greater than 140 mmHg and a diastolic pressure greater than 90 mmHg based on an average of two or more contacts with a health care provider, when the patient is in a resting position. It is also called "the silent killer because the people who have it are often symptom free.

Incidence

According to Heitkemper, Dirksen, Lewis, Bucher, and Harding (2017). Hypertension is a

worldwide epidemic with an estimated 690million people living with high blood pressure.

The incidence of the condition increases with age. Generally, hypertension is more common in

women than in men but women can tolerate hypertension better than men. Hypertension is higher among blacks than whites (Smeltzer and Bare, 2017). indicated that, between 21% and 36% of the adult population in the United States have hypertension. Of the population between 90% and 95% have primary hypertension, meaning that, the reason for the elevation in blood pressure cannot be identified. The remaining 5% to 10% of this group have high blood pressure related to specific cause such as narrowing of the renal arteries, renal parenchymal disease, certain medications, pregnancy and coarctation of the aorta. It is also high in South Eastern United State particularly among African Americans.

Table1 below shows the classification of blood pressure for adults.

Table 1: Classification of blood pressure for adults;

Hinkle and Cheever (2014)

Category	Systolic (mmHg)	Diastolic (mmHg)
Hypotension	<90	<60
Normotension	90-119	60-79
Pre hypertension	120-139	80-89
Stage 1 Hypertension	140-159	90-99
Stage 2 hypertension	≥160	≥100

Types of Hypertension

Smeltzer and Bare (2017), also assert that, basically there are three types of hypertension namely;

1.Primary hypertension: also known as idiopathic or essential hypertension. This type has no known cause and it accounts for about 80-90% of people suffering from hypertension. It develops

slowly over a long period.

2. Secondary hypertension: there is normally a known cause. It accounts for about 5-10% of hypertension cases among adults, but over 80% among children. It is more common in men than women.

3. Malignant hypertension: is a relatively rare condition occurring in less than 1% of individuals

with diagnosed hypertension. The most common etiology of malignant hypertension is poorly controlled primary hypertension.

Etiology of Secondary Hypertension

According to Smeltzer and Bare (2010), secondary hypertension may be caused by any of the following;

A) Heart Diseases

1.Coarctation of the aorta

2.Myocardial infarction

3.Stenosis of the cardiac Valve

4.Pulmonary disease

B) Endocrine Diseases

1.Thyrotoxicosis which increases heart rate

2.Cushing's syndrome leading to formation of atherosclerosis

3.Pheochromocytoma leading to over production of epinephrine

4.Primary aldosterone leading to increased cardiac output(hyper-aldosteronism)

5.Diabetes Mellitus.

C) Renal conditions

1.Acute glomerulonephritis

2.Renal tumors

3.Renal artery stenosis

4.Renal failure

D) Pregnancy Related Disease

1.Pregnancy induced hypertension

E) Drugs

1.Cocaine

2.Oral contraceptives

3. Non-steroidal anti-inflammatory drugs

Predisposing Factors of Primary Hypertension

Although the etiology is unknown, risk factors have been identified as initiators or accelerators of the condition. The factors are basically genetic which are non-modifiable, and environment which are modifiable.

I) Genetic (Non-Modifiable) Factors

These are factors, which deal with the genes, and they are; family history, gender and age.

1.Family History: individuals, whose parents have high blood pressure, have a high risk of developing this condition at a younger age

2.Gender: Although high blood pressure increases with age in both men and women, men experience it at high rates and at an earlier age than women do.

3.Age: The structural and functional changes in the peripheral vascular system are responsible for the increase in blood pressure that occurs with age, coupled with age related process of atherosclerosis plaques and loss of connective tissue elasticity can predispose the aged to high blood pressure resulting to hypertension.

ii) Environmental (Modifiable) Factors

According to Smeltzer and bare (2017), there are environmental factors or stimulations, which one

can do away with. These factors are stress profile, occupation, socio-economic status, nutrition, obesity, life-style habit e.g. excessive smoking, alcohol consumption and physical inactivity.

A) Stress Profile

Stress situations increase the release of catecholamine and also increase the peripheral resistance leading to high blood pressure.

B) Occupation

These are occupations, which are hypertension prone because of the stress level involved in them.

Example is theatre and emergency nursing.

C) Socio-economic Status

Groups of people who are economically deprived have higher incidence of increased blood pressure. The factors accounting for these include poor nutrition and habits, low status job, frustration, discontentment and suppression of hostility.

D) Nutrition

High blood pressure is a disease of excessive salt, calories and alcohol intake. It has been found that the body's normal supply of cholesterol also increases the cholesterol in blood, which forms deposits on the arteries causing hypertension.

E) Obesity

There is an association between weight increase and high blood pressure. This may be due to the increased blood volume associated with weight gain.

F) Life-Style / Habit

I) Alcohol consumption: It increases blood pressure but the exact mechanism is not known.

However, increased cardiac output, calcium levels and cortisol secretions are mentioned as possible explanations.

ii) Excessive smoking: Nicotine is a vasoconstrictor thereby increasing blood pressure.

iii) Physical activity: Those who do not do physical exercise have increased risks of about 5% for developing high blood pressure as compared to those who do exercise. This is because exercise increases endorphins in the brain cells, which contribute to one's sense of wellbeing, and increases high-density lipoproteins, which protects against cardiovascular disease.

Pathophysiology of Primary Hypertension

According to Smeltzer and bare et al, (2017), many factors that moderate the vasomotor and vasoconstrictor response, such as anxiety and fear. Occurring concurrently with sympathetic nervous system and stimulation of the blood vessels in response to emotional stimuli is stimulation of the adrenal gland; the adrenal medulla secretes epinephrine, which causes vasoconstriction. The adrenal cortex secretes cortisol and other steroids, which may enhance the vasoconstrictor response of the blood vessels. Vasoconstriction results in reduced blood flow to the kidneys causing the release of rennin by the juxtaglomerular cell of the afferent arteriole.

Rennin converts angiotensinogen, which is produced by the liver to angiotensin 1. Angiotensin converting enzyme (ACE) which is also produced by the lungs and the proximal convoluted tubule converts angiotensin 1 to angiotensin 2, which is a potent vasoconstrictor, which in turn stimulates secretions of aldosterone by the adrenal cortex. The hormone promotes sodium and water retention by the kidney tubules, causing increase in intravascular volume.

The increased intravascular volume causes the workload of the heart to increase, due to the increase pressure in the vessels. Increased workload on the heart leads to hypertrophy of the heart muscles resulting in Left ventricular hypertrophy. Increased intravascular volume and increased cardiac load leads to higher cardiac load, which leads to higher blood pressure manifested by hypertensive patients. Again, there is decreased supply of blood to the brain due to the constriction in the blood vessel, which will lead to mental confusion and dizziness, exhibited by hypertensive patients.

Clinical Manifestations of Hypertension

Hypertension is usually referred to as “silent killer” because it is frequently asymptomatic and usually detected on routine physical examination of blood pressure (Hinkle and Cheever 2014).

1. Headache
2. Shortness of breath
3. Restlessness
4. Mental confusion
5. Chest pains
6. Palpitations
7. Blurred vision
8. Dizziness
9. Numbness
10. General body weakness.

Diagnosis

According to Smeltzer and Bare (2017), measures used in diagnosing hypertension includes;

1. Echocardiogram, to detect abnormalities in the heart.

2. Physical examination, thus by the clinical manifestation as outlined above.

3. Urinalysis, to test for protein to see if the kidneys are involved

4. Plain chest radiography to see abnormalities of the heart example left ventricular

5. Hypertrophy

6. Serum lipid profile, cholesterol and triglycerides.

7. Electrocardiography may show left ventricular hypertrophy

8. Excretory autography may reveal renal atrophy indicating chronic renal disease.

9.Serum chemistry may reveal complications arising from hypertension

Hinkle and Cheever (2014) added the following;

10.Health history and

11.Physical examination

Medical Treatment

According to Smeltzer and Bare (2017), essential hypertension has no cure but can be controlled with drugs and modification of diet and life style. Secondary hypertension management involves treatment of the underlying cause and controlling hypertensive effect. Below are some classes of drugs used in the treatment of hypertension listed below;

Table 2 below shows the classes of drugs that are used for the treatment of hypertension

Table 2; Classes of drugs used for the treatment of hypertension and their examples

Nursing Management

Class of Drugs	**Examples**
1. Diuretics	Hydrochlorothiazide (Esidrex) Furosemide (Lasix)
2. Beta–Adrenergic blocker / Inhibitors	Propranolol (Inderal) Atenolol (Tenormin)
3. Vasodilators	Hydralazine hydrochloride (Apresoline) Diazoxide
4. Calcium Antagonists	Amlodipine Nifedipine (adalat or Procardia)
5. Analgesics	Diclofenac Sodium (Voltaren) Paracetamol (Tylenol)
6. Angiotensin – Converting Enzyme (A.C.E.) Inhibitors	Captopril (Capoten) Lisinopril (Zestril)
7. Angiotensin-converting Enzyme blockers	Losartan Valsartan

According to Hinkle and Cheever (2014), the nursing care of the hypertensive patient begins with reassurance and explanation of the condition to patient about the causes, prevention, predisposing and side effects of drugs. Knowledge of the disease condition allays anxiety, therefore reducing the high blood pressure. The patient should be educated on the following; rest, diet, observations, modification of life style, elimination, medication and exercise.

a) Rest

1.Rest is particularly enforced in severe hypertension

2.The nurse must provide a calm environment for patient to induce sleep

3.Group and carry out nursing care activities at a go to promote rest

4.Anxiolytics example diazepam may be prescribed by the doctor to encourage relaxation and rest.

b) Diet

1.Adopt DASH eating plan. DASH (**D**ietary **A**pproaches to **S**top **H**ypertension). Educate patient to consume diets rich in fruits, vegetables and low-fat dairy products. Dietary Sodium reduction should be encouraged.

2.Food should be served in small quantities because the cardiac output tends to increase with the intake of heavy food.

3.Encourage intake of potassium, magnesium diet e.g. banana, orange etc.

4.Assist client to stop smoking and alcoholism if he/she engages in any.

c) Observation

1.The patient's vital signs should be monitored regularly in the same position each time especially the blood pressure and report any adverse findings.

2.Patient should be encouraged to express his feeling and complaints. Examples dizziness, headache, pain and palpitations to the nurse or doctor anytime he experiences it.

3.Monitor patient for headaches, dizziness and palpitations.

4.Intake and output chart should be monitored to check fluid and electrolyte imbalance.

5.Observe client slowly for stressful events, especially psychological, financial and social.

6.Weight must be checked and recorded daily to detect any changes that may arise and to monitor overweight.

d) Lifestyle Modification

1.Obesity: Advice obese patients to maintain normal body weight (That is body mass index of 18.5-24.9kg/m^2) as stated by Smeltzer and Bare (2017).

2.Stress: Identify stress-producing situation in the patient's life and seek means to reduce them. If it cannot be managed by the nurse, patient should be referred for training in stress management, which will be necessary for some patients.

3.Smoking: Smoking should be discontinued since smoke contains nicotine and this can raise arterial blood pressure.

4.Alcohol: Cessation of alcohol intake helps reduce hypertension.

e) Elimination

Patient should be encouraged to empty her bladder and bowels according to patient's regular pattern. Roughages should be included in diet to avoid constipation, since constipation leads to straining during defecation, causing raised blood pressure. Adequate fluid intake should be encouraged.

e) Exercise

Encourage patient to engage in regular aerobic exercise at least 30 minutes per day. This will promote relaxation and prevents constipation.

g) Medications

Antihypertensive drugs need to be taken regularly for long period to control the blood pressure.

Complications of hypertension

According to Hinkle and Cheever (2014), if patient hypertension is not identified early for prompt and effective treatment, it results in complications. These complications usually relate to the various organs and structures which are dependent to the heart. The organs commonly affected are;

1.Myocardial infarction: It is a medical name for a heart attack. It occurs when the flow of blood to the heart becomes blocked. They can cause tissue damage, necrosis and can even be life threatening.

2.Heart failure: hypertension also increase the work load of the left ventricle, which must pump harder to eject blood into the arteries. Overtime, the increased workload causes the heart to enlarge and thicken (hypertrophy) and may eventually lead to heart failure.

3.Renal failure: Hypertension will result to renal failure because of vasodilation, it makes blood not to flow enough to the kidneys there by resulting from activation of the rennin-angiotensin-aldosterone axis and the concurrent increases aldosterone.

4.Angina Pectoris: The cause is insufficient coronary blood flow, resulting in decrease oxygenation. In other words, the need for oxygen is exceeded.

5.Cerebrovascular accident (CVA): also known as stroke. It is caused by cerebral hemorrhage due to an increased blood pressure.

6.Hypertensive retinopathy: The cause is due to inadequate blood supply and rapture of the blood vessels the nerve of the eye which finally leads to blindness as a result of hypertension

Prevention

A) Primary

1.Low intake of salt and fatty foods should be encouraged

2.Advice on the danger of smoking and alcohol intake

3.Obese people should join “Keep Fit Clubs” if possible.

4.Educate patient on the need regular exercise

B) Secondary

1.Report signs and symptoms early

2.Educate hypertensive patients to join societies and groups in the community to relieve stress or emotional disturbances.

3.Educate patient to monitor blood pressure and record for early detection of hypertension.

4.Advice patient on the need for adequate rest.

A) Tertiary

1.Recommend that people with high blood pressure should check and monitor their blood regularly and record.

2.Educate hypertensive patients to take prescribed hypertensive drug regimen as ordered

3.Encourage the patient to keep a record of the medications prescribed and their efficacy

Prognosis

According to Smeltzer and Bare, (2017) prognosis of hypertension is good if one seeks early medical attention but may worsen if left untreated for a long time.

1.11 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). Mr. S.A.O. present

condition started with headache and dizziness. The clinical features presented by the patient and diagnostic investigations conducted on him confirmed that he was suffering from hypertension.

Data was also taken from the patient, existing medical records, (folder with the number 011989/21 at Municipal Hospital Goaso) and also information from the home visits I made. I also questioned patient and patient's family members to confirm responses patient gave me during assessment. Data collected were compared with information from the literature review, it was similar and clear that the patient was suffering from Hypertension. I can therefore conclude that the data collected is free from errors, bias and misinterpretation hence suitable for the study. Also, during home visits, the information given by client and relatives were confirmed to be true by other relatives that were interviewed.

CHAPTER TWO

ANALYSIS OF DATA

2.0 Introduction

According to Weller (2012), analysis is the act of determining the component part of a substance.

The second stage of nursing process is analysis, whereby data collected earlier is analyzed to ensure accuracy of the data. Analysis of data is the second phase of the nursing process. It contains information on the comparison of data gathered with standards. Based on the analysis, the nurse is able to identify the problems of the patient, his strengths, makes nursing diagnoses, objectives and gives appropriate interventions

2.1. Comparison of Data with Standards.

This is where the data collected on the health of the patient is compared with those in the literature review. These include diagnostic investigation, causes, signs and symptoms, treatment and complications.

A. Diagnostic investigation/tests

According to Smeltzer, et al (2017), a test or an investigation is a kind of medical procedure performed to detect or monitor diseases, disease processes, susceptibility and determine the course of treatment.

The following diagnostic tests were ordered and carried out on my patient;

1.Full blood count

2.Blood sample for Malaria Parasites estimation

3.Urinalysis

Table 3 below shows the diagnostic investigations carried out on my patient compared with those outlined in the literature review.

Table 3: Diagnostic investigations carried out on Mr. S.A.O compared with those in the literature review.

Laboratory investigations outlined in the literature review	**Diagnostic investigations conducted on my patient**
1.Echocardiogram	This was not conducted on my patient
2.Urinalysis	Urinalysis was not done
3.Plain chest radiography	Plain chest radiography was not done
4.Serum lipid profile	Serum lipid profile was not conducted
5.Excretory autography	This was not conducted on my patient
6.Serum chemistry	This was not conducted on my patient
7.Electrocardiography	This was not conducted on my patient.

Comparing the diagnostic investigations to the literature review, fewer diagnostic investigations were carried out on Mr. S.A.O to confirm the diagnosis. Though few diagnostic investigations were carried out, it can be confidently concluded that, patient was rightly diagnosed based on elevated blood pressure which is a cardinal sign of hypertension.

On the day of admission, 25th November, 2021, my client's blood sample was taken for Full blood count, Urinalysis and malaria parasites estimation.

Full blood count was performed to indicate the number of blood cell.

Also, blood film for malaria parasites was performed to rule out malaria. Details of the test carried out on the patient have been presented in table 4.

Date	**Specimen**	**Investigations**	**Results**	**Normal value**	**Interpretation**	**Remarks**
25/11/2021	Blood	Malaria parasites estimation	Negative	Malaria parasites should not be seen(negative)	Malaria parasites were not seen. Patient was not suffering from malaria.	Treatment was not given
25/11/2021 25/11/2021	Blood	Full blood count 1.Haemoglobin 2.White blood cell count 3.Red blood cell count 4.Haematocrit.	Hemoglobin level was 13.2g/dl $5.9x10^3L$ $4.6.0X10^6L$ 38.4%	Males_12_18g/dl Females_11.5_16g/dl 4.60x10x109/L 3.0-6.5X10/L 33.3-56.1%	It was within the normal range. Patient was not anemic. All blood components were within their normal range.	Treatment was not given.

25/11/2021	Urine	1.Protein in urine 2.glucose in urine 3.Acidity of urine 4.Bilirubin in Urine	Negative	Foreign components was not seen in urine. (Negative)	Patient did not show any of the component present in urine	Treatment was not given

B. Causes of Patient's Condition

With reference to the factors that cause hypertension as indicated in the literature review, patient's condition may be attributed to stress as one of his occupational hazards since it triggers the sympathetic nervous system to activate vascular response which is typically associated with cardiac output and causes an elevation in blood pressure. His condition can also be said to have been associated with diet since he eats fatty diets like chicken, he eats late and goes to bed straight after eating.

C. Clinical Features /signs and symptoms

Comparison of clinical features exhibited by patient compared with those in the literature review. Table 5 below shows the comparison of clinical features.

Table 5; Clinical manifestations exhibited by patient compared with those in literature review

Clinical Features According to the Literature Review	**Clinical Features Exhibited by Patient**
1.Headache	Mr. S.O.A complained of headache.
2.Dizziness	He complained of dizziness.
3. Blood pressure greater than 140/90 mmHg	His blood pressure was elevated to 200/120mmHg on admission
4.Restlessness	He was not restless
5.Mental confusion	He was mentally sound
6.Blurred vision	There was no problem with his sight, as he was able to see things clearly

7.Shortness of breath	Patient did not have shortness of breath
8.Numbness	My patient was not feeling numbness in the legs
9.General body weakness	Mr. S. A.O was not weak.
10.Chest pain	My patient complained of no chest pains on admission

From the comparison above, patient exhibited some of the signs and symptoms stated in the literature review such as; elevated blood pressure, dizziness and headache. Patient did not exhibit restlessness, mental confusion, numbness, blurred vision, shortness of breath, general body weakness and chest pain as stated in the literature review. The reason why patient did not exhibit many of the signs and symptoms outlined in the literature review is because, client reported early to the hospital and right and immediate treatment was given

D. Medical Treatment Given to Mr. S.A.O

Treatment is the mode of dealing with a patient or disease. (Weller,2014).

Mr. S.A.O was put on the following drugs

1. Hydralazine hydrochloride (Intravenous)5mg slowly over 10 minutes, then 15mg in a crystalloid solution.

2.Tablet Amlodipine 10mg once dailylyx60 days

3.Tablet Lisinopril once dailyx60 days

4. Tablet Soluble Aspirin 300mg once dailyx30 days

Table 6. below shows the treatment given to patient compared with those in the literature review.

Table 6; Comparison of treatment outlined in Literature Review compared with those exhibited by patient

Treatment According to Literature Review	**Treatment Given to Patient**
Calcium Antagonist. Example; Amlodipine	Amlodipine was given to my patient
Vasodilators. Example; Hydralazine hydrochloride (Arecoline) Diazoxide	Hydralazine hydrochloride was given to my patient
Diuretics Example; Furosemide (Lasix)	Furosemide (Lasix) was not given to my patient
Beta – Adrenergic Blockers. Example; propranolol (Inderal) and Atenolol (Tenormin)	Atenolol was not given to my patient
Angiotensin Receptor Blockers	Losartan was not given to my patient
Analgesics Example; Diclofenac aspirin and paracetamol.	My patient was given Aspirin

The comparison above indicates that patient had the right treatment because many of the drugs given were seen in the literature review and this contributed to his full recovery.

Table 7: Pharmacology of Drugs given to Patient.

Date	Drug	Dosage and Route of administration per Literature Review	Dosage and Route of administration to patient	Classification	Desired Effects	Actual actions Observed	Side Effects
25/11/21	Tablet Amlodipine	**Dosage:** 10mg once daily (If patient is conscious.) **Route:** intravenous, oral	**Dosage:** 10mg once daily x 60 days orally **Route:** orally	Calcium Channel blockers	To dilate coronal arteries and peripheral arteries to reduce high blood pressure or angina⁄ chest pain.	Blood pressure reduced from 200/120mmHg to 1 30/80mmHg at the time of discharge	Dizziness, fatigue, diarrhea, nausea, headache, constipation, peripheral edema, and abdominal pain. None was observed on my patient.

25/11/21	Tablet soluble aspirin	**Dosage:** Orally, 325-650mg once every 4-6hours daily **Route:** Oral, Rectal, Intravenously	**Dosage:** 300mg once daily x30 days **Route:** Oral	Analgesics/Anti-platelet	To reduce the headache To prevent the formation of clots in the blood vessels. (Anti-thrombotic effect).	Headache was relieved as verbalized by my patient. Formation of blood clots were prevented	Enlargement of the liver. This was not observed on my patient.
25/11/21	Tablet lisinopril	**Dosage:** 10mg once daily. **Route**: Oral	**Dosage**: 5 mg once daily x 60, once orally. Route: oral	Angiotensin-sin enzyme inhibitors	They inhibit the absorption of sodium chloride by the kidney, leading to excretion of sodium into the urine to reduce blood pressure.	Patient urinates frequently thereby reducing the blood pressure from 200/120mmHg to 130/80mmHg at the time of discharge.	Severe stomach pains, difficulty in breathing, swelling of the face, lips tongue and throat. None was observed on my patient.

Table 7: Pharmacology of Drugs given to Patient continued.

Date	Drug	Dosage and Route of administration per Literature Review	Dosage and Route of administration to patient	Classification	Desired Effects	Actual actions Observed	Side Effects
25/11/21	Hydralazine	**Adult dose:**20- 50mg 12 hourly slow IV injection over 10- 20 minutes,5- 10 mg diluted with 10ml normal saline. Repeated after 20- 30 minutes if necessary. Orally,25 50mg 12 hourly. **Route**: intravenously, orally	5mg slowly over 5 minutes then 15 minutes in a crystalloid, intravenously	Vasodilator	They relax the muscles in the blood vessels to help them dilate	Blood pressure reduced from 200/120mmHg to 130/80mmHg at the time of discharge	Palpitations, hypotension, flushing, headache and nausea. None was observed on my patient

E. Complications of hypertension

With reference to the complications indicated in the literature review such as myocardial infarction, cerebrovascular accidents, renal failure etc. Mr. S.A.O did not experience any complication due to effective medical and nursing care rendered during hospitalization.

2.2 Patient and Family Health Strengths

Strength refers to the quality or state of been strong (Merriam-Wester,2020). The following strengths were observed on patient during the time of nursing care. A patient and family strengths refer to the factors or activities that can be identified on a patient irrespective of his/her illness that can help the nurse to plan an individualized care for the patient. This involves the activities that contribute to the well-being of patient and her family as well towards his speedy recovery.

1.Patient could verbalize the intensity of headache.

2.Patient could walk when assisted

3. Patient could express his fears.

4.Patient and family could verbalize some signs and symptoms of the condition like headache and dizziness.

5. Patient could sleep for about four (4) hours during the night

6.Patient could eat one third of 500mls porridge served

2.3 Patient and Family Health Problems

According to Mish, (2016), patient and family problems are the things that are difficult to deal with, and needs attention.

To give effective nursing care, health problems must be identified through observation and interactions. These problems include actual and potential health problems.

The following health problems were identified during interaction with the patient and family;

1.Patient complained headache. (25/11/ 2021).

2. Patient complained of dizziness. (25/11/2021)

3.Patient was anxious. (25/11/2021)

4.Patient and family had inadequate information on the disease condition. (26/11/2021).

5.Patient was unable to get enough sleep. (26/11/2021).

6.Patient had loss of appetite. (26/11/2021)

2.4 Nursing Diagnosis

According to Weller, (2009). Nursing diagnosis is a statement of a health problem or of potential health problems in the patient's health status that a nurse is professionally competent to treat.

The following nursing diagnoses were formulated for patient and family;

1. Headache related to increased cerebral blood pressure (25/11/2021)

2. Risk for injury related to dizziness (25/11/2021)

3.Anxiety related to unknown outcome of disease condition (25/11/2021)

4 Deficient knowledge related to inadequate information on the disease condition (26/11/2021).

5. Impaired sleep pattern(insomnia) related to change of environment (26/11/2021)

6. Imbalance nutrition (less than body requirement) related to loss of appetite (26/11/2021)

CHAPTER THREE

PLANNING FOR PATIENT AND FAMILY CARE

3.0 Introduction

Planning according to Smeltzer et al, (2010), is the development and outcomes, as well as plan of care designed to assist the patient in resolving the diagnosed problems and achieving the identified goals and desired outcome. Planning is the third stage of the nursing process in which the nurse and the 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. In planning, objectives are set and prioritized into short and long-term goals. Goals set are developed upon and a plan of care drawn to resolve the nursing diagnosis within the stipulated time frame.

3.1 Objectives/ Outcome Criteria.

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

a. Patient verbalizing relief of headache.

b. Nurse observing patient has cheerful facial expression.

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

a) Patient verbalizing that he has been relieved of dizziness.

b) Nurse observing patient performing daily activities without sustaining any injury.

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

a) Patient verbalizing that he no more anxious.

b) Nurse observing patient having a relaxed facial expression.

4.The patient and family will gain adequate information on hypertension within 24hours as evidenced by;

a) Patient and family being able to answer questions posed on the condition correctly.

b) Nurse observing patient and family answer questions posed on the condition correctly.

5.Patient will gain his normal sleeping pattern within 48hours as evidenced by;

a) Patient verbalizing an interrupted sleep in the night.

b) Night nurses observing patient sleeping undisturbed for about 6-7hours in the night.

6.Patient will gain his normal sleeping pattern within 72hours as evidenced by;

a) Patient verbalizing that he has regained his normal sleeping pattern.

b) Nurse observing patient eat more than half of meals served.

Table 8: Patient/Family Nursing Care Plan for Mr. S O A and family.

Date & Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
25/11/21 at 11:00am	Headache related to increased cerebral blood pressure	Patient will be relieved of headache within 24 hours as evidenced by: a. Patient verbalizing the relief of	1. Reassure patient that he will be relieved of headache. 2. Ensure bed rest. 3.Assess the degree and intensity of pain using the pain rating scale. 4. Monitor vital signs every two hours	1.Patient was reassured of regaining his comfort. 2.Patient was made comfortable in bed with noise free environment. 3.Degree and intensity of pain has been assessed with the use of the pain rating scale of 0-10. 4. Vital signs were checked and recorded every two hours.	26/11/21 at 11:00am	Goal was fully met as patient verbalized the relief of headache and nurse observed patient had a cheerful facial expression.	H S

		headache. b. Nurse observing patient has a cheerful facial expression.	5. Engage patient in diversional activities. 6.Serve prescribed medications.	5. Patient was provided with a radio set by relatives to listen to news. 6. Prescribed drugs (Aspirin) was served.			

Table 8: Patient/Family Nursing Care Plan for Mr. S O A and family continued

Date/ Time	Nursing Diagnosis	Objective/ Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
25/11/21 at 11:10am	Risk for injury related to dizziness.	Patient will be relieved of dizziness within 24hours as evidenced by: a) Patient verbalizing that he has been relieved of dizziness. b) Nurse observing	1. Reassure patient. 2. Raise side rails. 3. Ensure complete bed rest 4.Remove sharps/injurious object from Patient. 5. Monitor Patient vital signs every 4hourly.	1. Patient was reassured that he will be relieved of dizziness. 2. Side rails of bed were raised to prevent patient from falling. 3. Complete bed rest was ensured by restricting visitors during sleep and rest hours. 4. Injurious objects like needles were removed from patient. 5. Vital signs especially blood pressure was monitored every	26/11/21 at 11:10am	Goal was fully met as patient verbalized the absence of dizziness.	H S

		patient perform daily activities without sustaining any injury. .	6. Inform patient to wake up slowly in bed	4hourly and recorded.			

Table 8: Patient/Family Nursing Care Plan for Mr. S O A and family continued

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
25/11/21 at 11:30am	Anxiety related to unknown outcome of disease condition.	Patient will be relieved of anxiety within 24hours as evidenced by: a) client verbalizing that he is no more anxious b) Nurse observing client having a relaxed facial expression	1.Reassure patient 2.Assess knowledge of client on hypertension. 3.Educate client on condition to allay his fears and misconceptions 4.Allow client to ask questions and express fears.	1 Client was reassured that he was in hands of competent staff and that his condition was temporal and can be controlled. 2. Client's knowledge on hypertension was assessed. 3. Client was educated on the condition to clear his fears and misconceptions. 4. Client was allowed to ask questions and express fears.	26/11/21 at 11:30am	Goal fully met as Patient verbalized that he was no more anxious and had a relaxed facial expression.	H S

			5. Engage client in diversional therapy. 6.Explain every procedure and its importance to the client to remove any fear 7. Establish rapport and other approaches to create a good nurse patient relationship in the ward.	5. Client was engaged in conversation and diversional therapy to divert his attention. 6. All procedures were well explained to client. 7.			

Table 8: Patient/Family Nursing Care Plan for Mr. S O A and family continued.

Date/ Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
26/11/21 at 4:40pm	Deficient knowledge related to inadequate information on disease condition.	Patient/family will gain adequate knowledge on hypertension within 24 hours as evidenced by; a) Patient and family being able to answer questions posed	1.Allow patient and family to express their perception about hypertension 2.Establish rapport with client and family for effective communication. 3.Explain to client and family the need to ask questions and provide answers tactfully. 4.Educate patient and family on the disease condition	1.Ideas of patient/family about their perception of the disease condition was expressed 2.Rapport was established which created effective communication. 3.Explain to client and family the need to gain knowledge on hypertension	27/11/21 at 4:40pm	Goal was fully met as client and family was able to provide answers to questions posed on the disease condition correctly.	H S

		on the condition correctly. b)Nurse observing patient and family answer questions posed on the condition correctly	5.	4.Educate patient and family on the disease conditions. 5.Encourage client and family to ask questions and provide answers tactfully.			

Table 8: Patient/Family Nursing Care Plan for Mr. S O A and family continued

Date / Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing Orders	Nursing Interventions	Date / Time	Evaluation	Sign
26/11/21 at 8:30am	Impaired sleep pattern (Insomnia) related to change of environment	Patient will regain her normal sleeping pattern within 48hours as evidenced by: a)Patient verbalizing an uninterrupted sleep in the night. b) Night nurses observing	1. Straighten bed linens to avoid creases and crumps 2.Assist client to have a warm bath and serve warm drinks before bedtime 3.Provide quiet and well ventilated and environment by reducing the volume of radio and television. 4.Group and carry out all nursing interventions whenever possible	1.Bed linens were straightened to prevent wrinkles and creases to ensure comfort 2. Warm bath and warm milo drink was given before bed time. 3.The volume of radio and television set were reduced to provide a quiet environment 4. All nursing activities were made in such a way that they do not disturb his sleep.	28/11/21 at 8:30am	Goal fully met as patient verbalized an uninterrupted sleep in the night and night nurses observed patient sleep for 6-7 about hours in the night.	H S

		patient sleeping undisturbed for about 6-7 hours in the night	5. Restrict visitors during sleeping hours. 6.Serve client with food free of caffeine and nicotine to prevent stimulation. 7.	5. Visitors were limited during sleeping hours. 6.Client was served with food free of stimulants 7. Reassure patient that pain will be relieved of headache.			

Table 8: Patient/Family Nursing Care Plan for Mr. S O A and family continued.

Date/ Time	Nursing Diagnoses	Objective	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
26/011/21 at 8:30am	Imbalance nutrition (less than body requirement) related to loss of appetite	Patient will regain his normal eating pattern within 72 hours as evidenced by a)Patient verbalizing that he has regained his normal eating pattern.	1)Reassure patient he will regain his normal eating pattern 2) Plan diet with patient and family 3)Educate patient and family to serve meals attractively 4) Encourage family to serve soft easily digestible diet 5)Encourage patient to take in more fruits and vegetables	1) Patient was reassured. 2)Diet was planned with patient 3) Patient and family were educated to serve meals attractively. 4) Family were encouraged to serve soft easily digestible 5)Patient was encouraged to take in more fruits and vegetables.	29/011/21 at 8:30am	Goal was fully met as patient verbalized that he has regained his normal eating pattern and nurse observed patient eat more than half	H S

		b)Nurse observing patient eats more than half of meals served	6) Serve patient sweet drinks before meals.	6)Patient was served sweet drinks before meals		of meals served.	

CHAPTER FOUR

IMPLEMENTING PATIENT/ FAMILY CHAPTER FOUR CARE PLAN

4.0 Introduction

According to Hornby (2006), implementation is defined as making something that has been officially decided to start or to be used. Implementation is the fourth stage of the nursing process. It gives a vivid account of the actual nursing care given to the patient / family from the day of admission till discharge based on the health problems identified.

The nurse takes responsibility including the family and other health team members. While implementing care, the nurse should assess the patient's response to nursing care and make alterations where necessary. It also deals with the home visits and follow-ups to ensure continuity of care.

4.1 Summary of Actual Nursing Care Rendered to Patient and Family

The Nursing care rendered to Mr. S.A.O and his family commenced on the day of admission which was,25th November 2021, and continued to termination of care.

The summary of care was written on a daily basis as follows;

Day of Admission -25th November, 2021.

On the day of admission, Mr. S.A.O came to the ward per ambulatory at 11:00am, through the out-patients' department accompanied by a student nurse. On examination and history taking, patient was fully conscious and stable but complained of headache and dizziness.

Patient was diagnosed of hypertension. He was offered a seat and his name was confirmed and his particulars were entered into the admission and discharge book as well as the daily ward state and his folder, whiles assessment was also done on arrival. Some of these included vital signs check which were recorded as:

1.Temperature - 36.3^{oc}

2.Pulse - 79bpm

3.Respiration - 29cpm

4.Blood Pressure - 200/120mmHg

5.Weight - 62kg

He was put on the following drugs;

1.Hydralazine hydrochloride(intravenous) 5mg over 10mins as stat dose.

2. Tablet Amlodipine 10mg once dailyx60days

3.Tablet Lisinopril 5mg once daily x60days

4.Tablet soluble aspirin 300 mg dailyx30days

Diagnostic investigations requested were:

1.Blood sample for malaria parasites estimation.

2.Full blood count

3. Urinalysis

I collected patient's drugs from the pharmacy with patient's health insurance card since he is a registered member of the national health insurance scheme and a holder of the insurance card and the prescribed stat dose was served. Nurses' notes were also written. Patient was made to rest comfortably in a simple unoccupied admission bed in the male's ward of the general ward with bed number M- 9. Vital signs were ordered to be monitored two hourly. On admission, patient complained of headache and an objective was set at 11:00am to relieve patient of the headache within 24 hours and the following interventions were carried out; Patient was

reassured that he will regain his comfort, patient was made comfortable in bed in a noise free environment, the degree and intensity of pain was assessed using the pain rating scale of 0-10.

Vital signs were monitored every two hours, patient was also provided with a radio set to listen to news. At 11:10am on admission, patient also complained of dizziness and an objective was set to relieve patient of dizziness within 24 hours and the following interventions were carried out; Patient was reassured that he will be relieved of dizziness, side rails of bed were raised to prevent patient from falling, complete bed rest was ensured, noise was reduced at the ward by turning off radio and television sets injurious objects like needles were removed from patient, patient was told to call for assistance from any of the nurses when needed. On admission also patient was observed to be anxious and an objective was set at 11:30am to relieve patient of the anxiety within 24 hours and the following nursing intervention were rendered; Patient was reassured that he was in safe hands of competent staff and that his condition was temporal and can be controlled, client's knowledge on hypertension was assessed, client was educated on the condition to clear his fears and misconceptions, client was also allowed to ask questions and express fears, all procedures were well explained to client .At 1:00pm, vital signs were checked and recorded. At 3:00pm, vital signs were checked and recorded. At 6:00pm vital signs were checked and recorded. He had a warm bath at 7:30pm, he took banku with okro stew as supper at 7:45pm. Vital signs were checked and recorded. All procedures were recorded in the nurses' continuation sheet, Patient went to bed around 8:30pm

Second Day on Admission, (26th, November, 2021)

On the second day of admission being 26/11/2021, Mr. S.A.O. woke up at 5:30am. Patient had his bath and his oral care was done. His bed was neatly laid to make him feel comfortable. At 7: 30am, his wife brought porridge and bread to him from the house and I helped him eat his breakfast. At 8:00am, the following a medication were served;

1.Tablet Amlodipine 10mg once daily ×60days

2.Tablet Lisinopril 5mg once daily ×60days

3.Tablet Soluble aspirin 300mg once daily×30 days

Mr. S.A.O.'s vital signs was checked and recorded as temp-36.5, pulse 80bpm, respiration 20cpm and blood pressure 170/110mmHg. At 8:00am, doctor came for ward rounds and reviewed patient, patient said he had no complains so the doctor ordered that we should continue treatment. At 1:30pm, patient was served with kenkey with okro stew and fried fish as lunch. At 11:00am the objective that was set on 25/11/2021 at 11:00am, to relieve patient of headache was evaluated and goal was fully met as patient verbalized relieve of headache. At 11:30am also, objective that was set on 25/11/2021 at 11:30am to relieve patient of anxiety was evaluated and goal was fully met as patient verbalized the relieve of anxiety. At 11:10am also, the objective that was set on 25/11/2021 at 11:10am to relieve patient of dizziness was evaluated as patient verbalized relieve of dizziness. At 4:40 pm, during an interaction with patient and family, I realized that they lack adequate information on the disease condition and an objective was set to enable patient and family gain adequate knowledge on the condition within 24hours and the following interventions were carried undertaken; Ideas of patient/family about their perception of the disease were expressed, rapport was established which created effective communication, the need to gain knowledge on hypertension was explained to client and family, answers were also provided to all questions asked by client and family tactfully, client and family were educated on the disease condition. Patient took Rice and stew for supper at 6:00pm, vital signs were checked and recorded. Patient had his bath at 7:15pm. Bed was made free from creases and crumps and patient slept around 9:00pm.

Third Day on Admission, (27th, November,2021).

Patient woke up at 4:55am in a stable condition as verbalized by the night nurses, he performed his personal hygiene activities as usual including mouth care and had his bath. His vital signs were checked and recorded at 6:05am by the night nurses as temp-37.5C, pulse 93bpm, respiration 21cpm and blood pressure 180/90mmHg. His bed was neatly dressed to make him feel comfortable by the night nurses. He took tea and bread as his breakfast at 7:50am. His prescribed medications below were served at 8:00am;

1.Tablet Amlodipine 10mgx60 days

2.Tablet Lisinopril 5mgx30days

3.Tablet Soluble aspirin 300mgx30 days

At 8:30am, the doctor came for ward rounds and reviewed my patient. Patient complained of difficulty in sleeping the previous night and an objective was set to relieve patient of insomnia within 48 hours and the following interventions were carried out; Bed linens were straightened to avoid creases and crumps, warm milo was served before bed time, the volume of radio and television sets on the ward was reduced to provide a quiet environment, all nursing activities were carried out in such a way that they do not disturb his sleep, visitors were restricted during sleeping hours, client was also served with foods free of stimulants. Later I sought permission from my patient to visit his house to find out the actual and potential problems that may have contributed to his illness and find ways of solving them, he gave me the permission and then I handed him over to the staff present. I went with his wife who came to visit him. At 1:00pm, patient took "Banku" and groundnut soup with tilapia as lunch. At 4:40pm, the objective that was set on 26/11/21at 4:40pm to enable patient and family gain adequate knowledge on the disease condition was evaluated and goal was fully met as patient and family were able to answer questions posed on the disease condition correctly. At 5:00pm, patient had his bath and

took fufu and light soup with meat for supper at 5:30pm. Vital signs were checked and recorded at 6:00pm, patient conversed with other patients on the ward and slept around 9:30pm.

Fourth Day on Admission, (28rdNovember, 2021).

Mr. S.A.O woke up at about 5:40am, moved his bowels, brushed his teeth and had his bath.

At 6:00am his vital signs were checked and recorded as follows: Temperature-36.2˚C, Pulse - 75bpm Respiration-18cpm Blood pressure -160/90 mmHg. Due medications were served as well. I removed the old sheets and made a bed with new sheets for him to make him comfortable and to avoid creases which can cause discomfort to the patient. At 7:30 am, he was served with rice porridge with milk and a slice of bread for breakfast. During the doctor's ward rounds his blood pressure was checked and it was 150/90mmHg. The doctor ordered that we should continue treatment. At 8:30am during the doctor's review, Mr.S.A.O. complained that he had lost appetite and an objective was set to relieve him of the loss of appetite within 24hours and the following interventions were carried out; Patient was reassured, diet was planned with patient and family, patient's family were educated to serve meals attractively, patient' family were also encouraged to serve soft easily digestible diets, patient was also encouraged to take in more fruits and vegetables, patient was served with sweet drinks before meals. At 8:30am also, objective that was set on 26/11/2021 to enable patient regain his normal sleep pattern was evaluated and goal fully met as night nurses verbalized that patient was able to sleep for about 7 hours uninterrupted at night At 12:00pm, Mr. S.A,O took kenkey and fish for lunch with some fingers of banana. Vital signs were checked and recorded. At 5:30pm, his wife brought him Banku and okro soup with fish for him as supper, patient also took two slices of water-melon as dessert. At 7:30pm, patient had a warm bath and patient slept around 8:30pm.

Fifth Day on Admission, 29th November,2021 (Day of Discharge)

My patient woke up at about 5:30am, brushed his teeth and after that moved his bowels. His vital signs were checked and recorded at 6:00am as follows:

- Temperature - 36.5°C
- Pulse - 70 bpm
- Respiration - 16 cpm
- Blood pressure - 130/80mmHg

Mr. S.A.O had his bath after which he took bread and Hausa koko as his breakfast at 7:30am. At 8:00am due medications were served. At 8:30 am, the objective that was set on 26/11/21 at 8:00am to enable patient regain his normal eating pattern was evaluated and goal was fully met as patient verbalized that he has regained his normal eating pattern and nurse observed patient eat more than half of meals served.

Mr.S.A.O. was discharged during the doctor's ward rounds at 11:10am, He was informed about his discharge and was scheduled to come for review on 3rd December, 2021. His name was written in the Daily Ward state and admission and discharge book. I reminded him of the education I gave him and he was able to recall about 95% of it. Mr.S.A.O. was advised to continue with his medication and treatment regimen as prescribed to prevent relapse of the disease. Patient and family were also educated on the dosages of the medications and the side effects each of the drugs were explained to them. he was asked to report to the hospital when symptoms re-occur. He was discharged on the following drugs;

1.Tablet Amlodipine 10mg once daily x 60days

2.Tablet Lisinopril 5mg once daily x 60days

3.Tablet Soluble aspirin300mg once daily x30 days

I helped him packed his things and he went to show his gratitude to the ward-in- charge and other nurses who were present. He settled his bills with the national health insurance card since

he was a registered member of the national health insurance scheme. Patient was ready to go to the taxi station, so I escorted him to the taxi rank where he got a taxi then I bade him farewell. Afterwards I went back to the ward to remove the bed linen and place into dirty linen bin at the sluice room, I carbolized the bed with an already diluted solution of 0.5 percent bleach, bedside locker and chair, and made it ready to receive another patient.

4.2 Preparation of Patient/ Family for Discharge and Rehabilitation

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

Diet The**y** were educated on the importance of taking a well-balanced diet. He was encouraged to continue with low salt diet, fruits and adequate fluid intake to prevent constipation, and finally limit the intake of fatty foods.

Personal and Environmental Hygiene

My patient and his family were educated to maintain good personal and environmental cleanliness. He was advised on twice daily bath, washing of clothes frequently, proper disposal of refuse, weeding around the compound, and also avoids stagnant waters around their house.

Modification of Life Style

Patient was educated on the need to continue with the low salt diets, avoid high intake of fatty food, and avoid strenuous exercise. He was encouraged to continue with the active exercise at home and also adapt the habit of taking more fruits. I also encouraged him not to take alcohol and also avoid smoking.

Stress Tolerance / Management.

Mr. S.A.O. was educated on the management of stress to reduce hypertension. He was advised to prevent stressful situations and share problems with his family. He was also made to understand that, he could also contact someone he trusts for advice when he encounters any problem rather than keeping it to himself and avoid stress.

Drugs and Review

My patient was advised to continue with the medication or treatment regimen as prescribed to prevent relapse of the disease condition. The side effects of the drugs were explained to them. He was told to visit the nearest clinic or report to hospital when symptoms reoccur and come for review as told.

4.3. Follow Up/Home Visit/ Continuity of Care

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

First Home Visit, 27th November, 2021.

On 27 November 2021, being the third day of admission, permission was taken from the patient, Mr.S A.O., to visit his house in an attempt to identify risk factors, vulnerable people and the environmental conditions in the house and to also assess health facility available. The visit was scheduled with patient's wife, who took me to their house at Kasapin in the Ahafo Region with house number ABK-14 whilst patient was still on admission. The main purpose of the visit was to find out the actual and potential problems that might have contributed to the patient's illness

and find ways of solving them before the patient was discharged as well as factors that contribute to good health and also to validate data obtained from patient and family. We took off around 9:40am and reached their house (Kasapin) at 12:00pm. Mr. S O A wife introduced me to some of the family members who were present in the house, they welcomed me and my mission was asked. I introduced myself as a student nurse at Holy Family Nursing and Midwifery Training College, Berekum. I also told them that I am the student nurse taking care of Mr. S.A.O. at the hospital and I came to see where he stays and his family as well. They were very delighted and welcomed me once again after the brief introduction.

Patient stays with his wife and children at Kasapin in a completed self-contained building with house number ABK-14. They have not rented the house. The house is built with blocks, which is plastered and painted and roofed with aluminum iron sheets with three rooms, 3 bathroom and 3 toilets. With the three rooms all have windows, ventilation system was very good. I took the opportunity to encourage them on the need to maintain good ventilation system. Their source of water was tap water and waste is disposed at the community refuse dump which is also not far from their house. I educated them on the need to cover their cooked foods and store the uncooked ones in a hygienic environment and keep their water always safe for drinking, and washing of hands thoroughly before and after visiting the toilet as well as after eating.

The surroundings were clean and tidy. I encouraged them to keep it up. They stored water in a barrel in case the mechanized bore hole in their area does not flow, they use it but I realized that it was not covered because they thought the barrel was in said the house. I took the opportunity to educate them on the need to cover the water in the barrel with a lid regardless it being in the house.

Also, I found out about any health facility in the community. Likely there was a health facility, so walked to the facility to introduce myself as a student Nurse who came to visit a client and I will also be handing over the client to them very soon as am done and patient discharged from the Hospital. I equally met a public health nurse called S B who I personally introduced myself

to her and that I will be back soon so I can go to client house with to handover the health needs of the patient. She accepted and promised be around any time I call on her or wants her to go with to the client house for continuity of care.

The family members were advised on the need to maintain good personal and environmental hygiene and weed around their house since they were near the bush and were more prone to getting malaria, I then educated them on the causes, signs and symptoms of malaria.

They were advised to sleep under treated mosquito net, proper disposal of empty cans and keeping the environment clean and dry. I sought for permission from the family members and left the house around 2:30pm. They saw me off to the roadside where I picked a taxi and came back.

Second Home Visit (After Discharged) 3rd December 2021.

I paid patient and his family a surprise visit on 3rd December,2021 which was three days after patient was discharged. The purpose of the visit was to see how patient was faring at home, remind them of the review date and to assess whether he was taking his drugs as ordered, as well as assess whether he was developing any complication or not.

I set off around 11:10am and reached the house around 12:35pm due to delayance of the taxi driver. Upon entering the house, Mr. S.A.O. was sitting in a chair resting. I greeted them and they were very happy to see me. I asked of their present condition, they said they were very healthy by God's grace and I was given a seat on the corridor and was offered water. Patient asked me to wait while he called for other members in the house. I used the opportunity to observe the cleanliness of the environment, they kept their environment neat and tidy.

When all the family members came, I told them I came to find out how my patient and family were doing and to see his response to the treatment given in the house and also to remind them of the review date. I asked of his wife to bring his drugs and I realized that he was taking his drugs as prescribed.

Emphasis was placed on the need for balanced diet with low sodium, no fatty foods regular exercises, ensuring enough rest and the need to adhere to preventive measures to avoid recurrence. I asked the family members questions about the health education given to them previously and they were able to answer all questions correctly. Upon observation, I saw improvement in the education given as I realized that the house was kept tidy devoid of weeds and had a good drainage system. I praised the family on their positive responds towards the education I gave during the first home visit. Lastly, I reminded them of the review date which was on 5rd December, 2021 and its importance. I informed them that my interaction with them will end on my next visit and I would hand them over to a community health nurse who would continue with the care. I took permission to leave after scheduling to visit them again on the 20th of December 2021.The family thanked me for the visit and I was escorted to the roadside by his wife, and children and I left there around 3:00pm.

Day of Review (5rdDecember,2021)

On the said date of review, I called his wife on the 3nd of December 2021, at 7:00 pm to remind her and her husband about the review, she told me they were preparing to come. Mr. S.A.O accompanied by his wife came to the Municipal Hospital Goaso for review in the morning. On their arrival, I went with patient's wife to collect patient's folder from records. His vital signs were checked and they were within normal ranges, thus, Temperature: 36.2^{o}C, Respiration: 16cpm, Pulse:64bpm and B.P 120/70mmHg. Upon interaction with patient, I observed that his condition had improved.

I went in with patient when he was called to the consulting room at the main out-patient department and upon assessment by doctor A.M, he confirmed that his condition had really improved and expressed satisfaction. The doctor did not prescribe any drugs since there were no new complains. Mr. S.A.O was told by the doctor to continue taking his drugs and also to keep follow-ups on his care. I reminded them again of my last visit to him and family. They thanked me and I escorted them and bade them goodbye

Third Home Visit (20th, December,2021)

On the said date, I went for my third home visit at Kasapim with a public health nurse. Madam S.B from kasapim. The aim of the visit was basically to terminate my care with my patient and family and also to handover to a community health nurse for continuity of care and also aimed at finding out how the patient was doing after the review and also to assess whether they were following the treatment regimen. I set off around 10:30am and I arrived at around 11:00am. Upon arrival, we were welcomed by patient and family. We were offered a seat and they offered us water. Our mission for the visit was asked and I told them that, I came to visit them and find out how Mr. S.A.O was faring and also to handover to a public health nurse to continue with the home care to ensure continuity of care. I asked one of his to bring his drugs and I observed that he was taking his drugs as ordered. He had no complains and since that was my last visit, I highlighted on the various health education given previously. They were grateful and promised to adhere to the education. I therefore introduced the public health nurse to patient and family and handed over patient to the public health nurse at Kasapim health center. At 1:00pm, all necessary information regarding Mr. S.A.O were handed over to her and I told her to pay patient regular home visits and health education and proper monitoring of patient anytime he visits the facility. I also told patient and family not to hesitate to call me anytime they need my help. I used this opportunity to thank them for giving me the chance to use them for the patient and family care study. I told them that, I may not be able to visit them frequently but I will pay them friendly visits anytime I get the opportunity. I bade them goodbye and they escorted me to the roadside to board a car.

CHAPTER FIVE

EVALUATION OF CARE RENDERED TO PATIENT AND FAMILY

5.0 Introduction

According to Smeltzer et al (2017), evaluation in simple terms is the outcome of nursing actions against the anticipated goals and it is the final step in the nursing process. Evaluation is assessment of the patient's position on the health/illness continuum, and of effectiveness of patient care activities in bringing about a change in the patient's position.

This chapter gives information about the statement of evaluation, amendment of nursing goals and the termination of care rendered to the patient and family. It is the final stage of nursing process.

5.1 Statement of Evaluation

After five days of admission and maximum cooperation from the client, his family and staff of the general ward of Municipal hospital Goaso, client fully recovered from his illness and was discharged with all goals fully met. During the admission of Mr. S.A.O, six problems were identified and objectives were set to solve each of them. The degree to which the objectives set for the problems were achieved as discussed below:

1. Patient was relieved of headache

On 25th November 2021, at 11:00am, patient complained of headache and an objective was set to relieve patient of headache within 24hours.The following interventions were carried out: Patient was reassured of regaining her comfort, patient was made comfortable in bed in a noise free environment, the degree and intensity of pain was assessed using the pain rating scale of 0-10, vital signs were monitored every two hours, patient was also provided with a radio set to listen to news. At 11:00am, on 26/11/2021 objectives that was set on 25/11/21 at 11:00am was

evaluated and goal was fully met as patient verbalized the relief of headache and nurse observed patient comfortably relaxed in bed.

2.Patient was relieved of dizziness

On 25/11/2021 at 11:10am, when communicating with patient, patient complained of dizziness and an objective were set to relieve patient of dizziness within24hours.Nursing interventions rendered included: Patient was reassured that he will be relieved of dizziness, side rails of bed were raised to prevent patient from falling, complete bed rest was ensured, noise was reduced at the ward by turning off radio and television sets injurious objects like needles were removed from patient, patient was told to call for assistance from any of the nurses when needed. At 11:10am on 26/11/21, the objective that was set on 25/11/21 at 11:10am to relieve patient of dizziness was evaluated and goal was fully met as patient verbalized the absence of dizziness.

3. Patient was relieved of anxiety.

On 25/11/2021 at 11:30am, patient complained of anxiety. An objective was set to relieve patient of anxiety within 24 hours. The following interventions were rendered; patient was reassured that he was in safe hands of competent staff and that her condition was temporal and can be controlled, client's knowledge on hypertension was assessed, client was educated on the condition to clear his fears and misconceptions, client was also allowed to ask questions and express fears, all procedures were well explained to client. On 26/11/2021 at 11:30am, objectives that was set on 25/11/2021 at 11:30am to relieve patient of anxiety was evaluated and goal was fully met as patient verbalized the relieve of anxiety.

4. Patient and family gained adequate information on the disease condition

On 26/11/2021 at 4:40pm, patient and family lacked adequate information on the disease condition, an objective was set to enable patient and family gain adequate knowledge on the disease condition. The following interventions were carried out; Ideas of patient/family about

them perception of the disease was expressed; rapport was established which created effective communication, the need to gain knowledge on hypertension was explained to client and family, answers were also provided to all questions asked by client and family tactfully, client and family were educated on the disease condition At 4:40pm on 27/11/2021, the objective that was set on 26/11/2021 at 4:40pm to enable patient and family gain adequate knowledge on the disease condition was evaluated and goal was fully met as patient and family were able to answer questions posed on the disease condition correctly.

5. Patient regained her normal sleeping pattern.

On 26/11/2021, at 8:30am, client complained of insomnia. An objective was set to relieve patient of insomnia within 48 hours and the following interventions were carried out; Bed linens were straightened to avoid creases and crumps, warm milo was served before bed time, the volume of radio and television sets on the ward were reduced to provide a quiet environment, all nursing activities were carried out in such a way that they do not disturb his sleep, visitors were restricted during sleeping hours, client was also served with foods free of stimulants. At 8:30 am on 28/11/2021, the objective that was set on 26/11/2021 at 8:30am to relieve patient of insomnia was evaluated and goal was fully met as night nurses verbalized patient was able to sleep for about 6-7 hours uninterrupted at night.

6. Patient regained her normal nutritional pattern.

On 26/11/2021 at 8:30am, client complained of loss of appetite and an objective was set to relieve him of the loss of appetite within 72 hours and nursing interventions carried out included; Patient was reassured, diet was planned with patient and family, patient's family were educated to serve meals attractively, patient' family were also encouraged to serve soft easily digestible diets, patient was encouraged to take in more fruits and vegetables, patient was served with sweet drinks before meals. At 8:30 am on 29/11/2021, the objective that was set on 26/11/2021

at 8:30am to relieve patient of loss of appetite was evaluated and goal was fully met as patient verbalized that he has regained her normal eating pattern and nurse observed patient eat more than half of meals served.

5.3 Amendment of Nursing Care Plan for Partially Met or Unmet Outcome Criteria

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

5.4 Termination of Care.

Every nurse-patient relationship at the hospital needs to be terminated. It involves bringing to an end the care that was started on the client however, this is a very difficult step to take after a good rapport has been established. Because of this, the reality of termination of care has to be made known to both patient and family from the day of admission. Patient and family members were made to understand that patient's hospitalization was temporal since he would be discharged after his condition had improved. They were also told that I would not be able to stay on the ward for 24 hours with them, hence the need for their co-operation with other nurses and paramedical staff on the ward. The preparation started on the day of admission until day of discharge. Three visits were undertaken. The first visit was carried out on the 27thof November, 2021.The interaction was smooth as client's improvement began on admission through to discharge on 29th November,2021 with good nursing and medical care. Termination of care began from the first follow up visit. The purpose of this visit was to find out the actual and potential problems that contributed to patient's condition and ways to solve them and also to validate data obtained from patient and family. On arrival I realized that the house was untidy so I educated family members on the need to keep good environmental hygiene like proper disposal of refuse, sleeping under a treated mosquito net and the need to weed around their house whenever it is bushy. The second home visit was on 3rd December 2021.This was a surprise visit, the purpose of this visit was to find out how the patient was faring at home,

compliance to treatment regimen (e. g continuation of medications) and to remind them of the review date and also about the termination of care which would be on my last visit. Upon observation client was looking strong and healthy, and the surroundings were tidy and clean, this was an indication that client was adhering to treatment regimen and client and family were also adhering to the education given to them. Emphasis was made on the health education rendered previously like taking low sodium diets, keeping environmental hygiene, regular exercising, low or no fatty foods and also ensuring enough rest. 20th December, 2021 was the day of my last visit, I visited my patient and family at Kasapin with a public health nurse from kasapin community health Centre called Miss S B to ensure continuity of care. All necessary information that will be needed for Mr. S O A 's care was given to the public health nurse at Kasain health Centre to promote quick and effective care that will be rendered to patient without any difficulties. I promised to visit the family as well as the public health nurse anytime I had the opportunity, to know how patient was faring and thanked them sincerely for their co-operation. I sought their permission to leave at 2:00pm and Mr. S O A escorted me to the roadside.

CHAPTER SIX

SUMMARY AND CONCLUSION

6.0 Introduction

According to Hornby 2006, summary is a brief account giving the main point to a health problem. This is the last step of the patient/family care study which entails the student's personal appreciation of the therapeutic relationship with the patient as well as the use of the nursing process.

6.1 Summary

Mr. S O A is a Forty-one-year-old man who works in the forestry ministry from Gambian number1 who was admitted to the male's unit of the General Ward of the Municipal Hospital Goaso on the25th of November, 2021 Patient was diagnosed of Hypertension by the attending doctor, doctor A M. On observation and examination on admission he was fully conscious and stable. Client was warmly welcomed and his particulars entered into the admission and discharge book and daily ward state, vital signs were taken and recorded. Client and some family members were orientated to the ward and its surroundings. Client's identified problems included;

1. Headache
2. Dizziness.
3. Anxiety
4. Inadequate knowledge on the condition
5. Inability to sleep well(insomnia)and
6. Loss of appetite.

The prescribed drugs included; Tablet Amlodipine 10mg once daily x60 days, Tablet soluble aspirin 300mg once daily x30 days. Tablet Lisinopril 5mg once dailyx60 days, Hydralazine 5mg slowly over 5 minutes then 15mg in a crystalloid which were anti-hypertensives and an

analgesic/anti-coagulant. Laboratory investigations ordered were full blood count and blood sample for malaria parasites which were all carried out as ordered.

Nursing objectives were set, orders implemented and goals were fully met within time after interventions

Mr. S O A was nursed for a total of five days from 25thNovember to 29th November 2021, recovered fully and was discharged and reviewed on 5rd December 2021. Home visits were made to client and family on three occasions and all needed education were carried out and reinforced to client's family. First home visit took place on 27nd November, 2021, second home visit was on the 3th December, 2021.Client's care was finally terminated on the third home visit, 20th of December 2021 where he and his family were handed over to the community health nurse for continuity of care and they were thanked for their co-operation.

6.2 Conclusion/Recommendation

According to McIntosh (2013), a conclusion is the final part of something. The care rendered to Mr. S O A and his family has really helped me realized how important holistic care is and how important it is to involve the family in the care of an individual or client. It has broadened my knowledge on the disease condition and how to prevent it as well as well as the complications involved. The study has unbroadened my knowledge on hypertension and its management. It has also helped me to practice my skills acquired in the classroom theoretically. It is my recommendation that all students are given the opportunity to embark on the patient/family care study to implement the nursing process in order to render individualized care to patients and families.

APPENDIX

Table 5.1 shows the vital signs recorded for Mr. S O A

DATE	TIME	BLOOD PRESSURE (mmHg)	TEMPERATURE (℃)	PULSE (bpm)	RESPIRATION (cpm)
25/11/2021	4:00pm	200/110	36.3	69	16
	10:00pm	180/110	36.1	72	22
26/11/2021	6:00am	170/110	36.5	80	20
	4:00pm	170/100	36.3	74	19
	10:00pm	180/90	36.2	65	17
27/11/2021	6:00am	180/90	37.5	80	20
	4:00pm	170/100	36.6	86	22
	10:00pm	160/100	36.7	72	16
28/11/2021	6:00am	160/90	36.2	75	18
	4:00pm	160/80	36.6	86	22
	10:00am	150/90	36.1	73	17
29/11/2021	6:06am	130/80	36.5	70	20

Two hourly Blood Pressure Check

DATE	TIME	BLOOD PRESSURE (mmHg)
25/11/2021	2:00pm	200/120
	4:00pm	200/110
	6:00pm	190/110
	8:00pm	190/100
	10:00pm	180/110
26/11/2021	12:00am	180/100
	4:00am	180/110
	6:00am	170/110
	8:00am	160/100
	10:00pm	180/100
	12:00pm	150/100
	2:00pm	160/110
	4:00pm	170/100
	6:00pm	150/90
	8:00pm	170/90
	10:00pm.	180/90

Four hourly Blood pressure check.

DATE	**TIME**	**BLOOD PRESSURE (mmHg)**
27/11/2021	12:00am 4:00am 8:00am 12:00pm 4:00pm 8:00pm **TIME**	160/90 170/90 160/100 160/100 170/110 150/90
28/11/2021	12:00am 4:00am 8:00am 12:00pm 4:00pm 8:00pm	150/90 150/80 160/80 170/90 160/90 140/90

29/11/2021	12:00am	140/80
	4:00am	140/90
	6:00am	130/90
	8:00am	130/80

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OTHER

Patient's folder number- 011989/21. (Goaso Municipal Hospital.)

SIGNATORIES

THE STUDENT NURSE

NAME: SAASOR HAPPY

SIGNATURE .....

DATE 10th October 2022

THE NURSE IN-CHARGE, GENERAL WARD GOASO MUNICIPAL HOSPITAL

NAME: MR. ADU SARFO FELIX

SIGNATURE .....

DATE 10/10/2022

THE SUPERVISOR, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

NAME: MR. JOSEPH APPIAH

SIGNATURE .....

DATE 10/10/2022

THE PRINCIPAL, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

NAME: MONICA NKRUMAH

SIGNATURE .....

DATE 11th October 2022

ACADEMIC CO-ORDINATOR-NURSING
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